KALAMAZOO COMMUNITY
Mental Health
& Substance Abuse
Services

KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

REQUEST FOR PROPOSAL

Home-Based Therapy
(Ages 7-21 Years Old)
RFP 17-02

KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (KCMHSAS)
3299 Gull Road
Kalamazoo, MI 49074

REQUEST FOR PROPOSALS FOR Home-Based Therapy

I. INTRODUCTION

A. Purpose of the Request for Proposals

Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) is requesting information from providers who are willing and able to provide Home-Based Therapy Services for our local governmental agency. Home-based therapy is an intensive family service delivered in the community that includes case management, individual therapy and family therapy interventions. It is provided as a direct service for a minimum of four hours a month. It is also delivered within a system of care (see Attachment 3.0 for more information.)

B. Terms of Engagement

As a result of this RFP, KCMHSAS may elect to contract with one or more providers or may choose to not award a contract at this time. If a contract is awarded, the time period will be approximately October 1, 2017 through September 30, 2018 with an option for renewal.

II. DESCRIPTION OF ORGANIZATION

Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) has been delivering quality services and programs to improve the lives of those we serve for over 30 years. We provide a welcoming and diverse community partnership which collaborates and shares effective resources that support individuals and families to be successful through all phases of life. KCMHSAS works with youth, families, and adults with mental illnesses, intellectual/developmental disabilities, and substance abuse disorders to help them succeed.

We build on the strengths, hopes, and dreams of those who come in contact with KCMHSAS. We are fortunate to have dedicated and caring board members, families, individual's served, peers, staff, advocates, providers, and other collaborative partners.

III. SCOPE OF SERVICES

KCMHSAS is requesting information from providers who are able to provide Home-Based Therapy. See Attachment 1.0 and 2.0 for a full description of this service and the eligible participants.

IV. RFP Timeline

Activity	Timeline
Issuance of RFP	March 24, 2017
Vendor questions regarding the RFP submitted via e-mail in place of a bidder's conference. Questions should be submitted to cthomas@kazoocmh.org	April 10, 2017
Answers regarding the RFP posted on the KCMHSAS public website.	April 17, 2017
Proposals due to KCMHSAS	May 5, 2017
Oral presentations (if needed)	Late May 2017
Notification of Award	June 30, 2017
Contract Begins	October 1, 2017

IV. INSTRUCTIONS FOR PROPOSAL SUBMISSION

A. Response Date

1. **Seven (7) hard copies** of the proposal must be sent to:
   KCMHSAS
   Attn: Sheila Hibbs, Manager of Quality and Contract Services
   2030 Portage Street Kalamazoo, MI. 49001
2. Hard copies must be labeled "RFP 17-02" and include the name & address of the applicant on the envelope.
3. An electronic copy of the proposal must be sent to shibbs@kazoocmh.org Documents should be in PDF format *on or before May 5, 2017 at 3:00pm.*
4. All proposals are due to KCMHSAS by *May 5,, 2017 by 3:00 P.M.*
5. Faxed or late proposals will not be accepted.

B. Proposal Content

1. A written response is required for each item unless otherwise indicated. Failure to answer any of the items will negatively impact the applicant's score.
2. Applicants should be familiar with the exhibits referenced in this RFP.
3. Sections should be clearly labeled
4. An official authorized to bind the vendor to its provisions must sign all proposals.
5. For the Proposed Services for KCMHSAS section, please limit your response to a single page per question, using a font size of 11 or larger.

C. Incurring Costs

Proposals should be prepared simply and economically to provide a concise description of the vendor's capability to perform the services required. KCMHSAS will not be responsible for any costs incurred in the preparation of proposals in response to this RFP. Nor will KCMHSAS be responsible for any costs incurred if the vendor agency is invited to make an oral presentation to the evaluation team.

D. Effective Period

All proposals submitted to this RFP must be valid through the entire contractual process.

E. Withdrawal

The proposal may be withdrawn in person or by written request, unless KCMHSAS members have accepted the proposal in writing.

F. Questions

All questions relating to the preparation and/or submission of a response to this RFP should be directed to cthomas@kazoocmh.org.

G. Miscellaneous Provisions

1. Acceptance of Proposal Content
   Contents of the proposal may become contractual obligations. Failure to accept these obligations may result in cancellation of the selected vendor, who may be required to reimburse KCMHSAS for damages incurred.
2. Non-Discrimination
   Vendors shall not discriminate against persons with respect to hire, tenure, terms, conditions or privileges of employment, or a matter directly or indirectly related to employment, because of race, color, religion, national origin, age, sex, height, weight or marital status, or disability that is unrelated to the vendor's ability to perform the duties of a particular job or position. The vendor shall observe and comply with all applicable federal, state and local laws, ordinances, rules and regulations which shall be deemed to include, but not be limited to, the Elliott-Larsen Civil Rights Act and the Persons with Disabilities Civil Rights Act.
3. Non-Collusion
   The vendor certifies that this proposal has not been made or prepared in collusion with any other vendor and the prices, terms or conditions have not been communicated by or on behalf of the vendor to any other vendor and will not be so communicated prior to the official receipt of this proposal. This certification may be treated for all purposes as if it were a sworn statement made under oath, subject to the penalties for perjury. Moreover, it is made subject to the provisions of 18 U.S. C. Section 1001, relating to the making of false statements.
4. Freedom of Information Act
   Information submitted in response to this proposal is subject to the Michigan Freedom of Information Act and may not be held in confidence after the proposal is opened. The proposal will be available for review after all proposals received have been evaluated and vendors selected.

