COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE POLICY AND PROCEDURES MANUAL				
Chapter **Program Quality**	**Section** **Provider Network Management**	**Chapter** **05**	**Section** **05**	**Subject** **09**
Subject **Monitoring of Contracted Providers & CMHA Operated Programs**	**Authorization**		**Approved: 02/26/19** **Replaces: 12/30/14 (and replaces #05-04-06 Dated 06/25/13)**	

Updated: December 2020; Updated January 2022

I. PURPOSE: To establish policy and procedure for monitoring the performance of contracted providers and Community Mental Health Authority (CMHA) operated programs.

II. APPLICATION: CMHA providers employed directly, contracted, or subcontracted by CMHA.

III. POLICY: CMHA will regularly monitor the performance of CMHA operated programs and providers under contract with CMHA that provide services to CMHA consumers to ensure compliance with CMHA policy and contract as well as Federal and State standards and regulations. CMHA will ensure that providers are aware of all information necessary to provide care to consumers and to comply with CMHA's administrative requirements.

IV. DEFINITIONS: **MDHHS**: Michigan Department of Health and Human Services
CMHSP: Community Mental Health Services Program

V. PROCEDURE:

A. CMHA will monitor the performance of providers under contract with CMHA and CMHA operated programs that provide services to CMHA consumers. CMHA will verify that sub-contract providers residing and providing services in bordering states meet all applicable licensing and certification requirements within their state. The monitoring and evaluation process consists of the following applicable elements using audit tools developed for this purpose:

1. Federal regulations, including the Balanced Budget Act (BBA), applicable Code of Federal Regulations (CFRs), HIPAA, CMS protocols, accreditation standards, and applicable federal laws pertaining to the Medicaid Program and/or health plan.
2. State regulations, including PIHP/MDHHS Contract, Michigan Mental Health Code, Mental Health Administrative Rules, and Public Health Code.
3. Managed care administrative delegations made to contract providers, if applicable.
4. Contract provider participation standards.
5. PIHP and/or CMHA policies, standards, and procedures.

B. The Contract Manager/Program Director responsible for specific provider sub-contracts will coordinate contract reviews at designated intervals throughout the term of each contract. Provider performance will be reviewed no later than 30 calendar days subsequent to the date occurring one year after the previous year's visit (i.e., a site that

was visited on June 6, 2017 must be visited again *no later than* July 6, 2018); reviews can be conducted more frequently if deemed necessary. All CMHA operated programs will be reviewed no later than 30 calendar days subsequent to the date occurring one year after the previous year's visit (i.e., a home that was visited on June 6, 2017 must be visited again *no later than* July 6, 2018); reviews can be conducted more frequently if deemed necessary.

A service site where there is a contract but no placements **does not have to be visited**; however, when a recipient is placed, the CMHA Rights Office must be informed. In order to assure adequate rights protection is available, it will be the responsibility of the Office of Recipient Rights to visit or to assure that a visit is conducted at that site **within 10 business days**. The Recipient Rights Officer may accept a recipient rights site review conducted by another Michigan CMH, if after it is reviewed is found to be compliant with all required standards. If this is the case, a letter of acceptance of the review must be sent to the contracted site by the Recipient Rights Officer and a copy kept on file within the Recipient Rights Office of this CMHA.

C. Contract provisions that may be reviewed for provider compliance may include, but are not limited to:
- **1.** services provided
- **2.** billing
- **3.** employee training
- **4.** credentialing
- **5.** reporting
- **6.** recordkeeping
- **7.** recipient rights
- **8.** health and safety

D. The applicable site review forms (i.e., vocational, residential, Rights, etc.) required by NorthCare and/or MDHHS will be utilized for the site reviews; all indicators that are scored as 'No' (not compliant) will require a plan of correction (POC). Compliance ratings are:
- **1.** 95% and above = Full Compliance – POC is due within 30 days of report. Each standard scoring Partially Met and Not Met must be addressed in the POC.
- **2.** 90% but less than 95% = Partial Compliance – POC is due within 30 days of report. Each standard scoring Partially Met and Not Met must be addressed.
- **3.** 85% but less than 90% = Conditional Compliance – POC is due within 30 days of report and implemented within 180 days of report for each standard scoring Partially Met and Not Met.
- **4.** Less than 85% = Requires review of the contract, probation, and/or additional sanctions up to and including termination of contract. POC, as applicable, is due within 30 days and implemented within 90 days.

E. If during the review, a site review team member identifies an issue that places a consumer(s) in imminent risk to health or welfare, the site review team will invoke an immediate review and response by the provider.

F. Each contract/CMHA operated program is unique, so each review may be tailored to address relevant contract/program provisions.

