POLICY AND PROCEDURE MANUAL	BCCMHA	PAGE 1 OF 7
CATEGORY – PROVIDER NETWORK	CHAPTER 17	SUBJECT D
MONITORING PROVIDER PERFORMANCE AND CONTRACT COMPLIANCE	REVISED 09/15/03 09/05/13 12/27/04 08/21/14 09/12/05 10/08/07 09/23/11	EFFECTIVE 9/06/02

I. PURPOSE

To enhance service delivery system performance, to monitor and improve outcomes and quality of services provided to clients.

To coordinate performance and compliance reviews among governing and accrediting entities (e.g., CARF, JCAHO, Recipient Rights, Fire Marshall, Quality Improvement, Consumer and Industry Services, Michigan Department of Health and Human Services).

To outline actions which will be taken in the event of poor performance and other noncompliance issues.

To prevent fraudulent claims by assuring that documentation within the contractual provider records demonstrates actual service provision, and must establish standards and requirements as outlined by the Michigan Department of Health and Human Services (MDHHS) and Centers for Medicare and Medicaid Services.

II. DEFINITIONS

Southwest Michigan Behavioral Health (SWMBH): Regional alliance composed of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren mental health boards.

SWMBH Network Provider: An individual or entity delivering behavioral health services which have been credentialed and approved as a network provider.

Performance and Contract Compliance: Thorough site and record review of a provider's performance and compliance with elements specified in the contract.

Remedial Action: Any action which results in a temporary or permanent suspension of a plan of service, withholding payment, modifying a contract, terminating a contract, requiring a payback, or any other action deemed appropriate by the governing body.

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Serious Findings: Includes any or all of the following:

- An adverse action has occurred and conditions that caused the harm have not been corrected
- Continual noncompliance
- A pattern of fraudulent or false claims
- A failure to provide an acceptable written plan of correction within specified timeframes
- A sentinel event which has its root cause in an unresolved systemic deficiency
- Expiration of Licensures

III. CONDITION AND CIRCUMSTANCES

Data from site reviews, surveys, inspections, inspections for investigations from Michigan Department of Licensing and Regulatory Affairs, Department of Health and Human Services Consumer and Industry Services, JCAHO, CARF, Quality Improvement, MDHHS, Recipient Rights, Fire Marshall, other accrediting or licensing bodies and findings from clinical staff are routed to the Contract Manager and Executive Director who maintains a secure, confidential administrative file for each service provider. These reports are to be examined to identify performance and other noncompliance issues and will determine if a full contract compliance review is indicated. See Attachment A, Specialized Residential Provider Site Review and Attachment B, Provider Profiling, Consumer-Staff Interview.

As part of routine provider monitoring to ensure providers in and out of network have renewed their Michigan licenses and any applicable certifications in a timely basis, monitoring will be completed at a minimum of an annual basis and include: review of expired licensure or certification, liability insurance, workman's compensation insurance, and accreditation. Requests for updates of liability insurance, workman's compensation insurance, and accreditation will be completed by sending the provider a letter of request for evidence of updated insurance coverage. Review of licensure or certification will be conducted via primary source verification. Any provider who has not renewed their licensure or any certification within applicable grace periods of its expiration will be immediately terminated from the provider network. Providers who are terminated for lapsed licensure or certification may reapply for participation at the discretion of BCCMHA once licensure or certification is renewed.

As part of the coordination efforts between SWMBH and BCCMHA, contractual providers will either be audited by the SWMBH Provider Network Review Team, SWMBH Affiliate Review Team, or BCCMHA Review Team on an annual basis or more often as needed. Information sharing will occur between these entities to assure contract compliance and quality of service. Results from audits conducted by SWMBH or SWMBH Affiliate will be

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forwarded or made available to BCCMHA. Those providers not enrolled as a SWMBH provider, but who are a provider for BCCMHA, will be reviewed by BCCMHA's Review Team on an annual basis or more often as needed. Results from these audits may be forwarded to SWMBH Network Provider Relations Manager should the provider make application for enrollment in the provider network panel and/or funded with Medicaid monies for services provided.

The Review Team will consist of those individuals qualified to assess the contractor's compliance. This may include any or all of the following: Medical Director, Contract Manager, Residential Specialist, Case Manager, RN, MSW or LLP equivalent, finance/accounting, reimbursement, client representatives, and Peer Support Specialists. The Executive Director of BCCMHA will approve the review team for BCCMHA.