V. PROPOSAL CONTENT

A. Administrative Requirements

All applicants must submit the following with their RFP Response:

1. Cover Page with the following information
   - Legal Business Name
   - Address
   - Telephone Number(s)
   - Fax Number(s)
   - E-mail/Web Page Address
   - Tax ID Number
   - Owner (name/title)

- Person Authorized to Sign Contracts (name/title)
- Billing Entity Authorized to receive financial reimbursement/payment
- Billing Contact Person and Telephone Number
- Billing Address if different than above

2. Articles of Incorporation and proof of provider's ability to conduct business in the State of Michigan, and in what business capacity (Corporation, Sole Proprietor, etc.)
3. Statement that the applicant is independent of KCMHSAS.
4. Disclosure if the organization or any staff person currently working for the organization has been excluded from a Federal Healthcare Program. To find information on exclusions from a Federal Healthcare Program please consult the following sites:
   https://www.epls.gov/ (list of excluded parties/organizations);
   http://exclusions.oig.hhs.gov/ (list of excluded individuals/entities).
5. Regulatory Issues: Disclosure of circumstances and status of any disciplinary action taken or pending against the business during the past 3 years with federal or state regulatory bodies.
6. Proof of Insurance coverage to cover the work the vendor intends to perform. Insurance coverage shall include:
   - Workers compensation.
   - Liability and property damage insurance – protection for claims for property damage which may arise from operations under this bid, whether such operations are conducted by the vendor or any subcontractor.
7. Disclosure of any affiliation or subcontracting relationships, as applicable statements and/or other pertinent documentation identifying/describing parties that may be sub-contracted to provide services for the vendor.
8. Demonstrate your financial solvency. If your Agency does not submit financial audits each year, please include your past three financial audits with the RFP submission.
9. Make a statement agreeing to submit provider NPI numbers for all professional staff if your program is selected.
10. Describe your internal quality assurance program and how it meets the standards described in Attachment 4.0.
11. Include a statement agreeing to the rate in Attachment 5.0 and, if applicable, supporting evidence as outlined in Attachment 5.0
12. Describe your billing process. Providers must be able to either bill via an 837 or through the KCMHSAS Provider Access system.

B. Proposal for Services

1. Business Demographics
   - Provide a description of your business; number of years in business, clientele, services available and experience providing those services.
2. Personnel
   - Vendor should identify personnel who would be working with KCMHSAS along with brief qualifications of key personnel.
   - Identify any professional consulting service(s) that will be utilized in proposed services for KCMHSAS and their expected role(s).
3. Relevant Experience
   The proposal should list at least four similar projects completed over the last three (3) years. The list should include:
   - Name and location of business where service was provided.
   - Description of the project services.

- References and contact information for said references shall be provided. The RFP committee may elect to contact references on all responses.

4. Proposed Services for KCMHSAS

A. Proposal for KCMHSAS addressing the needs outlined in I. A & B of this RFP.

B. Describe the unique qualities that allow your agency to provide excellent services to consumers.

C. Provide the following information:

1. Submit evidence of demonstrated program outcomes - that are less than two years old- related to home-based services.
2. Submit information regarding your approach to ensure excellent care.
3. Submit evidence of a history of providing culturally proficient care.
4. Describe the level of service that you plan to provide and explain why your staff to youth ratio and staff to supervisor ratio will be ideal for providing excellent care.
5. Home-based Therapy includes transition planning for youth who are moving to adulthood. This includes teaches life skills and teaching youth about benefit information. It also includes moving youth between levels of care. Describe your plan to provide transition planning.
6. Home-based services also has active discharge planning to transition youth to adulthood. It also must include a plan to use natural supports to make discharge sustainable. Describe how you will meet these objectives.
7. Home-based therapy requires that each youth have a skill-based crisis plan that includes individualized crisis and safety plans that explicitly outline responses to family-specific crisis situations and safety risks and delineate who, including the family and others, is accountable for the various responses identified. Describe how you will provide crisis planning.
8. This service must also incorporate youth and family voice. This means that providers must help youth and their family to advocate for the services that they need. Providers of this service must also integrate family support partners and youth peer support specialists into treatment. Describe your plan to do this.
9. Home-based providers coordinate with primary care and psychiatric providers to integrate the health care needs of their youth. Describe how you will do this.
10. Home-based providers must report CAFAS/PECFAS scores on all of the youth they serve. They must also report BH-TEDS data. Describe your plan to do this.
11. Describe which evidence based treatments or speciality services that you can offer, if any.

VI. EVALUATION CRITERIA

The proposals submitted will be reviewed and evaluated by a committee designated by KCMHSAS comprised of persons who have operational, administrative and technical knowledge of the specifications contained in this RFP. Evaluation criteria include, but are not limited to, the understanding of the proposed engagement as evidenced by the quality of the RFP response submitted, relevant experience, qualifications of the vendor and the approach/methodology. Proposals will be scored using the following metric: 20% of the final score will be based on answers to the Adminstravtive Requirements section and 80% of the final score will be based on answers to the Proposal for Services section.