G. Monitoring and Evaluation Findings:

1. The Contract Manager/Program Director will assemble information received from individual reviewers as applicable and complete a final site review form (applicable to the provider), to include recommendations for improvement in the event of non-compliance with contract provisions/indicators.

2. A report detailing the provider's overall review and findings will be provided to the provider's CEO and/or designee within 45 days of the on-site or desk audit review. The report will contain findings pertaining to each indicator reviewed and recommendations pertaining to any finding that did not meet full compliance.

H. Plan of Correction (POC)

1. If a POC is required, it is due to CMHA within 30 days of the provider receiving the site review results.

2. CMHA will provide a letter to the provider, responding to the POC, that will contain acceptance of the POC, request additional information or further recommendation(s), and a deadline for submission of verification the POC is complete.

3. If a POC is required but is not submitted by the provider, a second request for the POC will be sent to the provider via certified mail. This request will give the provider 14 days to submit the POC. If the POC is not submitted within those 14 days, the Contract Manger, appropriate Program Director, and/or CEO/designee will send another letter indicating that the POC is past due and must be submitted within 14 days; if the POC is not submitted within those 14 days, the provider will be notified of CMHA's decision to withhold further payment until the provider submits evidence that deficiencies have been corrected.

4. If deficiencies are not corrected by the date indicated in the site review report and/or the POC, the Contract Manager and/or appropriate Program Director will notify CMHA's CEO and/or Compliance Liaison and discuss necessary action to take which could be, but not limited to:

a) Further corrective action.

b) If CMHA operated program, schedule a meeting with the appropriate supervisor and/or Program Director.

c) If a contract provider, recommendation for contract suspension until problem area(s) is corrected and approved by CMHA.

d) If a contract provider, notify CMHA's payables department to withhold payment until the provider submits evidence that deficiencies have been corrected. CMHA shall also notify NorthCare and other organizations, as applicable.

e) If a contract provider, terminate contract/revocation of delegation.

5. CMHA will review submitted POC documentation to assure corrective action plans have been implemented and that plans are effective in correcting findings of non-compliance noted during the initial site visit. CMHA may require further follow-up

on areas of initial non-compliance if POC documentation does not sufficiently meet audit standards, regulations, or requirements.

I. Contract providers in less than conditional compliance with recommended performance objectives within the fiscal year may result in non-renewal of the contract and/or revocation of delegation.

J. Information from the monitoring process for contract providers will be utilized in CMHA's credentialing consideration for continued provider participation.

K. For contract providers, monitoring results/site review reports may be obtained from another organization which contracts with the same provider for services. These results must be reviewed by CMHA's Contract Manager, or designee, for completeness and if found sufficient, may be accepted into the provider's file with documentation of the review process and approval. If the site review results are found to be incomplete, CMHA must obtain the necessary information directly from the provider or perform an on-site review.

L. Required Reporting

1. CMHA has procedures for reporting improper known organizational provider or individual practitioner conduct that results in suspension or termination from CMHA's provider panel to appropriate authorities (i.e., MDHHS, NorthCare, CMHA Board, Attorney General, etc.). Such procedures shall be consistent with current federal and state requirements, including those specified in the MDHHS Medicaid Managed Specialty Supports and Services Contract.
2. CMHA will notify NorthCare upon learning of the action, any adverse change in licensure, or certification status.
3. NorthCare may immediately suspend, pending investigation, the participation status of a provider who, in the opinion of the Medical Director (or Clinical Director), is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of consumers.
4. NorthCare will initiate an investigation and/or refer to the appropriate Office of Recipient Rights immediately upon learning of such action.
5. The grievance (dispute) and appeals process is available to any provider subject to suspension of participation status.

M. CMHA's Contract Manager will have overall responsibility for monitoring the evaluation process. Patterns and trends affecting quality of service will be referred to CMHA's Quality Improvement/Utilization Management Committee.

N. CMHA's Contract Manager will maintain the original site review documentation and a copy of such will be filed in the Quality Improvement Coordinator's office. Recipient Rights site review forms will be filed in the Recipient Rights Officer's office.

O. Completed site review forms are subject to NorthCare and/or MDHHS review.

VI. REFERENCES AND LEGAL AUTHORITY: Medicaid Master Contract; General Fund Master Contract; CARF Behavioral Health Standards; NorthCare Network Sanction Policy; NorthCare Network Contractual Relationships and Delegation Policy; BBA Section; URAC Standards Core 9 and 10; PIHP/MDHHS Contract Section 6.4 (J); P.6.7.1.1; ORR Guidance 17-01 (Final-dated 11/2/17); Northcare Network-Network Provider Oversight, Monitoring & Evaluation Policy

VII. EXHIBITS: None