MSHN
Mid-State Health Network

MSHN Monitoring of Delegated Functions – Admin/Managed Care Functions

CMHSP NAME:	DATE OF REVIEW:
NAMES OF REVIEWERS:	

#	STANDARD	Basis/Source	Evidence of Compliance could include:	Met Standard Yes/No	Evidence Found: Notes/Comments
1.1	**INFORMATION AND CUSTOMER SERVICES (CUSTOMER SERVICE)** Information, brochures and material that pertain specifically to the CMHSP/CA's provider network are routinely shared with individuals served and posted publicly.	MDCH Consumerism Practice Guideline MDCH Contract 6.3.3	Samples of brochures, links to website, policies related to information dissemination		
1.2	Information Requirements and Notices: The CMHSP shall provide the following information to all consumers: Names, locations, telephone numbers of, and non-English languages spoken by current providers in the consumer's service area, including information at least one provider when determined needed or requested.	PIHP contract attachment 6.3.1.1			
1.3	All informational materials, including those describing consumer rights, service requirements and benefits are provided in a manner and format that may be easily understood. Informational materials are written at the 4th grade reading level when possible (i.e., it may be necessary to include medications, diagnoses and conditions that do not meet criteria).	42 CFR. 438.10(b)(1); 42 CFR 438.10(d)(1)(i); MDCH Contract 6.3.3 42 CFR 438.10(b)(3) HSAG 8 2a	Samples of informational materials. Readability test.		
1.4	Written materials are available in alternative formats that consider the special needs of the consumer, including those	42 CFR 438.10(c)(3); MDCH Contract 6.3.3	Samples of written materials in alternative formats		

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	with vision impairments or limited reading proficiency as required by the ADA.				
1.5	A policy and/or procedure is in place for accessing the language needs of individuals served.	42 CFR 438.10(c)(4); MDCH Contract 6.4	Copy of policy/procedure. Reference materials on language needs of community.		
1.6	Written materials, including information developed by the PIHP, are available in the prevalent non-English languages of the service area.	42 CFR 438.10(d)(1)(ii); MDCH Contract 6.3.3; HSAG 8 2b	Samples of written materials in languages meeting LEP requirements.		
1.7	Oral interpretation of all languages is available free of charge		Policy, contract for language interpreter		
1.8	The following information is provided to all consumers within a reasonable time after notice of the consumers referral: • Names, locations and telephone numbers of current providers. This includes at a minimum information about case managers, psychiatrists, primary therapists, etc., and any restrictions on the consumer's freedom of choice among providers; • Amount, duration and scope of services available in sufficient detail to ensure that consumers understand the services to which they are entitled; • Procedures for obtaining services including authorization requirements; • Extent to which, and how, recipients may obtain benefits for out of network providers • Extent of and how after-hours crisis services are provided; including definitions and locations of emergency and post-stabilization services and the right to access such services.	Moved from 5.2 MDCH Contract 6.3.3.B.2			

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	• Annually (e.g., at the time of person-centered planning) provide to the beneficiary the estimated annual cost to the PIHP of each covered support and service he/she is receiving. (Technical Advisory P6.3.3, B.2 f provides principles and guidance for transmission of this information). • The Contractor is required to provide Explanation of Benefits (EOBs) to 5% of the consumers receiving services. The EOB distribution must comply with all State and Federal regulations regarding release of information as directed by DCH. (A model Explanation of Benefits consistent with Technical Requirement P6.3.3.B.2.g) • Consumer rights and protections, including information about the right to a State Fair Hearing, the right to file grievances and appeals, the requirements and time frames for filing a grievance or appeal, the availability of assistance in the filing process, the toll-free numbers that consumers can use to file a grievance or an appeal by phone, and the fact that benefits can continue if requested by consumer pending a hearing decision. • Any cost-sharing and how to access any other benefits available under the state plan but not covered in contract • Additional information is available upon request, regarding the PIHP operational structure and physician incentive plans. • Consumers are notified of their right to receive all required information at least once per year.				
1.8	Written notice of a significant change in its provider network including the addition of new providers and	42 CFR 438.10(d)(1)(ii); MDCH Contract 6.3.3; HSAG 8 2c	Policy or description of how changes to provider		

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	planned termination of existing providers is provided to each beneficiary.		network are communicated.		
1.9	Good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each beneficiary who received his or her primary care from, or was seen on a regular basis by, the terminated provider.	42 CFR 438.10(d)(1)(ii); MDCH Contract 6.3.3; HSAG 8 2c	Policy or description of how changes to provider network are communicated.		
2.1	**ENROLLEE RIGHTS AND PROTECTIONS (CUSTOMER SERVICE)** The CMHSP maintains an office(s) of Enrollee Rights and Recipient Rights in compliance with federal and state statutes.		Contact information provided, flyers, brochures		
2.2	Local communication with consumers regarding the role and purpose of the PIHP's Customer Services and Recipient Rights Office.		Flyers, brochures		
2.3	Consumers are allowed to choose their health care professional(s) to the extent possible and appropriate.	42 CFR 438.6(m);a MDCH Contract 3.4	Policy language related to consumer choice of treatment professional		
2.4	Policies and member materials include the enrollee's right to be treated with respect and due consideration of his or her dignity and privacy.	42 CFR 438.100(b)(2)(ii); 42 CFR 160 and 164	Recipient Rights brochures		
2.5	Policies and member materials include the enrollee's right to receive information about available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.	42 CFR 438.100(b)(2)(iii)	Recipient Rights brochures, polices		
2.6	A CMHSP not electing to provide, reimburse for, or provide coverage of, a counseling or referral service based on objections to the service on a moral or religious grounds	42CFR438.10(f)(6)(xii))			

