Report on Multiplicative Auditing and Monitoring of Certain Service Providers

to

Joint Legislative Oversight Committee on Health and Human Services

and

Fiscal Research Division

Session Law 2015-241, Section 12F.14

December 1, 2015

North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

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The national accreditation requirement went into effect in 2005 for providers of enhanced behavioral health (mental health and substance use) services covered under the Division of Medical Assistance (DMA) Clinical Coverage Policy 8-A and for the corresponding State-funded services. In an effort to offer providers sufficient choice in selecting the national organization from which to pursue national accreditation, four national accrediting bodies were approved by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) in Communication Bulletins # 36 – 4/11/2005 and #50 – 11/14/2005:

- Council on Accreditation of Rehabilitation Facilities (CARF)
- Council on Accreditation (COA)
- Council on Quality and Leadership (CQL)
- The Joint Commission (TJC)

The accreditation requirement for providers of Community Alternative Programs for Individuals with Mental Retardation or Developmental Disabilities (CAP-MR/DD) services (now referred to as services under the Innovations Waiver) went into effect with Session Law 2008-107 Section 10.15A(c) which also established benchmarks for attaining national accreditation. This national accreditation requirement for 1915(c) services applies to most Innovations waiver services with a few exceptions.

The Department of Health and Human Services (DHHS) was directed by the General Assembly in Session Law 2005-276 Section 10.35(A)(a) to study the feasibility of establishing an accreditation requirement for residential treatment facilities. Mental health residential treatment facilities were subsequently required to become nationally accredited as part of the General Assembly's effort to restructure children's mental health, developmental disabilities and substance abuse residential services in Session Law 2008-107 Section 10.15A(e3).

Per GS § 122C-81, providers who were enrolled in the Medicaid program or contracting for State-funded services prior to July 1, 2008 were given a three year window from the time of enrollment to become nationally accredited. Providers enrolled in the Medicaid program or contracting for State-funded services on or after July 1, 2008 who were providing services which required national accreditation were required to complete all accreditation requirements within one year of enrollment in the Medicaid program or within two years of contracting to provide State-funded services.

The accreditation requirement only applies to provider agencies, not to licensed independent practitioners. Many providers offer diversified services across disability areas. Providers choose the area of accreditation or service-specific standards that will be pursued in consultation

with the accrediting body. When the corporate entity attains national accreditation, that accreditation applies across the agency.

Most providers contract with more than one local management entity-managed care organization (LME-MCO). The following chart gives an indication of the number of providers that contracted with the LME-MCOs based on a survey conducted in June 2014. These figures include provider agencies and licensed independent practitioners in solo or group practices. To the extent possible, an effort was made to eliminate unduplicated counts.

Number of Providers that Contract with More than One LME-MCO Based on June 2014 Data	
# of providers that contract with 1 LME-MCO:	1817
# of providers that contract with 2 LME-MCOs:	622
# of providers that contract with 3 LME-MCOs:	210
# of providers that contract with 4 LME-MCOs:	109
# of providers that contract with 5 LME-MCOs:	43
# of providers that contract with 6 LME-MCOs	34
# of providers that contract with 7 LME-MCOs:	25
# of providers that contract with 8 LME-MCOs:	20
# of providers that contract with 9 LME-MCOs:	21
Total # of Providers:	**2901**

Currently, there are approximately 2,570 provider agencies that contract with the LME-MCOs to provide Medicaid and State-funded services.

Accreditation Status of Behavioral Health Providers by National Accrediting Organization October 2015				
	CARF	COA	CQL	TJC
# of Accredited Providers	626	85	89	348
# of Providers In Process of Being Accredited	162	5	2	
Total	**788**	**90**	**91**	**348**

There are currently approximately 1,150 provider agencies with national accreditation and 169 providers in the process of becoming accredited.

The national accreditation process looks at the organizational structure and governance of the agency, the quality of services provided and outcomes for the recipients of those services. Accrediting bodies evaluate providers against uniform standards of care and business practices for behavioral health services.

The national accreditation process involves a desk review and one or more on-site reviews. The period of accreditation ranges from 3 years (CARF and TJC) to 4 years (COA and CQL).

Auditing and Monitoring Activities to Which Service Providers are Subject

In addition to the national accreditation requirement, provider agencies are subject to monitoring by the LME-MCOs, by the Division of Health Service Regulation (DHSR) and by DMH/DD/SAS.