VII. SELECTION PROCESS

KCMHSAS reserves the right to request additional information or clarification from vendors, to allow correction of errors or omissions, and to waive irregularities and/or formalities when so doing may serve the best long-term interests of the organizations involved.

KCMHSAS reserves the right to reject any or all proposals and to proceed in any other manner selected by KCMHSAS.

All proposals submitted are subject to the terms of the Freedom of Information Act, and will be retained by KCMHSAS.

Attachment 1.0
(From the Michigan Medicaid Manual)

7.2.C. AGE SEVEN THROUGH SEVENTEEN

Decisions regarding whether a child or adolescent has a serious emotional disturbance and is in need of home-based services is determined by using the following dimensions: the child has a diagnosable behavioral or emotional disorder, substantial functional impairment/limitation of major life activities, and duration of the condition. For children age seven to seventeen, the Child and Adolescent Functional Assessment Scale (CAFAS) is used to make discriminations within the functional impairment dimension. All of the dimensions, as well as family voice and choice, must be considered when determining if a child is eligible for home-based services.

Diagnosis

The child/adolescent currently has, or had at any time in the past, a diagnosable behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current version of the DSM or ICD, excluding those with a diagnosis other than, or in addition to, alcohol or drug disorders, a developmental disorder, or social conditions (ICD-9 V-codes and ICD-10 Z-codes).

Functional Impairment

For purposes of qualification for home-based services, children/adolescents may be considered markedly or severely functionally impaired if the minor has:

- An elevated subscale score (20 or greater) on at least two elements of the Child/Adolescent Section of the CAFAS; or
- An elevated subscale score (20 or greater) on one element of the CAFAS Child/Adolescent Section, combined with an elevated subscale score (20 or greater) on at least one CAFAS element involving Caregiver/Care-giving Resources; or
- A total impairment score of 80 or more on the CAFAS Child/Adolescent Section.

Duration/History

The following specify the length of time the youth's functional disability has interfered with his daily living and led to his referral for home-based services:

- Evidence of six continuous months of illness, symptomatology, or dysfunction;
- Six cumulative months of symptomatology/dysfunction in a 12-month period; or
- On the basis of a specific diagnosis (e.g., schizophrenia), disability is likely to
- continue for more than one year.

Attachment 2.0
(From the Michigan Medicaid Manual)

SECTION 7 – HOME-BASED SERVICES

Mental health home-based services programs are designed to provide intensive services to children and their families with multiple service needs who require access to an array of mental health services. The primary goals of these programs are to support families in meeting their child's developmental needs, to support and preserve families, to reunite families who have been separated, and to provide effective treatment and community supports to address risks that may increase the likelihood of a child being placed outside the home. Treatment is based on the child's needs, with the focus on the family unit. The service style must support a family-driven and youth-guided approach, emphasizing strength-based, culturally relevant interventions, parent/youth and professional teamwork, and connection with community resources and supports.

7.1 PROGRAM APPROVAL

Applications for enrollment must identify home-based providers, either internal or contractual, who will serve children ages 0-17. Home-based services can be provided by one or more providers who serve one or more age groups. Once enrolled, a program must re-enroll every three years. (Refer to the Directory Appendix for contact information.) MDHHS approval will be based on adherence to the requirements outlined below.

Applications for enrollment must identify the target population to be served by the program. Providers must assure that staff providing home-based services meet the required qualifications. Information submitted to MDHHS must include basic program information submitted in a format prescribed by MDHHS. If necessary during an initial period, the provider may receive provisional approval that will allow them to provide services. However, any necessary additional actions must be completed within the timeframe specified by MDHHS or provisional approval will be withdrawn.

Organizational Structure

The organizational structure through which the mental health home-based services program shall be delivered must be specified. The following requirements must be met:

- Enrolled home-based services providers are available and sufficient to ensure that home-based services are provided to children ages 0-17 and meet the need across the entire catchment area.
- Responsibility for directing, coordinating, and supervising the staff/program must be assigned to a specific staff position. The supervisor of the staff/program must meet the qualifications of a Qualified Mental Health Professional and be a child mental health professional with three years of clinical experience.
- One staff member or a team of staff may provide these services. Home-based services programs are designed to provide intensive services to children and families in their home and community. The degree of intensity will vary to meet the needs of families.
- The maximum full-time home-based services worker-to-family ratio is 1:12. This can be adjusted to accommodate families transitioning out of home-based services. The maximum worker-to-family ratio in those circumstances is 1:15 (12 active/3 transitioning).
- If providers wish to utilize clinicians who serve mixed caseloads (home-based services plus other services, e.g., outpatient, case management, etc.), the percentage of each position dedicated to home-based services must be specified. The number of home-based services

cases assigned to each partial position cannot exceed the same percentage of the maximum active home-based services caseload. For example, a 50% home-based position could serve no more than 6 home-based cases. The total maximum caseload, including home-based and other services cases, for a full-time clinician serving a mixed caseload is 20 cases. To determine the appropriate caseload size for any home-based services worker, the intensity of service need presented by each family should be considered. The worker-to-family ratio can always be lower than the maximum to accommodate families with very high service needs.