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	must furnish information about the services it does not cover as follows: •Inform the PIHP prior to any action • To potential enrollees, before and during enrollment; and • To enrollees, within 90 days after adopting the policy with respect to any particular service, with the overriding rule to furnish the information 30 days before the policy effective date.				
2.7	The CMHSP policies provide the enrollee the right to participate in the decisions regarding his or her healthcare, including the right to refuse treatment.	42 CFR 438.100(b)(2)(iv)	Recipient Rights brochure. Language in IPOS, policy		
2.8	The CMHSP policies and member materials will provide enrollees the right to be free from any form of coercion, discipline, convenience or retaliation.	42 CFR 438.100(b)(2)(v)	Recipient Rights brochure. Language in IPOS, policy		
2.9	The CMHSP ensures that consumers are free to exercise their rights in a manner that does not adversely affect their services.	42 CFR 438.100 (3)(c); 42 CFR 438.210	Recipient Rights brochure, policy language		
3.1	**ACCESS & AVAILABILITY (UTILIZATION MANAGEMENT)** The Access System is available 24 hours per day, 7 days per week	PIHP Contract Access System Standards (July 2008)			
3.2	For non-emergent calls, a person's time on-hold awaiting a screening does not exceed 3 minutes without being offered an option for callback or talking with a non-professional in the interim.	PIHP Contract Access System Standards (July 2008)	Policy, procedure, call logs, Evidence of monitoring telephone answering rates, call abandonment rates,		
3.3	All non-emergent callbacks occur within one business day of initial contact	PIHP Contract Access System Standards (July 2008)	Policy, procedure, call logs		
3.4	Individuals with routine needs are screened or other arrangements made within 30 minutes	PIHP Contract	Policy, procedure, call logs		

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		Access System Standards (July 2008)			
3.5	Individuals are routinely screened and/or assessed for co-occurring disorders	PIHP Contract Access System Standards (July 2008)	Policy, procedure, call logs		
3.6	The Access System conducts a clinical screening for eligibility that results in a written screening decision which addresses the following items: • Identifying Problem • Need for services and supports • Identification of population group that qualifies the person for CMHSP services • Legal eligibility and priority criteria • Documentation of any emergent or urgent needs • How individual was linked to crisis services if necessary • Identification of screening disposition • Rationale for system admission or denial	PIHP Contract Access System Standards (July 2008)	Access screening Policy, procedure		
3.7	The access system provides information about and helps people get connected to: local and community resources, peer supports, transportation services, self-help groups and other local services as needed.	PIHP Contract Access System Standards (July 2008)	Policy & Procedure, Copies of brochures, evidence of written materials related to local community services		
3.8	State standards are met for timely access to care and services taking into account the urgency of need for services:	42 CFR 438.206(c)(1)(i); MDCH Contract Part II, 3.1; MDCH Contract Attachment P 4.86.5.1.1			
4.1	**CMHSP PROVIDER NETWORK - Sub-Contract Providers (PROVIDER NETWORK)**	42 CFR 438.206(b)(1) MSHN AFP Response Section 2.4.2			

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	The CMHSP maintains a network of appropriate providers that is supported by contracts.				
4.2	The network of providers is sufficient to provide adequate access to all services covered under the contract with the PIHP, based upon: • the anticipated number of referrals from the PIHP • the expected utilization of services taking into consideration the characteristics and health care needs of local populations; • the numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted services; and • the geographic location of providers and consumers, considering distance, travel time, the means of transportation ordinarily used by consumers, and whether the location provides physical access for people with disabilities.	42 CFR 438.206(b)(1) Medicaid Managed Specialty Supports and Services contract, Section 6.4; AFP Sections 3.8, 4.0 42 CFR 438.214.	Example of Evidence Needed Here		
4.3	If the CMHSP is unable to provide necessary medical services covered under the contract to a particular consumer, the CMHSP adequately and timely covers these services out of network.	42 CFR 438.206(b)(4); MDCH Contract 3.4.6	Example of Evidence Needed Here Define “Timely”		
4.4	The CMHSP coordinates with out-of-network providers with respect to payment and ensures the cost to the consumer is no greater than it would be if the services were furnished within the network.	42 CFR 438.206(b)(5)	Example of Evidence Needed Here		
4.5	Negotiate contracts between the CMHSP/CA and providers based on a procurement method that meets state and federal standards and in accordance with PIHP policy	MDCH site review template D.9.1			
4.6	The CMHSP manages procurement of local providers sufficient to fulfill all PIHP delegated activities and to meet identified needs, including recruitment of staff (or	42 CFR 438.206(c)(2); MDCH Contract 3.4.2 MDCH Contract 6.4			