Local Management Entity-Managed Care Organization (LME-MCO) – Session Law 2002-164 included the responsibility for the local monitoring of providers as one of the core functions of the LME-MCO under GS §122C-115.4(2). Furthermore, under the 1915(b)(c) waiver, providers enroll, contract with and are reimbursed by the LME-MCO rather than by the State. With the advent of the waiver, many of the responsibilities for the monitoring and auditing of providers were passed from the State to the LME-MCO, specifically routine monitoring of providers under 10A NCAC 27G.0601.

The DHHS Provider Monitoring Collaboration Workgroup was formed as the vehicle through which the State works with the LME-MCOs, providers and other stakeholders to establish uniform standards for conducting routine monitoring of providers. State-level participation in the workgroup includes the DHSR, DMA, DMH/DD/SAS, the Division of Social Services (DSS) and the North Carolina Council on Developmental Disabilities. All LME-MCOs participate in the workgroup as well as representatives from various provider organizations including Benchmarks, National Alliance for the Mentally Ill, NC Association of Rehabilitation Facilities, NC Mental Health Consumers' Organization, the NC Providers Council, the Professional Association Council, the Provider-LME Leadership Forum and representatives from the regional Consumer and Family Advisory Committees (CFAC).

State-level participation in the workgroup provides technical and logistical support in tool construction, design, automation and revisions, conducts research and data analysis and provides clarification of rules, statutes and policies to ensure compliance with federal and state requirements and contract provisions.

The central focus of the Provider Monitoring Workgroup is to develop tools and protocols for conducting routine monitoring of providers to reduce duplicative monitoring requirements in compliance with Session Law 2009-451. Session Law 2009-451 directed the Department to implement procedures to reduce the administrative burden on LME-MCOs and providers in assessing compliance with state requirements, to monitor implementation of the process and to make necessary refinements to increase the efficiency and effectiveness of the process.

A guiding principle in the development of the tool for routine monitoring was the elimination of items which were duplicative of DHSR surveys of licensed facilities and to promote the use of data analytics to monitor provider performance. Through the workgroup's process improvement efforts, there has been a substantial reduction in the number and scope of items on the routine monitoring tools, consolidation of tools and clarification of guidelines and protocols to increase reviewer reliability across LME-MCOs.

The LME-MCOs' provider monitoring process is designed to promote North Carolina's commitment to ensuring high quality services for individuals with mental health, intellectual/ developmental disabilities, and substance use issues. LME-MCOs monitor providers in the following contexts:

- Routine Monitoring

    - This process is used by LME-MCOs to monitor providers of publicly-funded MH/IDD/SA services, reviews both Medicaid-funded and State-funded services and includes the tools and guidance for monitoring licensed independent practitioners (LIPs) and MH/IDD/SA provider agencies and occurs on a 2 year cycle.

    - The Routine Monitoring Tool is designed to monitor all GS § 122C MH/IDD/SA services that are not licensed by DHSR and those services that are licensed by DHSR which are not surveyed by DHSR on an annual basis (e.g., PSR, Day Treatment, ADVP-IDD, SAIOP, SACOT, etc.). Attachment A identifies the services that are licensed under GS § 122C and the frequency with which surveys are conducted.

    - The LME-MCO accepts DHSR's surveys of residential facilities and opioid treatment programs in lieu of a routine review of these services since DHSR surveys these services on an annual basis (i.e., every 12-15 months). The

LME-MCO only conducts post-payment reviews of residential and opioid treatment programs.

- The Routine Monitoring Tool is used with providers of enhanced, residential, Innovations, other state-funded services, and outpatient behavioral services.

- Routine provider monitoring consists of two components--a routine review and a post-payment review which may be done together or separately. There are separate review tools for provider agencies and LIPs.

    - The routine review looks at protection of rights in terms of notification of rights, consent to treatment, release of information, coordination of care, access to treatment, including crisis services, the use of restrictive interventions, responsiveness to complaints and the reporting and follow-up on incidents.
    - Post-payment reviews are based on paid claims and are conducted to assure that the documentation to support service provision meets the requirements for reimbursement and billing, including the qualifications of the staff who provided the service.

- In addition to the routine review and the post-payment review, two tools have been developed to specifically monitor unlicensed facilities:
    - The Unlicensed Site Review Tool is used when an unlicensed site is added or moved to a new location. This tool looks at the accessibility of the service for individuals with physical limitations, the assurance of the security, privacy and confidentiality of program participants' personal health information by compliance with the Health Insurance Portability and Accountability Act (HIPAA) requirements.
    - There is also a tool for monitoring unlicensed alternative family living (AFL) programs. This tool looks at the accessibility of a medical preparedness plan, the accessibility of a participant's emergency information, completion of a background check for any persons in the home providing services, the presence of a back-up plan in the case of caregiver illness or emergencies, and the management of funds by maintaining an accurate accounting of receipts and disbursements from participants' personal financial accounts. The Unlicensed AFL Review Tool is used to monitor new unlicensed programs. This tool is used on an annual basis for

unlicensed AFLs under the Innovations Waiver and every two years for all other unlicensed AFLs.