- Home-based services staff must receive weekly clinical supervision (one-on-one and/or group) to help them navigate the intense needs of the families receiving home-based services. Evidence of the provision of this clinical supervision must be recorded via supervision logs, sign–in sheets, or other methods of documentation.
- The organization must have a policy or policies in place that support providing a comprehensive crisis/safety training curriculum that is required for all home-based services staff that includes de-escalation skills among other relevant trainings.
- There must be an internal mechanism for coordinating and integrating the homebased services with other mental health services, as well as general community services relevant to the needs of the child and family.

Qualified Staff

Properly credentialed staff must deliver home-based services. Home-based services professional staff must meet the qualifications of a child mental health professional. The initial training curriculum and 24 hours of annual child-specific training for homebased services staff should be relevant to the age groups served and the needs of the children and families receiving home-based services. For home-based services programs serving infants/toddlers (birth through age three) and their families, staff must be trained in infant mental health interventions and, effective October 1, 2009, must minimally have Endorsement Level 2 by the Michigan Association of Infant Mental Health; Level 3 is preferred. For home-based services programs serving children with developmental disabilities, the child mental health professional must meet the qualifications, as defined above, and also be a Qualified Intellectual Disability Professional (QIDP).

Trained paraprofessional assistants may assist home-based services professional staff with implementation of treatment plan behavioral goals related to positive skill development and development of age-appropriate social behaviors. Services to be provided by the home-based services assistant must be identified in the family plan of service, must relate to identified treatment goals, and must be under the supervision of relevant professionals. Home-based services assistants must be trained regarding the beneficiary's treatment plan and goals, including appropriate intervention and implementation strategies, prior to beginning work with the beneficiary and family. Activities of home-based services assistants do not count as part of the minimum four hours of face-to-face home-based services provided by the primary home-based services worker per month. The home-based services assistant's face-to face time would be in addition to hours provided by the primary home-based services worker.

Child Mental Health Professional

- A person who is trained and has one year of experience in the examination, evaluation, and treatment of minors and their families and who is either a physician, psychologist, licensed professional counselor or registered professional nurse; or
- A person with at least a bachelor's degree in a mental health-related field from an accredited school who is trained, and has three years of supervised experience in the examination, evaluation, and treatment of minors and their families; or
- A person with at least a master's degree in a mental health-related field from an

accredited school who is trained, and has one year of experience in the examination, evaluation, and treatment of minors and their families.

Plan of Service

Home-based services must be provided in accordance with a plan of service that focuses on the child and his family. The plan of service is a comprehensive plan that identifies child and family strengths and individual needs, determines appropriate interventions, and identifies supports and resources. It is developed in partnership with family members and other agencies through a person-centered, family-driven and youth-guided planning process. The plan of service should include evidence of a blending of perspectives and information from the child/youth, family, home-based services worker, assessment tools, and other relevant parties. Goals should be based on family needs and priorities and reflect the family culture and voice. Refer to the Family-Driven and Youth-Guided Policy and Practice Guideline (attached to the MDHHS/PIHP contract) for more explicit information on this topic.

The plan of service for youth receiving home-based services must also include individualized crisis and safety plans that explicitly outline responses to family-specific crisis situations and safety risks and delineate who, including the family and others, is accountable for the various responses identified.

Amount and Scope of Service

Home-based services programs combine services to restore or enhance social, psychological, or biophysical functioning of individuals, couples, or families and/or individual therapy, family therapy, group therapy, crisis intervention, case management, and collateral contacts. The family is defined as immediate or extended family or individual(s) acting in the role of family.

Services provided in a home-based services program range from assisting beneficiaries to link to other resources that might provide food, housing, and medical care, as well as providing more therapeutic interventions such as family therapy or individual therapy, or services to restore or enhance functioning for individuals, couples, or families.

A minimum of four hours of individual and/or family face-to-face home-based services per month will be provided by the primary home-based services worker or, if appropriate, the evidence-based practice therapist. In addition, it is expected that adequate collateral contacts, including non-face-to-face collateral contacts, with school, caregivers, child welfare, court, psychiatrist, etc., will be provided to implement the plan of service.

The amount and scope of home-based services to families as they transition out of home-based services into a less intensive service or to case closure can be determined by family-driven and youth-guided decision making to maintain continuity of treatment and ensure stability. Variation from the required intensity of services for families transitioning out of home-based services must be documented in the plan of service.This transition period is not to exceed three months.

Crisis intervention services must be available 24 hours a day, 7 days a week, via availability of home-based services staff or agency on-call staff. If after-hours crisis intervention services are provided to a family by staff other than the primary homebased services worker, procedures must be in place which provide the on-call staff access to information about any impending crisis situations and the family's crisis and safety plans.

Location of Service

Services are provided in the family home or community. Any contacts that occur other than in the home or community must be clearly explained in case record documentation as to the reason, the expected duration, and the plan to address issues that are preventing the services from being provided in the home or community.

Attachment 3.0
(From KCMHSAS Policy and Procedures)

DEFINITIONS

Serious Emotional Disturbance
A State and Federal Definition of the broad eligibility category serious emotional disturbance which is a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:

a. A substance use disorder.
b. A developmental disorder.
c. "V" codes in the diagnostic and statistical manual of mental disorders.