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	contracted) interpreters, translators, and bi-lingual/bi-cultural clinicians				
4.7	The CMHSP has an established process for monitoring the performance of each subcontracted provider relative to the contract. The monitoring process will minimally assess performance and compliance indicators established by the PIHP, deemed status and reciprocity by other CMSHPs in the region.	AFP Section 2.4.1 2 CFR 438.206(b)(1) Medicaid Managed Specialty Supports and Services contract, Section 6.4; AFP Sections 3.8, 4.0 42 CFR 438.214.			
4.8	The CMHSP has established and implemented a local level process for soliciting network provider feedback and/or complaints	MDCH site review template D.9.3			
4.9	The CMHSP has a process for ensuring that contractual providers comply with all applicable requirements concerning the provision of culturally competent services	42 CFR 438.206('c)(2)			
4.10	Provider performance reports are available for review by individuals, families, advocates, and the public. Attachment P6.8.2.3 Consumerism Practice Guideline	Attachment P6.8.2.3 Consumerism Practice Guideline			
4.11	The entire service array for individuals with developmental disabilities, mental illness, or a substance abuse disorder, including (b)(3) services, are available to consumers who meet medical necessity criteria.	Medicaid Managed Specialty Supports and Services Contract Part II, Statement of Work, Section 2.0 Supports and Services)			
5.1	**SERVICE AUTHORIZATION & UTILIZATION MANAGEMENT (UTILIZATION MANAGEMENT)** A utilization management program is in operation. The written utilization management program description includes:	42 CFR 438.210(a)(3)(ii); 42 CFR 438.210(a)(3)(iii)			

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	• procedures to evaluate clinical necessity, and the process used to review and approve the provision of clinical services, • mechanisms to identify and correct under-utilization as well as over utilization, and • preauthorization, concurrent and retrospective procedures. • Arbitrary denial or reduction of the amount, duration or scope of a required service solely because of a consumer's diagnosis, type of illness or condition is prohibited. • Any service limits imposed are appropriate and restricted to criteria such as medical necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.				
5.2	Initial approval or denial of requested service: • Initial assessment for and authorization of psychiatric inpatient services • Initial assessment for and authorization of psychiatric partial hospitalization services • Initial and ongoing authorization of services to individuals receiving community-based services • Grievance and Appeals, Second Opinion management, coordination and notification • Communication with consumers regarding UM decisions, including adequate and advance notice, right to second opinion and grievance and appeal				
5.3	Local-level Concurrent and Retrospective Reviews of Authorization and Utilization Management decisions/activities to internally monitor authorization decisions and congruencies regarding level of need with level of service are consistent with PIHP policy, standards and protocols.				

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5.4	Specifications for what constitutes "medically necessary services" are no more restrictive than the PIHP's.	42 CFR 438.210(a)(4)	Level of care criteria, policy & procedures for service eligibility		
5.5	Written policies and/or procedures are in place for processing requests for initial and continuing authorization of services through the person centered planning process.	42 CFR 438.210(b)(1); MDCH PCP Practice Guidelines P 3.3.1.1			
5.6	Mechanisms are in effect to ensure consistent application of review criteria for authorization decisions;	42 CFR 438.210(b)(2)			
5.7	Review decisions are supervised by qualified medical professionals	Need source			
5.8	Decisions to deny or authorize service in an amount, duration or scope that is less than requested are made by a health care professional who has the appropriate clinical expertise in treating the consumers condition or disease;	42 CFR 438.210(b)(3			
5.9	The CMHSP provides Medicaid consumers with written service authorization decisions no later than 14 calendar days following receipt of a request for service authorization, unless the PIHP has authorized an extension; and the CMHSP provides Medicaid consumers with written service authorization decisions no later than 3 days following receipt of a request for expedited service authorization, if warranted by the consumer's health or functioning, unless the PIHP has authorized an extension. Reasons for decisions are clearly documented and available to the recipient.	42CFR438.404(b)(2) 42CFR438.404(b)(3) 42 CFR 438.210(c); MDCH Contract 6.3.2	Policies, samples, chart reviews		
5.10	The involved provider is informed verbally or in writing of the action if a service authorization request was denied or services were authorized in an amount, duration or scope that was less than requested.				
5.11	A second opinion from a qualified health care professional within or outside the network is available to consumers upon request, at no cost to the consumer.	42 CFR 438.206(b)(3); MDCH Contract 3.4.5			
6.1	**GRIEVANCE & APPEALS (CUSTOMER SERVICE)**				

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	There are mechanisms to evaluate the effects of the program using data on customers or provider satisfaction				
6.2	There are publicized and available appeal mechanisms for providers and consumers				
6.3	Notification of a denial is sent to both the consumer and the provider. This notification of a denial includes a description of how to file an appeal				
6.4	Incentives are not present for the denial, limitation or discontinuation of services to any consumer	42 CFR 438.210(e); MDCH Contract 3.4.8			
6.5	Consumers are provided with written adequate notice of action regarding authorization of services: at the time of the decision to deny payment for a service (on the same date the action takes effect); at the time of the signing of the individual plan of services/supports; within 14 calendar days of the request for a standard service authorization if the decision will deny or limit services; and within 3 working days of the request for an expedited service authorization if the decision will deny or limit services.	42 CFR 438.210(c); 42 CFR 438.404; MDCH Grievance System			
6.6	The advanced and adequate notice letter template from the PIHP/MDCH Contract is used to ensure consistency across the region.	42 CFR 438.404(b), etc.; MDCH Grievance System			
6.7	The adequate and advance notices meet the language and alternative format needs of the consumer.	42 CFR 438.404(a), etc.; MDCH Grievance System			
6.8	Consumers are provided with written advance notice of action 12 calendar days before the intended action will take effect, when an action is being taken to reduce, suspend or terminate previously authorized services.	42 CFR 438.404(c), etc.; MDCH Grievance System			
6.9	Consumers are given reasonable assistance to complete forms and to take other procedural steps to file a grievance, appeal and/or State Fair Hearing request. This includes but is	42 CFR 438.406(a); MDCH Grievance System			

