KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

REQUEST FOR PROPOSAL

INTEGRATED RECOVERY SUPPORTS (TARGETED CASE MANAGEMENT) AGES 18 AND UP

RFP 17-03

KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (KCMHSAS)
2030 Portage Street
Kalamazoo, MI 49001

REQUEST FOR PROPOSALS FOR INTEGRATED RECOVERY SUPPORTS (TARGETED CASE MANAGEMENT)

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 Integrated Recovery Services/Targeted Case Management (IRS/TCM) for adults 18 and over residing in Kalamazoo County. As this RFP is intended to reestablish our panel, any current providers of IRS/TCM that are interested in continuing to provide this service are expected to re-apply for consideration.

B. Terms of Engagement

As a result of this RFP, KCMHSAS may elect to contract with three or more selected providers for this service, or 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 to renew.

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. As quasi-governmental organization, 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 IRS. IRS is a comprehensive service for adults with severe mental illness/co-occurring disorders. It includes Targeted Case Management; peer supports and physical health care coordination to assist individuals to move towards recovery.

KCMHSAS serves 2,000 individuals in IRS/TCM annually. We are seeking three or more provider agencies with the ability to provide high quality IRS/TCM to eligible persons.

IV. RFP Timeline

Activity	Timeline
Issuance of RFP	April 14, 2017
Vendor questions regarding the RFP submitted via e-mail. Questions should be submitted to cthomas@kazoocmh.org	April 28, 2017
Bidders Conference at 2030 Alcott at 9:00am	May 5, 2017
Answers regarding the RFP posted on the KCMHSAS public website.	May 12, 2017
Proposals due to KCMHSAS	May 26, 2017
Scoring of proposals	May/June 2017
Oral presentations (if needed)	June 9, 2017
Notification of Award	July 14, 2017
Contract Begins	October 1, 2017

IV. INSTRUCTIONS FOR PROPOSAL SUBMISSION

A. Response Date

1. **10 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 17-03" 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.
4. All proposals are due to KCMHSAS by ***May 26, 2017 by 4:00 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.

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 for 90 days.

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 (20 percent of total score)

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. Attach proof of your accreditation.
9. A statement agreeing to the rates in Attachment B.
10. Attach a copy of your organizational chart demonstrating appropriate clinical and administrative support.
11. 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.
12. Describe your internal quality assurance program and how it meets the standards described in Attachment C.

B. Proposal for Services (80 percent of total score)

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.

4. Proposed Services for KCMHSAS

~~A. Proposal for KCMHSAS addressing the needs outlined in I. A & B of this RFP. Provide a sample report for the services you are proposing.~~

B. Describe why your services would benefit KCMHSAS over other competitor's services.

C. Provide the following information:

1. Describe how the organization will provide the services outlined in Attachment A including any evidence based practice use, the number of consumers that can be served by the agency and the anticipated case management program staffing patterns. Also, describe the agency clinical staff to individual ratio as well as the agency staff to supervisor ratio.

2. Describe how peer support services will be used to truly enhance case management through support, role-modeling mentoring, and assistance to persons in achieving community inclusion, independence and recovery.

3. Describe the organizational on-call process used during office hours (8:00am to 5:00pm Monday through Friday).

4. Identify program outcomes and submit demonstrated evidence of program outcomes - less than two years old- related to case management services.

5. Submit evidence of a history of providing culturally proficient care.

6. Describe the scope, amount and duration of service that the agency expects to provide to meet clinical outcomes.

7. IRS includes active discharge planning to transition individuals to other levels of care. It also must include a plan to use natural supports to make discharge sustainable. Describe how the agency will meet these objectives.

8. Crisis planning is an important element of IRS. It includes safety plans that explicitly outline responses to specific crisis situations and safety risks and delineates who, including the family and others, is accountable for the various responses identified. Describe how the agency will provide crisis planning.

9. IRS providers coordinate with primary care and psychiatric providers to integrate the health care needs of their individuals. Describe how the agency will accomplish this.

10. IRS assists individuals in gaining employment as a part of the recovery process. Describe how the agency will address this through the entire treatment process.

11. An important part of IRS, is the completion of a level of care assessment. Describe how the agency will ensure that LOCUS assessments are completed on all consumers.

12. Describe the organization plans to address interim behavioral support plans that utilize intrusive or restrictive interventions and how they will meet Behavioral Treatment Team requirements. See **Attachment D** for the template for interim behavioral plans.

13. Trauma-informed care is an important initiative of KCMHSAS. Describe how the organization integrates trauma-informed care principles into service provision and the organizational culture.

14. If the organization does not currently hold a contract with KCMHSAS, please provide three funder or stakeholder references. These references will be contacted for information such as quality review results. If the organization is a current provider, information such as QMU audits, history of sanctions, Recipient Rights evaluations and other internal data will be reviewed. **This review process will consist of 32 of the 80 points in the Proposal for Services section.**

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.