POLICY

A. Therapeutic interventions shall be consistent with System of Care values including family-driven with youth voice, individualized, integrated, community based, strength-based, needs-based, evidence-based, culturally responsive, and outcome driven. The System of Care for Kalamazoo County is named Kalamazoo Wraps.
B. All services, supports, and interventions shall be consistent with System of Care philophy in which all partners collobarate for greatest impact and use innovative approaches.
C. Assessments, evaluations and interventions shall be provided within the Person-Centered Planning process.
D. Assessments shall include opportunities to complete a CRAFFT; a trauma screen; a Clinical Profile to Assist in Demonstrating Medical Necessity for Primary and Ancillary Services; and a developmentally matched functional assessment tool of the CAFAS, PECAFAS, DECA, or Ages and Stages.
E. Youth receiving services through the KMCHSAS network of providers shall provide a clear and thorough assessment and specialty screens to assure that youth and families are linked to needed, effective services.

All primary clinicians providing clinical services to minors and all staff, volunteers, interns, students and contractors providing services to children receive clinical and administrative supervision necessary efficiently, effectively and safely deliver supports and services.

All families will have a Child and Family Crisis/Safety Plan unless the family provides a clear denial of the crisis/safety plan. In such instances where an individualized crisis/safety plan is declined, the primary clinician shall provide general information on who to call in a crisis and document this information in the electronic medical record.

Attachment 4.0
(From KCMHSAS Policy and Procedures)

KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

ADMINISTRATIVE POLICY 02.08

Subject: Provider Network Monitoring	**Section:** Provider Network Management	
Applies To: ☒ KCMHSAS Staff ☒ KCMHSAS Contract Providers		**Page:** 14 of 24
Approved: (Jeff Patton, Chief Executive Officer)		
Revised: 03/07/2016	**Supersedes:** 01/01/2014	**First Effective:** 12/20/2004

PURPOSE

To provide an overview of the means and processes used by Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) for monitoring the compliance of service providers with contract and other requirements and to assure the highest quality of services to individuals served by KCMHSAS.

DEFINITIONS

Sub-Recipient
An entity that expends Federal awards received from a pass-through entity to carry out a program. In other words, as found in the OMB Circular A-133 Compliance Supplement, "a sub-recipient relationship exists when funding from a pass-through entity is provided to perform a portion of the scope of work or objectives of the pass-through entity's award agreement with the…awarding agency."

Single Audit
For new Federal awards made after December 26, 2014, A non-Federal entity that expends $750,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single audit conducted in accordance with §200.514 Scope of audit except when it elects to have a program-specific audit conducted in accordance with paragraph (c) of this section; the Code of Federal Regulations (CFR), Title 45, Part 96.31; the Single Audit Act Amendments of 1996 (31 U.S.C. 7501-7507); and updated Office of Management and Budget (OMB) Circular A-133 "Audits of State, Local Governments, and Non-Profit Organizations". The Single Audit also applies to a **Sub-Recipient** (a non-federal entity that expends federal awards received from a pass-through entity to carry out a federal program but does not include an individual who is a

beneficiary of such a program; a sub-recipient may also be a recipient of other federal awards directly from a federal awarding agency).

Net Cost
Cost-reimbursement types of contracts provide for payment of allowable incurred costs, to the extent prescribed in the agreed upon budget.

POLICY

It is the policy of KCMHSAS to ensure the performance, quality, regulatory and contract compliance of each entity that holds a contract with the KCMHSAS.

STANDARDS

I. A KCMHSAS monitoring plan will be evaluated and revised as needed on at least an annual basis to determine:

A. Contract providers who will require formal monitoring in the next fiscal year.
B. Methods in which monitoring will take place, including but not limited to:
    1. On site provider reviews
    2. Desk audit monitoring
    3. Sharing of monitoring reviews and activities between the Southwest Michigan Behavioral Health PIHP and partnering Community Mental Health Services Programs within the region.
    4. Ongoing monitoring of provider external audits and financial report submissions, when required.
C. Focus areas of monitoring based on assessed and identified risks.

II. Individuals and organizations under contract with KCMHSAS for the provision of services:
A. Must be credentialed prior to finalizing an initial contract. Organizations must provide evidence that there are adequate processes in place for credentialing and re-credentialing their staff (refer to policy 02.09 [Credentialing, Re-Credentialing and Criminal History Screening]).
B. Are subject to the ongoing monitoring by KCMHSAS.
C. Are required to implement improvement plans as indicated through identified deficiencies or areas needing improvement.

III. The components and tools utilized in provider monitoring review processes are outlined in exhibit A.

IV. Quality Monitoring Reviews (QMR) are a significant part of reviewing providers. A QMR of a provider may include one or more of the following components:

A. Clinical Record/Claims Verification Review (CVCRR)
B. Utilization Management Reviews (UR)
C. Organizational Practices Review (OPR)
D. Certification Reviews
E. Sub-recipient Monitoring
F. Net Cost Contract Monitoring

V. QMRs are to:

A. Include a representative sampling of persons served within a service program.
B. Be conducted by individuals who have the expertise and qualifications for assessing the quality of the area being reviewed.
C. Be conducted with no disruption to services.
D. Provide accurate, timely and useful information.
E. Include clear recommendations for improvement where needed.

VI. KCMHSAS will establish and maintain a written description of monitoring activities in the following areas:

A. All components of the review (made available to providers prior to conducting a review).
B. Performance goals and requirements for each QMR component.
C. Criteria for making recommendations for improvement.
D. Assure consistency of all aspects of monitoring with accreditation, regulatory, funding and other applicable requirements.