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	not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.				
6.10	A copy of grievance, appeal and fair hearing requirements and timeframes are given to each provider when they join the provider network.	42 CFR 438.414; MDCH Contract 6.4			
6.11	A local appeal process has been established for Medicaid consumers to appeal action, and consumers are informed of the availability of this process.	42 CFR 438.402(a); MDCH Grievance System			
6.12	An expedited appeal process has been established for Medicaid consumers to appeal an action, and consumers are informed of the availability of this process.	42 CFR 438.410(c); MDCH Grievance System			
6.13	If a request for an expedited resolution of an appeal is denied, the CMHSP: •Transfers the appeal to the standard resolution time frame. •Initiates reasonable efforts to provide prompt oral notice of the denial. •Provides follow-up written notice to consumer within 2 calendar days. •Consumers are given 45 calendar days from the date of the notice of action to request a local appeal.	42 CFR 438.402(a); MDCH Grievance System 42 CFR 438.410(c);			
6.14	Receipt of each appeal is acknowledged.				
6.15	Oral requests for a local appeal of an action are accepted and confirmed in writing (unless the consumer requests expedited resolution for which oral response is allowed).				
6.16	Maintain a log of all requests for appeal to allow reporting to the PIHP Quality Improvement Program, that ensures individuals who make the decisions on appeal were not involved in the previous level review or decision-making	42 CFR 438.416; MDCH Grievance System 42 CFR 438.405(a);			
6.17	The content of notices of disposition includes an explanation of the results of the resolution and the date it was	42 CFR 438.408(d)(2)(i); 42 CFR 438.408(e);			

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	completed. When the appeal is not resolved wholly in favor of the consumer, the notice of disposition must also include: • the right to request a state fair hearing, and how to do so; • the right to request to receive benefits while the state fair hearing is pending, if requested within 12 days of the mailing the notice of disposition, and how to make the request; and the consumer may be held liable for the cost of those benefits if the hearing decision upholds the action.	MDCH Grievance System			
6.18	Medicaid consumers are informed of their right to access to the State Fair Hearing process for appeal of actions, including the 90 calendar day deadline (from the date of notice of an action) for filing a request.	42 CFR 438.414; 42 CFR 438.10(g)(1); MDCH Grievance System			
6.19	CMHSP provides acknowledgement of grievance and appeals, Adequate and Advance Notice and disposition notices within timeframes specified by and according to MSHN Medicaid Beneficiary Appeals and Grievances Policy	MSHN Medicaid Beneficiary Appeals and Grievances Policy			
7.1	**PERSON-CENTERED PLANNING & DOCUMENTATION STANDARDS (UTILIZATION MANAGEMENT)** The right for all individuals to have an Individual Plan of Service developed through a person-centered planning process is clearly communicated to all service recipients.	MDCH/PIHP Contract Section 3.4.1 Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1. Person-Centered Planning Practice Guideline			
7.2	Implement person-centered planning in accordance with the MDCH Person Centered Practice Guideline.	Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1. Person-Centered	*Separate Consumer Chart review for compliance with Person Centered Planning* Policy/procedure		

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		Planning Practice Guideline MHC 712 Chapter III, Provider Assurances & Provider Requirements	Internal CMHSP chart audits, peer review of PCP		
7.3	The individual plan of service adequately identifies the individual's chosen or preferred outcomes.	MCL 330.1701(g)	Samples of consumer records		
7.4	Services and supports identified in the individual plan of service assist the individual in pursuing outcomes consistent with their preferences and goals.				
7.5	Family driven and youth guided supports and services are provided for minor children		Family-Centered Planning Policy, evidence of monitoring, peer review of records for PCP		
7.6	Individuals are provided with ongoing opportunities to provide feedback on how they feel about services, supports and/or treatment they are receiving, and their progress towards attaining valued outcomes.		Policy/procedure		
7.7	The Person-Centered Planning Process is used to modify the individual plan of service in response to changes in the individual's preferences or needs.				
7.8	The Person-Centered Planning process builds upon the individual's capacity to engage in activities that promote community life.	MCL 330.1701(g)			
7.9	Person-centered planning addressed natural supports.				
7.10	Person-centered planning addressed health and safety.				
7.11	The individual plan of service identifies the roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and providers in implementing the plan.	Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1. Person-Centered			

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		Planning Practice Guideline			
7.12	Specific services and supports to be provided, including the amount, scope, and duration of services, are identified in the plan of service.				
7.13	The IPOS identifies available conflict resolution processes.				
7.14	Services and treatment identified in the IPOS are provided as specified in the plan.				
7.15	The frequency of plan review for the individual is specified in the plan. Frequency and scope of monitoring of the plan reflects the intensity of the beneficiary's health and welfare is identified in the plan.	MH Code 330.1714 Medicaid Manual Mental Health and Substance Abuse sec. 3.24			
7.16	All forms/documents placed in consumer records identify the consumer with name and medical record number	Medicaid Provider Manual; recordkeeping MDCH site review protocol 6.2.3			
7.17	Consumers have been provided a copy of his/her plan within 15 days of the PCP meeting				
8.1	**ADVANCED DIRECTIVES (CUSTOMER SERVICE)** The CMHSP has a written advance directives policy and procedures.	42 CFR 438.6(i)(3); 422.128	Policy and procedures		
8.2	The policy requires that there is documentation in a prominent part of the beneficiary's current medical record as to whether or not the beneficiary has executed an advance directive.				
8.3	The CMHSP provides for education of staff concerning its policies and procedures on advance directives		Evidence of staff training		
8.4	CMHSP subcontracts, as applicable, contain advance directive requirements appropriate to the subcontract.		Samples of subcontract language related to advanced directives		
8.5	The CMHSP provides all adult beneficiaries with written information on advance directive policies, including a	42 CFR 438.6(i)(3); 422.128			