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.

KCMHSAS reserves the right to award to the vendor that it believes, in its sole discretion, best meets the needs of the organization. RFP responders may appeal a decision.

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

ATTACHMENT A

1.0 PURPOSE

To provide Integrated Recovery Services (IRS)/Targeted Case Management (TCM) for adults with a primary diagnosis of mental illness and individual's with co-occurring disorders. Providers of Integrated Recovery Services should have a diversity of staff, including peers to accommodate the needs of a diverse population.

2.0 SERVICES

A. Integrated Recovery Services will be delivered as consistent with the requirements of the Medicaid Provider Manual for Targeted Case Management and the MDHHS Guideline on Person-Centered Planning.

B. Integrated Recovery Services focus on both process and outcome. Successful services are flexible, creative, active and rehabilitative in focus and driven by a person-centered philosophy.

C. For all individuals receiving Integrated Recovery Services, a set of core requirements and responsibilities should be followed:

1. Assure initial and on-going participation of the individual in the PCP process.
2. Overseeing implementation of the IPOS, including supporting the individual's dreams, goals and desires for independence, promoting recovery and assisting in the development of individual supports. The case manager must review services at intervals defined in the IPOS. A formal review of the plan shall not occur less often than annually to review progress and to assess the individual's satisfaction.
3. Coordinating the individual's services and supports, making referrals and advocating for the individual.
4. Accessing language interpreter, translation services and sign language interpreter services, if necessary.
5. Assisting the individual in accessing financial, medical and other assistance programs.
6. Coordination with primary health care providers to assure continuity of care.
7. Coordinating and assisting in crisis intervention, and inpatient service provision. This includes:
   - i. Pre-Admission screening and discharge planning of inpatient and crisis residential services.
   - ii. When individuals are placed in crisis residential settings, the placing clinician (EMH, Supports Coordinator, IRS staff, etc.) will ensure that a plan addendum with at least one recovery goal that crisis residential staff shall follow is written upon admission.
   - iii. Active involvement in treatment team meetings for individuals receiving crisis residential services and/or psychiatric inpatient services; including admission, plan development, plan implementation, discharge planning, and follow up to discharge recommendations.
   - iv. Individuals must be seen by the next business day of admission and discharge from inpatient services and crisis residential services (including weekends and holidays).
   - v. Individuals should be seen regularly while involved in crisis residential and/or psychiatric inpatient services.
8. Assisting with crisis planning which may include:
   - i. Development of a crisis/safety plan
   - ii. Medical and psychiatric advance directives
   - iii. Clinical management of suicidal ideation or impulses
   - iv. Crisis intervention, as needed, following the individual's crisis plan
9. Developing an interim behavior plan utilizing KCMHSAS Behavior Treatment Committee template prior to movement into a specialized residential setting for individuals with a history of aggressive behavior or health/safety issues
10. Facilitating transitions – from school to work, dependent to independent living, etc.
11. Identifying the process for afterhours contact
12. Focus on recovery and incorporating peer support into service delivery
    - i. Work collaboratively to hire and utilize Peer Support Specialists.

ii. Provide professional assistance to Peer Support Specialists who support individuals with in this model.

D. Other Service Expectations

1. Advocacy, support and monitoring of psychiatric symptoms. The intensity of service is based on individual need.
2. Individuals in a correctional setting or jail must receive some aspect of service planning coordination by the next business day of notification of the incarceration.
3. It is expected that the primary worker will attend Mental Health Recovery Court (MHRC) when scheduled and be prepared to actively participate, ensuring a positive working relationship with the court. KCMHSAS and Provider Agencies will work together to determine the best role for IRS staff which may require Agencies to designate specific IRS staff to work with the MHRC.
4. Dual diagnosis capability allowing for a welcoming environment with mental health and substance abuse (MH/SA) integrated screenings, assessments and treatment planning.
5. Peers working within the Integrated Recovery Services model are utilized for support, mentoring and assistance to persons in achieving community inclusion, participation, independence, recovery, resiliency and/or productivity.
6. IRS programs provide on-call coverage between the hours of 8:00am and 5:00pm Monday through Friday for individuals served in their program. This does not include recognized holidays. KCMHSAS providers on-call for all other times.

3.0 ACCESS, AUTHORIZATION AND DISCHARGE

A. Eligibility

Integrated Recovery Services are available to adults with serious mental illness, persons with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, and require access to a continuum of mental health services.

The support and services provided by Integrated Recovery Services could be expected to result in stabilization and/or improvement in the level of functioning and community integration **and recovery**.

The KCMHSAS Access Unit determines eligibility and level of care decisions. Provider capacity concerns will be addressed internally through utilization management and/or by the Access Unit (external utilization management). The Provider is expected to accommodate referrals to Integrated Recovery Services by integrating flexibility within programming. Individuals receiving ACT services or Supports Coordination may not be authorized for Integrated Recovery Services.