Section 10.15(x) of Session Law 2008-107 requires LME-MCOs to be accredited. The Utilization Review Accreditation Committee (URAC) accredits all of the LME-MCOs with the exception of Cardinal Innovations which is accredited by the National Committee for Quality Assurance (NCQA). Several variances have been requested and approved by the Utilization Review Accreditation Committee (URAC) in an effort to reduce duplication and administrative burden in the system, including the delegation of local monitoring of designated licensed facilities to DHSR in lieu of the LME-MCO conducting routine monitoring of those licensed facilities and the ability of an LME-MCO to accept the credentialing of a provider by another LME-MCO to facilitate timely access to medically necessary services and to minimize the disruption in treatment.

In addition, the Provider Monitoring Workgroup drafted a proposal to allow LME-MCOs to accept the results of routine monitoring conducted by another LME-MCO when a provider contracts with multiple LME-MCOs. The Utilization Review Accreditation Committee (URAC) granted a variance to the URAC-accredited LME-MCOs for this to occur by waiving the requirement in their standards for all accredited entities to monitor the providers with which they contract. This proposal has been approved by the LME-MCO CEOs but has not been has not been fully implemented; however, some LME-MCOs have participated in joint monitoring of providers they share. When fully implemented, a substantial reduction in the volume of monitoring is expected.

Attachment B provides additional information on the background and accomplishments of the Provider Monitoring Workgroup through September 2014. On October 1, 2015, new tools for provider monitoring were implemented. These tools represent the culmination of approximately 15 months of intensive review of the guidelines and criteria for scoring the items on the tools in order to increase consistency and redundancy. The result of this effort was additional streamlining and consolidation of the tools for routine monitoring. Additional information about the routine monitoring of providers and the new tools can be found on the Provider Monitoring web page at http://www.ncdhhs.gov/providers/provider-info/mental-health/provider-monitoring.

- Other Monitoring Conducted by the LME-MCOs
    - Targeted reviews based on incident reports, complaints and quality of care issues including investigation of health and safety concerns and allegations

- Focused reviews based on over or underutilization of services or the provision of services in a manner that does not maintain fidelity to the service definition

These reviews are conducted on-site, via desk review or by a combination of both methods.

North Carolina Division of Medical Assistance (DMA) - The post-payment reviews and the program integrity activities conducted by the LME-MCOs are under the guidance of DMA. These activities are authorized under 42 CFR 455 and 42 CFR 456 involve auditing claims for overpayments, recovering improper payments and to detect and address fraud, waste and abuse. LME-MCOs are required to conduct routine post-payment reviews every two years. Program integrity reviews are conducted on a random and targeted basis. Under the guidance of the DMA Program Integrity Behavioral Health Section, the LME-MCOs use a sanctions grid to determine the appropriate disposition for non-compliance in certain areas. Substantiated cases of fraud and abuse are referred to DMA for follow-up.

North Carolina Division of Health Service Regulation (DHSR) - The Mental Health Licensure and Certification Section (MHLC-S) licenses and regulates 32 different types of residential and day programs for individuals with mental illness, developmental disabilities and substances abuse issues. These are:

- 2,219 residential facilities: This includes a variety of group homes, residential facilities and apartment programs. Three hundred and thirty seven (337) are licensed as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IIDs)
- 1,524 day facilities: This includes vocational programs for individuals with developmental disabilities, day programs for people with mental illness, as well as day programs for individuals with substance abuse issues. There are 49 methadone clinics.

The MHLC-S has two branches: the ICF-IID Branch and the Mental Health Branch.

The MHLC-S is the state survey agency responsible for certification and recertification of ICF-IIDs, on behalf of the Centers for Medicare and Medicaid Services (CMS). The ICF-IID Branch conducts initial certification and annual recertification surveys, as well as complaint and follow up surveys. All surveys performed by the ICF-IID branch include observation, interview, and record review to determine compliance with the federal regulations governing this program.