Full contract compliance reviews may occur other than on an annual basis under the following circumstances:

- Substantiated Class I abuse or neglect or other sentinel event.
- Substantiated rights complaint that suggests a pattern of noncompliance with the Mental Health Code or the contract.
- Health and/or safety findings or other significant negative findings from a review body, including, but not limited to JCAHO, CARF, Consumer and Industry, MDHHS, Fire Marshall, Recipient Rights, routine observation or findings by clinical staff or case manager, quality improvement groups, and utilization management groups.
- Reported or suspected fraudulent claims, which may result from missing or fraudulent documentation.
- Randomly selected review will be used to validate the assumption that favorable reports from other reviewers suggest overall contract compliance.
- As part of the process for selection of a new program or vendor.

IV. PROCEDURES

FULL COMPLIANCE REVIEW PROCESS

a. The Contract Manager will recommend appropriate participants for the review team and leader, to be approved by the Executive Director.
b. The Review Team will notify the provider that a performance and contract compliance review will be conducted. A date and time will be agreed upon.
c. The review is completed by the team. The provider receives a verbal summary of the findings at the conclusion of the review and is provided with an opportunity to dispute those findings and provide additional supporting documentation.

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d. The review team prepares a preliminary written summary of findings of the review and presents it to the Contract Manager. The summary report will include any recommendations for remedial action (see below).
e. Upon review by the Contract Manager, the report, with recommendations, is forwarded to the provider.

ACTION PLANS FOR REMEDIATION

a. If no corrective action is required, the report will be filed with the Contract Manager and housed in administrative files.
b. If corrective action is required, the Review Team will select from the following options:
   - Require a written plan of action from the provider to be submitted within a defined number of days of notification.
   - Recommend withholding further payment for service until the plan of action is accepted and/or there is evidence noted that deficiencies have been corrected. (Required approval from the Executive Director).
c. If corrective action is required, a follow-up compliance review will be conducted within thirty (30) days of the last date noted on the action plan.
d. If deficiencies have not been corrected, the Contract Manager will select from the options noted in (b) above.
e. The Contract Manager or Executive Director will notify the provider of any adverse action.
f. Corrective Action Plans will contain the following information:
   - Action to be taken to correct each noted deficiency
   - Responsible party for assuring the corrective action is effective for each deficiency
   - Target date (should not exceed 60 days from the date of the review)

PROCESS FOR TAKING ACTION ON SERIOUS FINDINGS

a. The Contract Manager or other designee will inform the provider of the seriousness of the issue and the action to be taken.
b. The Executive Director will be immediately notified of the serious findings and provided with a copy of all supporting documentation.
c. The Executive Director will select an option from above, seek counsel as needed, and notify the Contract Manager within three (3) business days.
d. The Contract Manager will follow-up with notification to the provider and relevant others.

NOTIFICATION OF ADVERSE ACTION

a. If a provider's status changes, the Contract Manager will notify the Management Team, claims payment and the Executive Director.

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b. The Executive Director and designated staff will authorize no further service by the provider.
c. The Executive Director or designee will notify relevant staff.
d. Staff will notify affected members, within 15 days of action, and modify plans of service to assure a smooth transition to another provider.
e. Claims payment will remove the vendor/provider from the system following their process.

V. REFERENCES

MDHHS
SWMBH
CARF

QUALITY ASSURANCE

GOAL

To ensure that services provided by contracted providers for which invoices/claims and payment were submitted by Barry County Community Mental Health Authority are contractually compliant.

OBJECTIVE

To monitor and detect fraudulent invoices/claims and assist providers in maintaining appropriate record keeping to reflect service provision and utilization of person-centered planning.

To monitor compliance with the contract held with Barry County Community Mental Health Authority and regulations associated with those contractual services.

QUALITY ASSURANCE

The Contract Manager will be responsible for overseeing the system and reporting process. Please see the attached Indicator for Methodology for specifics regarding this study.

QUALITY IMPROVEMENT

This policy/procedure will be evaluated by the Quality Improvement Committee on an annual basis to enhance and improve the quality.

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At any time employees can request in writing, on the form provided, that this policy or items in this policy be reviewed by the Quality Improvement Committee. Employee's written requests can be given to any Quality Improvement Committee member.

When an area for improvement is indicated, the process for improvement as identified in the Quality Improvement Plan will be followed.

APPROVED BY:

Jan M. McLean — Date
Executive Director

Jill Bishop, MA, LLP, CMHP, QMHP, QMRP — Date
Clinical Director

Tamie Case, MPA, CHC — Date
Corporate Compliance Officer

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REVIEW DATE

06/11/03
08/25/04
08/24/05
10/11/06
09/12/07
11/04/09
09/08/10
09/14/11
08/29/12
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12/02/2020