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	description of applicable State laws. This includes information on the beneficiary's right to make decisions concerning his or her medical care, including the right to accept or refuse treatment, and the right to formulate advance directives				
8.6	The information provided to adult beneficiaries must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.	42 CFR 438.6(i)(4)			
9.1	**COORDINATION OF CARE (QUALITY IMPROVEMENT)** Coordination of care agreements are in place with the QHP's within the CMHSP/CA's catchment area	HSAG XIII.4	PIHP Evidence		
9.2	CMHSP staff pro-actively assume responsibility for engaging the inpatient team during consumer's hospital stay. This includes participating in team meetings and initiating discharge planning with staff, consumer, family/guardian and community resources.	MSHN AFP response Section 5.2.1.4	Progress notes, continuing stay reviews or hospital discharge plans showing evidence of CMHSP participation		
9.3	CMHSP has developed service coordination agreements with each of the pertinent public and private community-based organizations and providers to address issues that relate to a shared consumer base	HSAG XIII.2	Copies of coordination agreements		
9.4	The CMHSP has procedures to ensure that coordination occurs between primary care physicians and the CMHSP and/or its network. Procedures ensure that the services the CMHSP furnishes to the beneficiary are coordinated with the services the beneficiary receives from other MCOs and PIHPs.	MDCH Contract, Part II, 6.4.4 and 6.8. HSAG XIII.2	Policies/procedures related to coordination of care		
10.1	**BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE (QUALITY IMPROVEMENT)** The CMHSP has a Behavior Treatment Plan Review Committee (BTPRC) to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions.	Medicaid Provider Manual 3.3 Technical Requirement for Behavior Treatment Plan Review. Revision FY 12.	Copies of CMHSP meeting minutes; committee membership; etc. Stakeholder survey PIHP BTC data spreadsheet and meeting minutes		

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		MDCH P.1.4.1	PIHP BTC data spreadsheet and meeting minutes; consent form in file		
10.2	The Behavior Plan Review Committee is comprised of at least 3 individuals: • one of whom should be a licensed physician/psychiatrist. • A representative of the Office of Recipients Rights shall be a non-voting, ex-officio member. • One member should be a licensed psychologist as defined in Section 2.4 Staff Provider Qualifications The Committee and Committee Chair are appointed by the CMHSP for a term of no more than two years. Members may be reappointed for consecutive terms.	MDCH P.1.4.1 MSHN BTR Procedure	CMHSP Policy		
10.3	Person Centered Plans with restrictive and intrusive, techniques are accompanied by and include the approved behavior plan and special consent form from consumer or the parent/guardian prior to implementation of plan. Annual signed special consent.	MDCH P.1.4.1	Chart reviews show signed consents and plans		
10.4	All plans with restrictive and intrusive interventions must be reviewed at a minimum of quarterly.	MDCH P.1.4.1	Chart reviews show periodic reviews		
10.5	Each committee must establish a mechanism for expedited review of a proposed behavior treatment plan in emergent situations. "Expedited" means the plan is reviewed and approved in a short time frame such as 24 or 48 hours.	MDCH P.1.4.1 MSHN BTR Procedure	CMHSP Policy		
10.6	Evaluate the committee's effectiveness by stakeholders, including individuals with plans, family and advocates	MDCH P.1.4.1	Surveys, or other evaluative process, is being utilized		
10.7	The CMHSP quarterly tracks and analyzes the use of all physical management, involvement of law enforcement, and the use of intrusive and restrictive interventions. • Dates and numbers of interventions, • The settings (e.g individual's home or work) where behaviors or interventions occurred.	MDCH P.1.4.1	BTC data spreadsheet and meeting minutes;		

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	• Observations about any events, settings or factors that may have triggered the behavior. • Behaviors that initiated the techniques. • Documentation of analysis performed to determine the cause of the behaviors that precipitated the intervention • Description of positive behavioral supports used. • Behaviors that resulted in termination of the interventions • Length of time for each intervention • Staff development and training and supervisory guidance to reduce the use of these interventions. • Review and modification or development, if needed, of the individual's behavior plan.				
10.8	Should physical management or use of law enforcement be used more than 3 times in a 30 day period the plan is revisited and modified accordingly if needed.	MDCH P.1.4.1	Samples of Plans BTC Policy Samples of minutes		
10.9	Behavior plans that are forwarded to the committee must be accompanied by: • Results of assessment to rule out physical medical and environment causes of the challenging behavior • A functional behavioral assessment • Results of inquiries about any medical, psychological or other factor that might put the individual subjected to intrusive or restrictive techniques at high risk of death injury or trauma. • Evidence of the kinds of positive supports or interventions, including amount scope and duration. • Evidence of continued efforts to find other options. • Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention. • Reference to the literature should be included on new procedures, and where the intervention has limited or not support in the literature, why the plan is the best option available.	MDCH P.1.4.1	Samples of plans Samples of minutes		

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	• The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s).				
10.10	Each Behavior Treatment Plan has • Goal-expected outcome of the Behavior Treatment Plan • Objectives –baseline and steps to achieving the behavior goal • Methodology-interventions implemented to decrease target behaviors, a schedule and /or timing and things to be done to increase additional adaptive behaviors. • Measurement-how the baseline will be established, what is being measured, and assessment of the impact of behavior treatment interventions on the individual. • Plan Review- frequency of reviewing collected data • Staff In-Service –who is responsible for training staff and when the plan will be implemented. • Staff Responsible- the CM who will implement and manage the plan.				
11.1	**CONSUMER INVOLVEMENT (CUSTOMER SERVICE)** The CMHSP provides meaningful opportunities and supports for consumer involvement in service development, service delivery, and service evaluation activities.	(Medicaid Managed Specialty Services and Supports Contract, Consumerism Practice Guideline Attachment P 6.8.2.3.) (Consumerism Practice Guideline V.A.6.)	• Consumers and family members are on CMHSP/PIHP boards and advisory councils • Stakeholders and the public attend meetings for comments and information. This evidence may be found in the following areas: minutes, agendas, sign-in sheets, peer support specialists positions, mystery shopper programs, customer service information on		

