MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Compliance		
Title:	**Provider Contract Non-Compliance Procedure**		
Policy: ☐ **Procedure:** ☒ **Page:** 1 of 7	**Review Cycle:** Biennial **Author:** Deputy Director	**Adopted Date: 07.29.2016** **Review Date:** 11.07.2023	**Related Policies:** Provider Network Policy

Purpose

The Mid-State Health Network (MSHN) Provider Non-Compliance Procedure exists to define the process by which non-compliance will be defined, action steps including corrective action applied and potential sanctions/withholds determined.

Procedure

In the event of non-compliance with established standards, corrective action will be required by the CMHSP Participant and/or the Substance Use Disorder Provider. Corrective action will occur on a consistent and progressive basis, to resolve outstanding issues identified within contract requirements, policies, procedures, performance standards and indicators and/or quality performance concerns.

Prefatory step related to non-compliance:

1. Ongoing discussion and technical assistance with the Provider to identify potential barriers to effective performance and to identify and implement mutually agreeable solutions to performance problems.

The following steps may be implemented when a provider is identified as being out of compliance with established standards, and/or lack of implementation of the corrective action. The same process will apply regardless if non-compliance is identified through Finance, Information Management, Quality, SUD Clinical, Utilization Management, etc.

1. MSHN will give a written sixty (60) day notice that a pattern of non-compliance is noted and the related below next steps will be followed if compliance is not achieved within sixty (60) days.
2. If a withhold and/or sanction has been applied by MDHHS, MSHN will report the pattern of non-compliance to the Finance Council (CMHSP only) to confirm the amount of withhold and/or sanction as deemed appropriate to confirm applicability and related reductions by category. (PEPM, County, CMHSP, etc.)
3. If the applicability is related to the CMHSP participants, SUD Providers and/or MSHN direct operations, once the financial penalty has been determined, the amount along with the detailed pattern of non- compliance will be reviewed by the Chief Finance Officer and Deputy Director to determine and answer the following questions in order to provide a recommended course of action to the MSHN Chief Executive Officer (CEO):
    a. Is the penalty/withhold/sanction applied across the CMHSPs, Provider Network, MSHN, or a single entity?
    b. How will it be applied? (Equally, based on PEPM, total amount, etc.)
    c. Is it allowable to be covered with savings and/or the Internal Service Fund?
    d. Will it affect the financial viability of continued services?
    e. If future acceptable corrective action is obtained, will the penalty/withhold/sanction be refunded?

4. The MSHN Chief Executive Officer will review the recommendation and carry-out the related penalty/withhold/sanction in accordance with the recommended terms. The MSHN CEO has the ultimate decision-making authority and responsibility to manage the funds in accordance with the contract requirements and therefore may choose to not proceed with the recommended actions.
5. MSHN reserves the right to revoke delegated functions.
6. Exclusions: Sanctions, withholds and non-compliance related to a single entity that does not have regional implications will be addressed directly by MSHN staff.
7. MSHN may terminate the contract in accordance with contract termination language. Contractor may file an appeal in accordance with the process identified in contract language and the MSHN Provider Appeal Procedure.

Corrective Action Plan/CAP Implementation Plan/Performance Enhancement Plan:
In accordance with MSHN Monitoring and Oversight policy and procedures, a corrective action plan (CAP) is required for findings identified during monitoring activities.

A CAP Implementation Plan is required when a provider has a history of specific repeat findings over a series of years of reviews. The process is intended to provide technical assistance as well as an increased level of continuous monitoring specific to the repeat findings. This is intended to be a quality-based effort to assist the provider in becoming compliant.

A performance enhancement plan (PEP) will be required when a CAP Implementation Plan does not progress into increased improvement, when any department identifies non-compliance with contract requirements, policies, procedures, performance standards and indicators and/or quality performance concerns.

When requiring a CAP/Implementation Plan or a PEP, the following information will be communicated to the provider:

1. Identification of standards/requirements found out of compliance
2. Timeframe for submitting the plan
3. Timeframe for MSHN to approve the plan or request additional information (as applicable)
4. Timelines for when the plan must be fully implemented
5. Timeframe and frequency of monitoring and oversight for the plan
6. Next steps that will be taken if the plan does not result in full compliance with standards/requirements

The CAP Implementation Plan or PEP will include the following elements:

1. Causal factors/problem statement that led to non-compliance (directly and/or indirectly)
2. Interventions that will be implemented to correct non-compliance
3. Timelines for when the interventions will be fully implemented
4. How the interventions will be monitored on an ongoing basis
5. Any other actions that will be taken to correct future occurrences

If the review of clinical records is deemed necessary as part of the monitoring process, the following timelines will be followed:

1. MSHN will provide a 30-day notice to the provider prior to the start of the review
2. MSHN will provide 15 business day notice to the provider for the case selection
3. MSHN will provide the report of the review within 15 business days to the provider

Claims Voiding and Recoupment of Funds (as needed):
To be considered a valid claim, the standards within the Medicaid Provider Manual, Medicaid Services Verification contract attachment and the MSHN Medicaid Event Verification policy and procedure must be followed.

