Policy: Monitoring Provider Performance and Contract Compliance 12-D		Application: BCCMHA Staff & Providers
Reviewed 12/20/2023	Revised 12/2/2020	First Effective 8/6/2002

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. POLICY

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 Provider Network Specialist 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.

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 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 an 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, Provider Network Specialist, 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:

1. Substantiated Class I abuse or neglect or other sentinel event.
2. Substantiated rights complaint that suggests a pattern of noncompliance with the Mental Health Code or the contract.
3. 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.
4. Reported or suspected fraudulent claims, which may result from missing or fraudulent documentation.
5. Randomly selected review will be used to validate the assumption that favorable reports from other reviewers suggest overall contract compliance.
6. As part of the process for selection of a new program or vendor.

III. <u>PROCEDURES</u>

<u>FULL COMPLIANCE REVIEW PROCESS</u>

The Provider Network Specialist will recommend appropriate participants for the review team and leader, to be approved by the Executive Director.

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. 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. The review team prepares a preliminary written summary of the findings of the review and presents it to the Provider Network Specialist. The summary report will include any recommendations for remedial action (see below).

Upon review by the Provider Network Specialist, the report, with recommendations, is forwarded to the provider.

ACTION PLANS FOR REMEDIATION

If no corrective action is required, the report will be filed with the Provider Network Specialist and housed in administrative files.

If corrective action is required, the Review Team will select from the following options:

1. Require a written plan of action from the provider to be submitted within a defined number of days of notification.
2. 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).
3. 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.
4. If deficiencies have not been corrected, the Provider Network Specialist will select from the options noted in (2) above.

The Provider Network Specialist or Executive Director will notify the provider of any adverse action. Corrective Action Plans will contain the following information:

1. Action to be taken to correct each noted deficiency
2. Responsible party for assuring the corrective action is effective for each deficiency
3. Target date (should not exceed 60 days from the date of the review)

PROCESS FOR TAKING ACTION ON SERIOUS FINDINGS

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

NOTIFICATION OF ADVERSE ACTION

If a provider's status changes, the Provider Network Specialist will notify the Management Team, claims payment and the Executive Director. The Executive Director and designated staff will authorize no further service by the provider. The Executive Director or designee will notify relevant staff.

Staff will notify affected members, within 15 days of action, and modify plans of service to assure a smooth transition to another provider. Claims payment will remove the vendor/provider from the system following their process.

REFERENCES

MDHHS

SWMBH

CARF

APPROVED BY:

Richard Thiemkey Date

Executive Director