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			assistance with input for the brochures and educational materials provided, consumer oriented job-descriptions, and consumer involvement in quality management reviews of the CMHSP programs and services.		
11.2	Development of local activities designed to engage consumers, and other stakeholders, including members of the general public, in decision oriented activities throughout the CMHSP/CA, including its subcontractors	Consumerism Practice Guideline P.6.8.2.3	Trainings offered to consumers, opportunities to serve as members of committees, Consumer Advisory Councils		
11.3	Training and orientation of customers, to participate actively in Advisory Groups, task forces, working committees.		Trainings offered to consumers, opportunities to serve as members of committees, Consumer Advisory Councils		
12.1	**PROVIDER/STAFF CREDENTIALING (PROVIDER NETWORK)** The CMHSP follows a documented process consistent with State policy for credentialing and re-credentialing of providers who are employed by or have signed contracts or participation agreements with the CMHSP.	MDCH Credentialing and Re-Credentialing Processes P.6.4.3.1	NOTE: Will require sample of employee records to confirm credentials and primary source verification		
12.2	CMHSP assures that all individuals, whether employed or contracted by the CMHSP, as identified in MDCH/PIHP contract P.6.4.3.1 are credentialed; whether employed or contracted by the CMHSP	MDCH Credentialing and Re-Credentialing Processes P.6.4.3.1			
12.3	The CMHSP's Policy reflects the scope, criteria, timeliness and process for credentialing and re-credentialing providers.	MDCH Credentialing and Re-Credentialing Processes P.6.4.3.1			

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12.4	Credentials are verified, by primary source, prior to employment. This includes criminal background check for any staff having direct access to consumers served.	Public Act 218 of 1979, MCL 400.734 (b) MSHN AFP response Section 2.4.5			
12.5	Copies of all licenses, registrations, and/or certifications are kept in the employees' or contractors' files.	MDCH Credentialing Policy			
12.6	Prior to employment, the CMHSP verifies that the individual is not included in any excluded or sanctioned provider lists. This verification process shall also occur at the time or re-credentialing or contract renewal.	MDCH Credentialing Policy			
12.7	The CMHSP follows written procedures to determine whether: • Physicians and other licensed healthcare professionals are qualified to perform their services • Non-licensed providers of care or support are qualified to perform their jobs	HSAG IV B & C			
12.8	The CMHSP's policy and procedures for re-credentialing require, at a minimum: • Re-credentialing at least every two years • An update of information obtained during the initial credentialing. • A process for ongoing monitoring, and intervention when appropriate, of provider sanctions, complaints, and quality issues pertaining to the provider, which must include, at a minimum, a review of: o Medicare/Medicaid sanctions. o State sanctions or limitations on licensure, registration, or certification. o Beneficiary concerns, which include grievances (complaints) and appeals information. o CMHSP quality issues	MDCH Credentialing and Re-Credentialing Processes P.6.4.3.1			

#	STANDARD	Basis/Source	Evidence of Compliance could include:	Met Standard Yes/No	Evidence Found: Notes/Comments
12.9	The CMHSP has a policy and procedures to address granting of temporary or provisional credentials and the policy and procedures require that the temporary or provisional credentials are not granted for more than 150 days and at a minimum: 1. A provider must complete a signed application that includes the following items: • Lack of present illegal drug use • Any history of loss of license and/or felony convictions • Any history of loss or limitation of privileges or disciplinary action • Summary of the providers work history for the prior five years • Attestation by the applicant of the correctness and completeness of the application. 2. CMHSP must conduct primary source verification of the following: • Licensure or certification • Board certification, if applicable, or the highest level of credential attained • Medicare/Medicaid sanctions	MDCH Credentialing and Re-Credentialing Processes P.6.4.3.1			
12.10	The CMHSP's processes require that an individual file be maintained for each credentialed provider and each file include: • The initial credentialing and all subsequent re-credentialing applications. • Information gained through primary source verification. • Any other pertinent information used in determining whether or not the provider met the CMHSP's credentialing standards.	MDCH Credentialing and Re-Credentialing Processes P.6.4.3.1			

#	STANDARD	Basis/Source	Evidence of Compliance could include:	Met Standard Yes/No	Evidence Found: Notes/Comments
12.11	The CMHSP's policy and procedures require that, at a minimum include: 1.A written application that is completed, signed and dated by the provider and attests to the following elements: • Lack of present illegal drug use • Any history of loss of license and/or felony convictions • Any history of loss or limitation of privileges or disciplinary action • Attestation by the applicant of the correctness and completeness of the application. 2. A summary of the provider's work history for the prior 5 years 3. Verification from primary sources of: A. Licensure or certification B. Board certification, if applicable, or the highest level of credential attained C. Documentation of graduation from an accredited school D. National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or in lieu of, all of the following must be verified: o Minimum 5 year history of professional liability claims resulting in a judgment or settlement o Disciplinary status with regulatory board or agency; and • Medicare/Medicaid sanctions E. If a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to	MDCH Credentialing and Re-Credentialing Processes P.6.4.3.1			