VII. Other applicable components of the provider monitoring review process (i.e., Targeted Utilization Reviews, Sub-recipient and Net Cost Reviews, or a Recipient Rights Review) may be conducted in conjunction with the QMR.

VIII. Provider monitoring results may be shared in summary performance reports that will be presented to the Provider Network Workgroup (PNWG) and other applicable teams and individuals for consideration and decision-making as needed. The KCMHSAS Quality Improvement Council (KQIC) will review the aggregate results for opportunities for system improvement.

IX. All instances of fraud and/or abuse discovered during a provider monitoring review will be reported to the KCMHSAS Compliance Officer who will report to the Program Investigations Section (per MDHHS contractual requirement, section 10.0) and the Southwest Michigan Behavioral Health (SWMBH) as required.

X. KCMHSAS will take firm and expedient action in the event of significant non-compliance as outlined in policy 02.04 (Contract Compliance).

XI. Disagreement with any aspect of the provider monitoring review process or findings may be addressed informally and/or formally.

A. The informal process consists of :
    1. Contacting the Director of Quality Management and Contract Services or designee with:
        a. A description of the disagreement (i.e., specific case #, specific QMR item #)
        b. Remedy sought
        c. A rationale for the change, including substantiating documentation

2. The Director of Quality Management and Contract Services or designee may request additional information or may research the issue, but must respond within 10 days of the initial contact.
3. The informal process must be initiated before the date a Plan for Improvement is due.

B. The formal process consists of following policy 02.02 (Provider Grievance and Appeals [non-clinical]).

REFERENCES

- Balanced Budget Act 438.230(b)(3)-(4)

- MDHHS Contract Attachment P 39.0.1 or C7.6.1 (Compliance Examination Guidelines)

- KCMHSAS Policy
  - 02.01 (Procurement of Mental Health and General Management Services)
  - 02.04 (Provider Contract Compliance)
  - 02.09 (Credentialing, Re-Credentialing and Criminal History Screening)

- Southwest Michigan Behavioral Health Policy
  - 2.13 (Provider Network Monitoring)

SCHEDULING QUALITY MONITORING REVIEWS

A. Quality Monitoring Reviews (QMR) can be initiated through any of the following:
   1. An annual review process
   2. A request from the primary clinician or another stakeholder in which KCMHSAS has granted approval
   3. The request of the service provider
   4. An identified compliance and/or performance issue(s) which needs follow-up
   5. As follow-up to significant recommendations from a previous review or citation(s) from DCH monitoring activities

B. The schedule for reviews will be organized by the lead reviewer as assigned. Providers will be notified of dates and times of reviews at least two weeks prior to the start of the review cycle.

C. Requests for rescheduling a review will be approved by the Director of Quality Management & Contract Services or designee and only in the case of the absence of a critical staff, a conflict with another funding or accrediting body review, a natural disaster, or other unforeseen event.

D. Service providers will normally be given a minimum of 24 hours notice for special and/or targeted reviews so that a service provider representative will be available at the site. However, KCMHSAS reserves the right to do unannounced reviews based on alleged or identified issues of compliance and/or health and safety concerns.

E. Review Exemptions
   Service Providers may receive an abbreviated follow up review from a component of the annual

   QMR if all the following conditions are met:

   1. An overall compliance rate on the previous review of 90% or higher for the Organizational Practices Review and 95% or higher for the Clinical Record/Claims Verification Review.
   2. No citations in the past year from any other related regulatory reviews (i.e., MDHHS Site Review, PIHP Review)
   3. No substantive organizational changes have occurred since the last review
   4. The compliance items being reviewed have not been substantially revised since the last review (i.e., a new or major change in compliance protocol by MDHHS or CMS)

SAMPLING

The sample for a review will be drawn according to the following guidelines when not designated by an accrediting and/or funding body. The sample will be the responsibility of KCMHSAS Quality Management Department (QMD) review team.

A. For reviews that involve cases of individuals served:
   1. The sample will be representative of the population served and/or service provided
   2. The sample will be a representation of the selection criteria chosen by the KCMHSAS Provider Network Workgroup and/or KCMHSAS Compliance Committee.
   3. The sample number will be representative of the number of individuals currently served by the provider for each service provided at the time of the sample pull. The number will be:
      a. 10% of current persons served per service/program provided, but not less than 5 cases
      b. Not more than 20 cases for any one review session
   4. The sample will include at least 1 case for each agency/program professional providing services to individuals

B. For Specialized Residential providers, the sampling will be as follows:
   1. Providers with > 15 homes: at least 3 homes reviewed per-year
   2. Providers with 5 – 15 homes: at least 2 homes reviewed per year
   3. Providers with < 5 homes: a minimum of 1 home reviewed per-year
   4. For providers with multiple homes, the sampling size will generally be augmented if the overall compliance rate of the previous year is lower than 85%

CONDUCTING THE REVIEWS

A. QMD will make available to all service providers before the beginning of a monitoring review a copy of:
   1. The current scoring descriptors
   2. The monitoring review tools to be used
B. Reviews will begin at the scheduled time.
   1. The list of the clinical records to be reviewed for the Clinical Record Review and Claims Verification Review will be sent to the provider within one week of the scheduled review date
   2. A Provider representative will be available to the reviewers during the course of the review
C. Provider staff will have the opportunity to make available any missing items/information prior to the departure of the reviewers. This may be subject to partial credit being given if the provider needs to request documentation from another source (e.g. another provider).
D. Any score of less than "2" (full compliance) on a scoring sheet will be accompanied by an explanation.
F. Any information gained during a review, whether or not the focus of that particular review, believed by the reviewer to have a significant adverse impact on the quality of care provided to any individual or the well-being of the person receiving services will be reported to the appropriate authorities as soon as possible.
G. An exit conference will be offered to the provider representative and other interested program staff at or near the end of the review. Reviewers will share general impressions of the results of the review and will indicate when the program may expect to receive the review data.