A valid claim will include the following elements:

1. Code submitted for billing is approved under the contract
2. Eligibility of the beneficiary on the date of service
3. For CMHSP Participants, the service provided is part of the beneficiary's individualized plan of service (and provided in the authorized amount, scope and duration); For SUD Providers, the service provided was provided as authorized and included in the treatment plan
4. The date and time of the service
5. Services were provided by a qualified individual and falls within the scope of the code billed and paid
6. The amount paid does not exceed the payer contracted amount
7. Modifiers are used following the HCPCS guidelines

Only a claim that does not meet the established standards will be voided and the funds will be recouped. Other issues, such as non-compliance with MSHN policies, procedures or contract requirements, will require a corrective action plan/CAP Implementation Plan/PEP but will not result in voiding of claims.

If the required action includes voiding claims, the following steps will be followed:

1. The MSHN staff who completed the review will work in collaboration with the Chief Finance Officer to provide supporting documentation to the Chief Compliance and Quality Officer. The documentation will include the following for each claim that is identified as invalid:
    a. Explanation of why the claim/encounter is not valid based on the seven (7) identified standards above
    b. Consumer Name
    c. Date of service
    d. Time of service (start and stop time)
    e. Quantity/Number of Units
    f. Procedure code
    g. Modifier(s) (if applicable)
2. The Chief Compliance and Quality Officer will complete the following steps:
    a. Review the submitted information
        i. If there are questions, then it will be reviewed with the MSHN staff, department lead and/or finance as needed.
    b. Notify the provider, by letter, of the findings and provide 10 business days for the provider to respond to the findings that may include documentation to support the claim(s).
    c. Review documentation submitted by the provider refuting one or more of the claims, if applicable.
    d. Consult with appropriate MSHN staff to determine if review results should be adjusted/revised based on documentation submitted by the provider, if applicable.
    e. Send letter, and final invalid claims, to the provider notifying them of the intended action, provide information on the right to submit an appeal following the Provider Appeal Policy and the ability to resubmit claims with corrected information as appropriate.
    f. Once the period to submit an appeal is past, the claims will be submitted to Finance with the appropriate information identified on an excel spreadsheet.
3. Providers:
    a. SUD Providers: MSHN Finance staff will complete the following:
        i. Void the identified claims
        ii. Complete recoupment of funds used to pay for claims that were voided during the next scheduled payment or based on a payment plan if requested by the provider.
        iii. Notify the Chief Compliance and Quality Officer when completed.
        iv. Copy of void and recoupment document will be placed in the appropriate folder in Box.
    b. CMHSP Participants:
        i. CMHSPs must complete the following:
            1. Void the claims (including prior years if applicable)
            2. Ensure fund source adjustments are made in accordance with generally accepted

accounting principles (GAAP) and MDHHS contractual guidelines to ensure accurate cost settlement with the PIHP

3. Provide evidence of the completed voids to MSHN's Compliance Officer (ie: excel spreadsheet)

ii. MSHN staff will complete the following:

1. Complete end-of-year cost settlement with the CMHSP.
2. The Chief Compliance and Quality Officer will verify that the required claims have been voided.

Recoupment of Funds Not Associated with a Submitted Claim/Encounter:
Funds will only be considered for recoupment in a situation where the provider was out of compliance with state requirements and federal requirements.

1. MSHN staff will inform the Chief Finance Officer and Chief Compliance and Quality Officer of the following:
   a. The unallowable program requirements.
   b. The unallowable expenses.
2. The Chief Finance Officer and Chief Compliance and Quality Officer will complete the following:
   a. Review the submitted information.
   b. If there are questions, then it will be reviewed with the MSHN staff and/or department lead as needed.
   c. If it is not agreed that recoupment of funds is necessary, then other action such as a plan of correction to include increased monitoring will be considered.
3. If it is agreed that recoupment of funds is appropriate, the Chief Compliance and Quality Officer will complete the following:
   a. Notify the provider, by letter, of the findings and provide 10 business days for the provider to respond to the findings that may include documentation to support the expenses.
   b. Review documentation submitted by the provider, if needed.
   c. Consult with appropriate MSHN staff to determine if findings should be adjusted/revised based on documentation submitted by the provider, if applicable.
   d. Send a letter to the provider notifying them of the final decision and intended action, provide information on the right to submit an appeal following the Provider Appeal Policy and the right to request a repayment plan. MSHN's CFO will review and make a decision on any requested repayment plan.
   e. Once the period to submit an appeal and a request for a repayment plan has passed, Finance will proceed with the recoupment amount.

Sanctions/Withholds/Contract Termination:

If a significant material breach occurs, MSHN will provide written notification to the provider within seven (7) business days that a withhold will occur at the next scheduled payment.