#	STANDARD	Basis/Source	Evidence of Compliance could include:	Met Standard Yes/No	Evidence Found: Notes/Comments
	satisfy the primary source requirements for (A), (B) and (C) above.				
12.12	The CMHSP's credentialing policy was approved by the CMHSP's governing body and identifies the CMHSP administrative staff member responsible for oversight of the process.	MDCH Credentialing and Re-Credentialing Processes P.6.4.3.1			
12.13	The CMHSP's program for staff training includes: training for new personnel related to their responsibilities, program policy , and operating procedures methods for identifying staff training needs in-service training, continuing education and staff development activities	Need source			
12.14	The CMHSP validates, and revalidates at least every two years, that an **organizational provider** is licensed as necessary to operate within the State and has not been excluded from Medicaid or Medicare.	MDCH Credentialing and Re-Credentialing Processes P.6.4.3.1			
12.15	If the CMHSP accepts the credentialing decision of another CMSHP for an individual or organizational provider, it maintains copies of the current credentialing CMHSP's decision in its administrative records.	MDCH Credentialing and Re-Credentialing Processes P.6.4.3.1			
12.16	The CMHSP's policy and procedures address the requirement for the CMHSP to inform an individual or organizational provider in writing of the reasons for the CMHSP's adverse credentialing decisions	MDCH Credentialing and Re-Credentialing Processes P.6.4.3.1			
12.17	The CMHSP's policy and procedures address the CMHSP's appeal process (consistent with State and federal regulations) that is available to providers for instances when the CMHSP denies, suspends, or terminates a provider for any reason other than lack of need.	MDCH Credentialing and Re-Credentialing Processes P.6.4.3.1			
12.18	The CMHSP has procedures for reporting, to appropriate authorities (i.e., PIHP, MDCH, the provider's regulatory board or agency, the Attorney General, etc.), improper known organizational provider or individual practitioner conduct which results in suspension of termination from the CMHSP's provider network. The procedures are consistent with	MDCH Credentialing and Re-Credentialing Processes P.6.4.3.1	Policies and procedures		

#	STANDARD	Basis/Source	Evidence of Compliance could include:	Met Standard Yes/No	Evidence Found: Notes/Comments
	current federal and State requirements, including those specified in the MDCH Medicaid Managed Specialty Supports and Services Contract.				
13.1	**QUALITY & COMPLIANCE (QUALITY IMPROVEMENT)** The CMHSP has a process in place for carrying out corporate compliance activities across the service area, including the following: • written policies, procedures, and standards of conduct that articulates the organization's commitment to comply with all applicable Federal and State standards, and to guard against fraud and abuse; • designation of a compliance officer and a compliance committee accountable to senior management, focused on regulatory identification, comprehension, interpretation, and dissemination; • training of the compliance officer, committee members and the organization's employees on the compliance policies and procedures; • provision for internal monitoring and auditing to assure standards are enforced, identify high risk compliance areas and where improvements must be made; • provision for prompt response to detected offenses, and for development of corrective action.	42 CFR 438.608.(a); 42 CFR 438.608(b)(1) MDCH Contract 6.9; CMS State Medicaid Director Letter, 6/- 08	CMHSP policies & procedures Compliance Officer job description CMHSP Corporate Compliance Plan Staff training records Risk Management Plan Compliance investigation records		
13.2	CMHSP accreditation status is current and without provisions.		Accreditation letter and report, and improvement plans if applicable		
13.3	Local functions of quality assurance and management. These activities shall include: - develop and implement a Quality Improvement Program to - ensure that Best Practice Guidelines are adhered to - ensure that compliance issues are adequately addressed and reported to the PIHP.	Attachment C6.8.1.1 of the General Fund (Managed Specialty Supports and Services)			

#	STANDARD	Basis/Source	Evidence of Compliance could include:	Met Standard Yes/No	Evidence Found: Notes/Comments
13.4	Submission of performance indicator data to PIHP.	MDCH P6.5.1.1	Receipt by PIHP of performance indicator data as required		
13.5	The CMHSP has an established quality improvement program and plan consistent with the MSHN QAPIP.	MSHN QAPIP	CMHSP QAPI Plan and Report		
13.6	Conduct two Performance Improvement Projects (PIPs) during each Medicaid waiver period.	HSAG II.3	Receipt by PIHP of input and data from the CMHSP as required		
13.7	Procedures and a mandatory compliance plan are in place at each CMHSP to guard against fraud and abuse consistent with the MSHN Compliance Plan. This includes: • CMSHP follows established disciplinary guidelines for their respective employees who have failed to comply with the standards of conduct, policies, and procedures, federal and state law, or otherwise engage in wrongdoing. • The CMHSP informs, in writing, the MSHN Chief Executive Officer (CEO) of any notice to, inquiry from, investigation by any Federal, State, or local human services, fiscal, regulatory, investigatory, prosecutory, judicial, or law enforcement agency or protection and/or advocacy organization regarding the rights, safety, or care of a recipient of Medicaid services • The CMHSP CEO/ED shall report compliance violations to external parties (i.e. OIG, DCH) as required per DCH contract and/or MSHN/CMHSP contract. • CMHSP staff with firsthand knowledge of activities or omissions that may violate applicable laws and regulations are required to report such wrongdoing to the MSHN Compliance Officer or to the CMHSP Compliance Officer.	42 CFR 438.608(a) MSHN Corporate Compliance Plan	CMHSP Corporate Compliance Plan CMHSP policies and procedures		