The Mental Health Branch conducts state licensure and regulatory activities pursuant to NCGS § 122-C for all other non ICF-IID residential and day facilities. These include initial, annual, complaint and follow up surveys to determine compliance with the NC

administrative rules. The MHLC-S is mandated to conduct annual surveys of all residential facilities (NCGS § 122C-25). Annual surveys occur on a 12-15 month basis. This mandate began in 2007, and the section has met that mandate since that time. In addition, due to some serious incidents and deaths in methadone clinics, the MHLC-S began conducting annual surveys of the methadone clinics in 2008.

The MH Branch surveys are on site. The purpose is to determine if quality of care and treatment is being provided in a safe and healthy environment. Surveys are conducted through observation of interactions between consumers and staff; interview of consumers, staff and collateral contacts; and record review of incident reports, progress notes, and other relevant information.

Pursuant to North Carolina General Statute § 122C-24 and § 122C-24.1, the MHLC-S can impose fines, and deny, suspend or revoke a license.

Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) – In compliance with the Office of Management and Budget's Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (2 CFR 200), the Division conducts annual reviews of the Community Mental Health Block Grant (CMHBG), the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and the Program for Assistance in Homelessness (PATH). Since the LME-MCOs, as subrecipients of DMH/DD/SAS, have divested of direct service provision, these reviews also include providers with which the LME-MCOs contract in order to carry out the special programs and services associated with these programs.

DMH/DD/SAS manages the Incident Response Improvement System (IRIS), a web-based system for providers to report and document responses to Level II and III incidents involving consumers receiving mental health, developmental disabilities, and/or substance use services. Providers of publicly-funded services licensed under NC General Statutes §122C (Category A providers), except hospitals, and providers of publicly funded non-licensed periodic or community-based services (Category B providers) are required to report these incidents. Follow-up and monitoring of these incidents are done by the LME-MCOs and in collaboration with DHSR for licensed facilities.

In connection with the Harold Rogers Prescription Drug Monitoring Program, DMH/DD/SAS conducts a desk review on the prescribing of controlled substances by providers and an on-site inspection when controlled substances are dispensed in a treatment program. Under GS §122C-100 of the NC Substance Abuse Control Act, DMH/DD/SAS is responsible for the registration of facilities that distribute and manufacture controlled substances and for witnessing the destruction of expired controlled substances in hospitals, clinics and in long-term care facilities.

Plan for Further Addressing Multiplicative Auditing and Monitoring

In the development of the routine monitoring tools, any monitoring that was found to be duplicative of the DHSR survey process was eliminated, thereby reducing the amount of monitoring required by the LME-MCOs. Moreover, the variances granted by URAC -- for LME-MCOs to accept each other's credentialing and to accept another LME-MCO's monitoring -- further reduce duplication. However, despite these strides and efforts to delineate responsibilities between DHSR and the LME-MCOs, some duplication of monitoring continues to occur (e.g., in the case of quality of care concerns). The LME-MCO has an obligation to investigate some provider issues by virtue of their oversight role as the local mental health authority and due to the risk assumed by the LME-MCOs as managed care organizations. While DHSR has the authority to impose fines, deny, suspend or revoke licenses, their purview is limited to licensed services. The LME-MCO has a broader span of responsibility – for the service system as a whole (including licensed and unlicensed services and licensed professionals). They also have a responsibility as payer to ensure the integrity of the billing and reimbursement for publicly-funded services. Conducting service authorizations and utilization reviews, post-payment reviews and program integrity activities are responsibilities that are specific to the LME-MCO. Sometimes issues arise when DHSR reports a finding related to a licensed provider and the LME-MCOs take action based on that finding. The DHHS is working with the LME-MCOs to further explore reasonable resolution in these situations.

There has been some collaboration among LME-MCOs in coordinating the scheduling of on-site monitoring visits, however, each LME-MCO has tended to conduct their own monitoring. Reciprocity in terms of accepting each other's monitoring and devising a methodology by which the sampling would be inclusive enough to allow adequate sampling across the LME-MCOs has not been achieved and needs to be fully implemented in order to reduce inefficiencies in the system. Provider monitoring does involve a level of risk management, and each at-risk entity is ultimately responsible for determining what level of risk is worth an increased burden on providers. The DHHS is working closely with representatives of providers and LME-MCOs to facilitate this collaboration.

Session Law 2015-286 provides another avenue through which efficiency in monitoring can be achieved in directing the NC Commission for Mental Health, Developmental Disabilities and Substance Abuse Services to establish procedures for providers who are nationally accredited to be exempted from any routine monitoring that is duplicative of the national accreditation process while at the same time giving the Secretary of DHHS the ability to perform inspections and monitoring that is not duplicative of the national accrediting bodies. Under the provisions of Session Law 2015-286, no requirements of federal law may be waived. Areas of duplication can be identified by conducting a crosswalk of the national accreditation standards to the areas looked at during routine monitoring and further delineating the responsibilities of the State and the LME-MCOs for monitoring providers.