A pattern of non-compliance or lack of implementation of the CAP and/or PEP can result in one or more of the following:

1. Prior to withholding payments as noted below, the PIHP will give sixty (60) day notice to allow for a period of correction.
   a. This notice will be in the form of a letter from the Chief Compliance and Quality Officer.
   b. The letter will contain the following information:
      i. Standards and/or requirements that are out of compliance
      ii. CAP/CAP Implementation Plan and/or PEP that has been implemented related to non-compliance and progress/status of implementation
      iii. Technical assistance that has been provided (if applicable)
      iv. Next steps that will be taken if the provider is not in compliance at the end of the 60-day period
      v. Supporting documents

c. If, after the 60-day period, the provider is still not in compliance with the identified standards, a notice will be sent out to the provider that withholding of payment will occur as follows
   i. 1st withhold - 20% of the next scheduled payment following the notice period
   ii. 2nd withhold – 25% of the next scheduled payment
   iii. Subsequent withholds will occur at an additional 5% of anticipated provider payment until compliance is achieved
   iv. Once the withhold amount reaches 40%, MSHN will consider additional contract action.
2. Revocation of identified applicable delegated functions (CMHSP Participants only).
3. Temporary hold on new client admissions may occur in the event of contractual non-compliance and/or identified health or safety issued (SUD Provider Only)
4. Immediate termination of the contract may result in the event that MSHN determines that a covered consumers health or safety is in immediate jeopardy, in instances of material breach, or where corrective action plans and/or payment withholds have not been successful.

Decision Making:
The final decision to deviate from the above process to implement sanctions, withholds, and/or contract termination is at the discretion of MSHN's Chief Executive Officer (CEO) or an Ad-Hoc committee at the discretion of the CEO. Recommendation for action will be presented to the CEO by the Chief Compliance and Quality Officer for consideration. The recommendations will be based on the following information provided by MSHN staff responsible for the completion of the review and monitoring of plans of correction.

- Pattern of non-compliance with standards and/or requirements
- Corrective Action Plans and/or Performance Enhancement Plans that have been implemented related to non-compliance and progress/status of implementation
- Technical assistance that has been provided (if applicable)
- Health and safety concerns if present

Dispute Resolution/Appeal Process:
Should the provider engage in a "dispute resolution/appeal" process, following MSHN's Provider Appeal Procedure, any financial penalties/withholds will be delayed until final resolution is made by the MSHN Appeal Committee.

Applies to:
☐ All Mid-State Health Network Staff
☐ Selected MSHN Staff, as follows:
☒MSHN's CMHSP Participants: ☐Policy Only ☐Policy and Procedure
☒Other: Sub-contract Providers

Definitions:
Corrective Action Plan (CAP): A step by step plan of action developed to achieve targeted outcomes for quality improvement.
CAP Implementation Plan: Process to support technical assistance and monitoring of provider CAP implementation after subsequent years of repeated findings.
Casual Factors:

a. Common cause variations are system related and require long term system wide improvements to resolve; there are many small reasons for the variations, and they occur relatively constantly. Sources of common cause variation are manpower, material, method, measurement, machine and environment.
b. Special or assignable cause variations result from an identifiable cause which can be addressed; they often appear as individual data points that vary greatly from the rest; if the result is a desired variation in performance, the cause should be replicated; if undesired, then identified and eliminated.

CEO: Chief Executive Officer
CMHSP: Community Mental Health Service Program
Contractor: Independent or organizational entity that has a signed agreement with MSHN.
Non-compliance: Failure to meet contract requirements, policies, procedures, performance standards and indicators and other contractually obligated mandates of the PIHP
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
Performance Enhancement Plan (PEP): A supportive measure to offer a provider more intensive technical assistance and monitoring to address quality, performance, outcomes, and compliance issues. It is typically developed and implemented by the MSHN Treatment Team in partnership with the MSHN Utilization Management Team, QAPI Team, and Quality/Compliance Team.
PEPM: Per Eligible Per Month (Medicaid funding formula)
SUD: Substance Use Disorder

Other Related Materials:
Medicaid Subcontracting Agreement – Monitoring the Agreement
MSHN CMHSP Participant Monitoring & Oversight Procedure
MSHN Delinquency Procedure for SUD Providers MSHN
MSHN Medicaid Event Verification Procedure
Monitoring & Oversight of SUD Services Providers Procedure
MSHN Provider Appeal Procedure

References/Legal Authority:
N/A

Change Log:

Date of Change	Description of Change	Responsible Party
03.2016	New Procedure	Deputy Director
08.2017	Annual Review	Director of Compliance, Customer Service & Quality
08.2018	Annual Review	Director of Compliance, Customer Service & Quality
04.2020	Added SUD Non-Compliance Section	Director of Compliance, Customer Service & Quality
08.2021	Biennial Review	Chief Compliance and Quality Officer
09.2021	Revised to include additional action for contract non-compliance	Chief Compliance and Quality Officer
June 2022	Revision to void and recoupment process	Chief Compliance and Quality Officer
08.2023	Biennial Review; added CAP Implementation; added recoupment of funds not associated with a claim	Chief Compliance and Quality Officer

Provider Contract Non-Compliance Flowchart