#	STANDARD	Basis/Source	Evidence of Compliance could include:	Met Standard Yes/No	Evidence Found: Notes/Comments
13.8	The CMHSP conducts internal monitoring and quality assurance and have a process to identify chart documentation/billing errors that includes a system for correction and reporting accuracy	42 CFR 438.608(a) MSHN Corporate Compliance Plan MSHN QAPIP	CMHSP policies and procedures PIHP receipt of data from the CMHSP as required		
13.9	The CMHSP has written procedures for reporting to the PIHP any suspicion or knowledge of fraud or abuse within the Medicaid program.	42 CFR 455.17			
13.10	The CMHSP has a process to collect information about the nature of fraud and abuse complaints, the name of the individuals or entity involved in the suspected fraud or abuse, including name, address, phone number and Medicaid identification number and/or any other identifying information, the type of provider, approximate dollars involved, and legal and administrative disposition of the case including actions taken by law enforcement officials to whom the case has been referred.	42 CFR 455.17			
13.11	The CMHSP has a process in place to report to the PIHP on a semi-annual basis as stated in 13.10 regarding the complaints of fraud and abuse that warrant investigations.	42 CFR 455.17			
14.1	**ENSURING HEALTH & WELFARE /OLMSTEAD (QUALITY IMPROVEMENT)** CMHSP has processes for addressing and monitoring the health, safety and welfare of all individuals served. These may include: • Systematic reporting and review of critical incidents and use of Emergency Physical Intervention • Recipient Rights systems that meet the standards set by the Office of Recipient Rights • Personnel practices that include the use of criminal background checks, Office of the Inspector General Reports, National Practitioner Data Bank, and others as necessary	MSHN AFP Response Section 2.4.11 HSAG II 4a & 4b	Evidence of processes as described in AFP response CMHSP policies and procedures Provider Network monitoring practices in place, including background checks and quality reviews. CMHSP Recipient Rights certification by DCH		

#	STANDARD	Basis/Source	Evidence of Compliance could include:	Met Standard Yes/No	Evidence Found: Notes/Comments
	• Assuring that staff who provide services in residential settings receive training using approved Michigan Department of Community Health group home curriculums. • Quality reviews at provider locations that include documentation of health and safety practices that meet the standards of the Michigan Department of Community Health and accreditation bodies • Ensuring that providers identify and attend to the healthcare needs of all individuals served and coordinating care with other health systems and providers • Imposing plans of correction on providers that do not satisfactorily meet established standards • Sanctions and termination of providers that consistently violate standards				
14.2	The CMHSP has processes for reporting and analyzing adverse events and risk factors. This includes: • critical events • risk events • events requiring immediate notification to MDCH. Data on all types of incidents is monitored, reviewed and reported through a quality assurance process. The CMHSP process includes analysis of any identified patterns or trends, the completion of identified actions, and recommended prevention strategies for future risk reduction.	MSHN AFP Response Section 2.4.11 AFP Response Section 5.2.2.3 HSAG II 4a & 4b	Policy/procedure, evidence of tracking events, root cause analysis		
14.3	The CMHSP provides a semi-annual report to MSHN that includes the number of individuals living outside the region, the date and outcome of their last PCP/FCP meeting with regard to community-of-choice, any barriers to transitioning individuals to their home community, goals for the following year, and other pertinent information.	MSHN AFP Response Section5.3.1.10	Annual report		

#	STANDARD	Basis/Source	Evidence of Compliance could include:	Met Standard Yes/No	Evidence Found: Notes/Comments
14.4	Each CMHSP will develop a process for establishing and monitoring standards regarding the availability and implementation of activities in licensed homes. Each CMHSP will insure that consumer choice is inherent in the development and participation in community integration and productivity activities.	MSHN AFP Response Section 5.3.1.8	CMHSP policies and procedures Quality Reviews of licensed homes		
14.5	The CMHSP works collaboratively with the local licensing office to ensure awareness of issues or deficiencies and to ensure that these are addressed in a timely manner. CMHSP has a quality monitoring program that is sufficient to ensure adequate monitoring and oversight of all licensed residential living arrangements.	MSHN AFP Response Section 5.3.1.8	Quality Reviews of licensed homes Agreements with local licensing office		
14.6	The CMHSP has a written infection control plan which addresses monitoring for and responding to infectious disease as required by local health departments, applicable laws or rules, requirements by accrediting bodies.	MSHN AFP Response Section 5.2.2.3	Infection Control Plan		
14.7	The CMHSP has policies/procedures for medication consents, prescriptions, monitoring side effects, documentation.	MSHN AFP Response Section 5.2.2.3	Copy of policy & procedures		
14.8	The CMHSP has a response system to emergencies and staff are trained to act immediately and decisively when appropriate for the following events including, but not limited to: 1) Seeing to the immediate safety and welfare of an individual and others potentially affected, including transfer to another provider when necessary 2) Violence (or threat of violence) on premises 3) Fire 4) Tornadoes/severe storms 5) Power outages 6) Medical emergencies	MSHN AFP Response Section 5.2.2.3	Emergency response plan Evidence of staff training in emergency preparedness		
14.9	CMHSP routinely collects information on individual's health conditions and ensures that health conditions, health status	MDCH/PIHP Contract Attachment 6.5.1.1 element #39-41	QI data completeness on health conditions		

#	STANDARD	Basis/Source	Evidence of Compliance could include:	Met Standard Yes/No	Evidence Found: Notes/Comments
	and current health care providers are documented in the consumer's clinical record.	MSHN AFP response 5.2.1.2 Medicaid Provider Manual, MH and Substance Abuse 3.24 and 13.3	Chart reviews show evidence of health conditions, health status and current health care providers		