Due to the short period between the assignment of this report to DHHS and the due date of December 1st, an in-depth analysis of every element of inspection common to various options under the four accrediting bodies could not be crosswalked to all provider monitoring activities undertaken by the LME-MCOs. Additionally, because providers can select their accrediting body and because they have some additional options in selecting elements to subject to accreditation, a simple recommendation that a particular element of provider monitoring be exempted for all

providers is unlikely. By March 1st, 2016, DHHS plans to have a firm plan, with initial implementation, for how LME-MCOs will be directed to analyze each agency's accreditation and determine which elements of accreditation are duplicative with routine provider monitoring. DHSR and program integrity (post-payment review) monitoring cannot be waived due to federal and state regulations.

Licensed MH/DD/SA Services and Frequency of Surveys Conducted by DHSR Mental Health Licensure and Certification Section
Survey Categories Types of Surveys Conducted
January 2013

			Type of Survey		
Service Category	**Name of Service**	**Residential or Day**	**Annual (w/n 15 mo.)**	**Complaint**	**Follow-Up**
.1100 Partial hospitalization-Individuals-Acute MI	Partial Hospital	Day		X	X
.1200 Psychosocial Rehab-Individuals-SPMI	Psychosocial Rehabilitation	Day		X	X
.1300 Residential treatment-Minors—Level II	Residential Treatment Level II	Residential	X	X	X
.1400 Day treatment-Minors-MI	Child and Adoldescent Day Treatment	Day		X	X
.1700 Residential Tx Staff Secure-Minors-Level III	Residential Treatment Level III	Residential	X	X	X
.1800 Intensive Residential Tx-Minors-Level IV	Residential Treatment Level IV	Residential	X	X	X
.1900 PRTF – PRTF-Minors	Psychiatric Residential Treatment Facility (PRTF)	Residential	X	X	X
.2100 Specialized community residential for individuals with developmental disabilities	Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities	Residential	X	X	X
.2200 Before/after school & summer-Minors-IDD	Before and After School Day Care Program Operated by NC Public Schools	Day		X	X
.2300 ADVP-IDD	Adult Day Vocational Program	Day		X	X
.2400 Day Services for children-IDD	Developmental Day Care Program	Day		X	X
.3100 Non-hospital med detox	Non-Hospital Medical Detoxification	Residential	X	X	X
.3200 Social setting detox-SA	Social Setting Detox	Residential	X	X	X
.3300 Outpatient detoxification-SA	Ambulatory Detoxification	Day		X	X
.3400 Residential treatment-SA	Medically Monitored Community Residential Treatment; Residential Recovery Program for Adolescents	Residential	X	X	X
.3500 Outpatient-Individuals with SA	Substance Abuse Outpatient Facility	Day		X	X
.3600 Outpatient narcotic addiction treatment	Opiod Treatment	Day	X	X	X
.3700 Day treatment-Adults-SA	Day Treatment for SA	Day		X	X
.4100 Therapeutic res-Adults/Child	Non-Medical Community Residential Treatment (NMCRT)	Residential	X	X	X
.4300 Therapeutic Community-Adults-SA	Supervised Therapeutic Community	Residential	X	X	X
.4400 SAIOP	SA Intensive Outpatient Program (SAIOP)	Day		X	X
.4500 SACOT	SA Comprehensive Outpatient Treatment (SACOT)	Day		X	X
.5000 Facility based crisis-All disability groups	Facility-Based Crisis Services	Residential	X	X	X
.5100 Community respite-All disability	Community Respite	Residential	X	X	X
.5200 Residential camps-Minors	Residential Therapeutic (Habilitative) Camp; Wilderness Camp	Residential	X	X	X
.5400 Day activity-All disability	Day Activity	Day		X	X
.5500 Sheltered Workshops-All disability	Community Rehabilitation Program	Day		X	X
.5600**A** Group homes-Adults-MI	Supervised Living MI Adult	Residential	X	X	X
.5600**B** Group homes-Minors-IDD	Supervised Living DD Minor	Residential	X	X	X
.5600**C** Group homes-Adults-IDD	Supervised Living DD Adult	Residential	X	X	X
.5600**D** Group homes-Minors-SA	Supervised Living SA Minor	Residential	X	X	X
.5600**E** Adult Halfway House-SA	Supervised Living SA Adult	Residential	X	X	X
.5600**F** Alternative family living	Supervised Living/Alternative Family Living	Residential	X	X	X