DISSEMINATION OF RESULTS

A. Within 30-45 days of the review, the lead reviewer will send a cover letter, the review report(s) and a Plan for Improvement (as needed) to the provider representative, Executive Director and/or designee.
B. The provider representative is responsible for distribution of individual scoring sheets to the appropriate provider staff.
C. When the review cycle has been completed, the lead reviewer of each component of the QMR will aggregate data from the reviews across the provider system, including:
   1. A comparison of present year scores with those of the previous year, as available.

   2. A narrative summary that includes:
      a. an analysis of the results
      b. recommendations for system improvements

D. A System Summary report will be distributed to KCMHSAS committees and leadership as per policy 02.08 (Provider Network Monitoring). Copies of the aggregated data across the provider network system will also be made available to service providers.
E. Copies of all review materials, cover letters and data summaries will be maintained by the QMD.

PLANS FOR IMPROVEMENT

Plans for Improvement are required if the overall compliance rate falls below the identified level of acceptable compliance on monitoring reviews.

A. The completion of a Plan for Improvement will be identified as part of the narrative summary sent to the provider. Items to be specifically addressed will be identified as "recommendations".
B. The deadline for submission of each Plan for Improvement will be stipulated in the cover letter. The deadline may vary depending on the seriousness and/or the repetitive nature of the deficiencies that were discovered during the review. Generally, 30 calendar days will be the requirement for the Plan for Improvement submission with implementation of corrective action within 90 days of the acceptance of the plan.
C. The Director of Quality Management and Contract Services or designee will review each submitted Plan for Improvement for accuracy and inclusiveness. QMD staff will work with the submitting service provider as needed until a mutually acceptable Plan has been developed.
D. A provider is subject to sanctioning for poor performance, failure to submit a Plan for Improvement or failure to make the changes as outlined in the Plan for Improvement (refer to policy 02.04 [Provider Contract Compliance]).

FOLLOW-UP REVIEWS

Follow-up monitoring through the QMD and/or Provider Network may occur within the same fiscal year to ensure contract compliance and implementation of the formal plan for improvement. The QMD will provide immediate follow-up when needed based on concerns and improvement areas directly related to the Quality Monitoring Review. Provider Network staff will provide ongoing monitoring long term as management of contract compliance and ongoing implementation. QMD and the Provider Network will collaborate to determine needed follow-up activities, frequency, and desired outcomes from the additional monitoring activities.

A. Follow-up reviews will occur:
    1. When the overall rating of the initial review was 80% or less
    2. When there has been a lack of demonstrated improvement in the areas cited from the initial review
    3. At the discretion of the Quality Improvement Manager or other official with responsibility for the integrity of the provider network system
B. The procedures noted above on the "Dissemination of Results" and "Plans for Improvement" will be used on all follow-up reviews.

Activity/ Review	Type	Scope of Review	Frequency	Procedures/ Protocols	Forms
Credentialing	Qualifications of provider	Facility ▪ Necessary licensure, accreditation ▪ Staff qualifications ▪ Malpractice/liability insurance ▪ Financial audit ▪ Risk management (e.g. convictions, malpractice claims & pending cases, OIG, SAM, etc) Individual ▪ Criminal Background Check, ▪ Individual credentialing including primary source verification of licensure and education, etc. in accordance with KCMHSAS policy and procedure ▪ NPDB for licensed professionals When responsibilities include driving ▪ Drivers License (or signed letter of attestation) ▪ Evidence of auto insurance (or signed letter of attestation)	Prior to acceptance as a Network Provider	KCMHSAS policy 02.09 (Credentialing, Re-Credentialing and Criminal History Screening) and procedure 02.09_01 (Credentialing, Re-Credentialing and Oversight Implementation)	Provider / Credentialing Application
Re-Credentialing	Continued qualifications of provider	▪ Update of any changes on application along with signed attestation from Provider and/or Staff as relevant ▪ QMR, UM, Sentinel events, RR site reviews, accreditation or certification status, external reports, etc.	Every two years	KCMHSAS policy 02.09 (Credentialing, Re-Credentialing and Criminal History Screening) and procedure 02.09_01 (Credentialing, Re-Credentialing and Oversight Implementation)	Per KCMHSAS process (e.g., Desk Audit)
Claims Verification/ Clinical Record Review	QMR	Clinical Documentation Standards Monitoring: ▪ Primary Assessment ▪ Pre-plan ▪ Individual Plan of Service ▪ Progress Notes ▪ Review ▪ Medical/Psychiatric ▪ Person Served Input Feedback ▪ Termination & Discharge ▪ Inpatient Psychiatric Hospital Admission Core Elements of Claims Verification (as specified by MDHHS requirements for the verification of the delivery of Medicaid Services) ▪ Services provided are identified in the current/active Individual Plan of Service ▪ Services provided are those identified in Medicaid Provider Manual ▪ Claims submitted are substantiated by documentation in the clinical record	Annually for contract providers, per discretion of PNWG may complete an abbreviated review if overall rating of 95% or above is achieved; additional monitoring within year if overall rating is < 80%	▪ KCMHSAS policy exhibit 02.08B (Quality Monitoring Review) ▪ Clinical Records Review Protocols	Clinical Record Review Report
Organizational Practices Review (Mental Health)	QMR	▪ Accreditation/Certification ▪ Health & Safety ▪ Staff Training & Qualifications	Annually for contract providers, per discretion of PNWG may complete an	▪ KCMHSAS policy exhibit 02.08B (Quality Monitoring Review)	Organizational Practices Review Report

Activity/ Review	Type	Scope of Review	Frequency	Procedures/ Protocols	Forms
		▪ Outcomes/Performance Objectives ▪ Quality Improvement ▪ Person Served Involvement/Satisfaction ▪ Customer Services/Access to Care ▪ Administrative Compliance/Finance	abbreviated review if overall rating of 90% or above is achieved; additional monitoring within year if overall rating is < 80%	▪ Organizational Practices Review Protocol	
Utilization Management Review	Utilization Review	▪ Current level of needed assistance or current level of functioning ▪ Current supports and resources ▪ Current risk to health, safety and/or psychiatric stability ▪ Current type, level, and amount of mental health and/or substance abuse services	KCMHSAS Policy 30.01 (Utilization Management)	Utilization Management	Utilization Review
Other Provider Reviews	Subrecipient Monitoring, Net Cost Monitoring, Consumer (Resident) Funds Review	Subrecipient Monitoring as per attachment C.7.6.1 (Compliance Examination Guidelines) of the MDHHS Contract with the CMHSP Consumer [Resident] Funds reviews will be completed by the KCMHSAS Office of Recipient Rights during their annual provider site reviews. If the ORR finds significant concern and deficiency, a reviewer from QMD will complete a follow-up, more in depth review of the management of Consumer [Resident] funds	Subject to an annual reviews for contract providers in accordance with KCMHSAS inter-department planning	As noted under "Scope of Review	Forms used for review can be obtained through the KCMHSAS QMD
Special Monitoring	Providers subject to special reviews or on a probationary status or other sanctions	▪ Special reviews may include "Single Audits", Personal Funds Review and Targeted Utilization Reviews. ▪ Reviews of providers on probation or a sanction are typically customized to monitor the specific compliance issue(s)	Reviews are conducted throughout a probationary/ sanctioned period and as otherwise determined by PNWG	Protocols developed by PNWG or delegated to KQIC in response to specific situations	Forms/tools as developed by KCMHSAS in response to specific situations
Performance & Outcomes	Performance Indicator/ Outcomes Reports	▪ Provider Outcome Reports ▪ Provider Performance on MMBPIS Indicators ▪ Performance Objectives/ Requirements in contracts	Reports Cards completed annually	MMBPIS as per MDHHS Code Book and Other indicators as set by PNWG	
Incidents & Events	Review of Critical Incidents & Events	Critical Incidents & Events as defined by MDHHS are recorded and tracked and have follow-up as needed. Analysis of trends will be completed and utilized for process improvement. Of special interest are Sentinel Events, use of emergency use of physical management, risk events, and other incidents considered to be of high significance	As they occur. KQIC reviews Critical Incident & Event Summary reports quarterly	KCMHSAS policy 03.06 (Incident, Event and Death Reporting)	▪ Incident Report ▪ Emergency Use of Physical Management
Recipient Rights Site Review	Recipient Rights	▪ Annual site visit ▪ Recipient Rights investigations	Annual and PRN	Mental Health Code and KCMHSAS procedures	MDHHS and KCMHSAS forms
MDHHS Site Review	External	As determined by MDHHS including ▪ Habilitation Support Waiver ▪ CDTSP Review ▪ SED & Children's Waiver ▪ Certification Review ▪ Autism Waiver	Annually or based on MDHHS schedule	MDHHS Site Review Protocol, Technical Advisories, CMHSP Contract, Medicaid Provider Manual	MDHHS Site Review Report

Activity/ Review	Type	Scope of Review	Frequency	Procedures/ Protocols	Forms
		▪ Recipient Rights Certification Review			
MDHHS Licensing Review	External	AFC & CFC Residential	At least every 2 years	Licensing Rules	MDHHS Licensing Report
Southwest Michigan Behavioral Health (PIHP)	External	▪ Annual Delegation Review ▪ External Compliance and VDMS reviews	At least annually or based on SWMBH scheduling	SWMBH/CMHSP Contract, MDHHS PIHP Contract	SWMBH Review Reports
Financial Audits	External	As per contract with KCMHSAS	Annually	Per KCMHSAS contract	Ratio Analysis Form
Accreditation Survey	External	Varies by accreditation body	As per accreditation body	As per accreditation body	Accreditation Report

Attachment 5.0
Payment Rates

KCMHSAS expects to provide a rate of approximately **$24.00 per 15 minute unit.** This is based on actual historical expenditures with a 35% productivity rate. If your proposed rate is lower or higher, please submit that rate along with the methodology and supporting evidence of that rate was reached. KCMHSAS may elect to negotiate a single new rate for the home based service.