B. Initial Authorization

The determination of need occurs at the completion of the intake process (for individuals presenting with routine concerns) or by KCMHSAS Emergency Mental Health/Access Team for individuals presenting with severe and immediate concerns where psychiatric inpatient and/or crisis residential services are needed. Justification of need based on existence of eligibility criteria must be documented in the record. Scope and duration of service is determined during the person-centered planning process and authorized in the IPOS. The duration of the authorization will be based on Targeted Case Management admission and discharge criteria. In addition, peer services that assist in the delivery of case management will also be authorized concurrently based on individual need, peer functions related to case management, and amount, scope, and duration variables identified in the IPOS.

C. Ongoing Authorization

Services may be reauthorized based on documentation of continued progress in meeting individual goals and a positive response to treatment and integrated recovery support. For an Existing Beneficiary (Person who has been receiving IRS/TCM for greater than 1 year), the duration of the authorization will be based on Targeted Case Management admission and discharge criteria.

D. Discharge

For complete and the most up-to-date criteria see “Admission and Discharge Criteria for Targeted Case Management”.

Recovery must be sufficient to maintain functioning without support of integrated recovery services as identified through the person-centered planning process.

It is the expectation of the KCMHSAS that any discharge from a service will be a coordinated effort involving the current provider, primary clinician, the person served and legal representative if necessary. A transition plan / time line will be established to ensure all treatment elements are covered. This transition must allow adequate time unless serious health or safety issues arise. Planning will occur to meet the needs of the person served. The plan will include input from the primary clinician, person served, new provider and legal representative, if necessary. As a result of this collaboration a new service provider and start date will be established.

4.0 CREDENTIALS

A. Staff qualification requirements for MDHHS and Medicaid services are noted in the documents referenced in Section 5.0, References.

B. Peer Support Specialist Services
1. Peer Support Specialists must work under the supervision of a fully qualified case manager.
2. Services provided by Peer Support Specialists must demonstrate their experience in relationship to the types of guidance, support, and mentoring activities they provide.
3. Individuals using peers must choose the person providing those services.
4. Training and/or certification as deemed necessary by MDHHS.
5. Weekly face to face supervision.

5.0 REFERENCES

Services and provider credentials must be consistent with the requirements of the following documents as applicable (all documents are accessible through the links provided):

Medicaid Provider Manual – Mental Health and Substance Abuse Services
• Section 13 Targeted Case Management Services
• Section 17.3.H Peer Delivered or Operated Services
• Section 17.3.H.1 Peer Specialist Services
Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) Provider Policies & Procedures
• Section 2 Provider Network Management
• Section 3 Quality Improvement
• Section 6 Customer Services
• Section 10 Compliance and Risk Management
• Section 23 Grievance and Appeals
• Section 24 Rights of Recipients
• Section 25 Rights Complaints and Dispute Resolution
• Section 26 Recipient Rights/Substance Abuse
• Section 30 Utilization Management and Access
• Section 31 Clinical Practices
• Section 32 Intake and Assessment
• Section 33 Consumer Planning
• Section 34 Transition, Discharge and Follow-up
• Section 36 Records of Individuals Served
• Section 40 Services Coordination
• Section 42 Children and Adolescents
• Section 44 Psychiatric Services

• Section 45 Prevention-Diversion
Children's Administrative Rules
• Section 330.2125
MDHHS PIHP/CMHSP Provider Qualifications Per Medicaid Services & HCPCS/CPT Codes*

**Periodically, modifications are made to the MDHHS Provider Qualifications Per Medicaid Services and HCPCS/CPT Codes. Modifications shall supersede prior definitions and the Provider shall be responsible for ensuring compliance with any changes made to these standards during the contract period*

ATTACHMENT B

Procedure Code	Associated Code	Code Description	Reporting Units	Rates
T1017		Integrated Recovery Supports	15 Minute Unit-Face-to-Face	**$33.00**
	T1017:HE	Integrated Recovery Supports (delivered by certified peer with IRS Recovery Specialist present)	15 Minute Unit-Face-to-Face Delivered by Certified Peer	**$33.00**
	T1017:HE:HM	Integrated Recovery Supports (delivered by certified peer without IRS Recovery Specialist present)	15 Minute Unit-Face-to-Face Delivered by Certified Peer	**$33.00**
	H0038	Peer Support Service (delivered by certified peer)	15 Minute Unit Face-to-Face	**$33.00**
	T1002	Nursing Service	15 Minute Unit Face-to-Face	**$33.00**
H0032		Treatment Planning [1]	Encounter	**$78.43**
H0031	n/a	Initial Intake Assessment [2]	Encounter	**$156.85**
H2015	n/a	Community Living Supports-IRS [3] (delivered by non certified peer)	15 Minute Unit Face-to-Face	**$4.43**

Specific information related to service or payment

Services with an associated code must be reported with the service activity code for payment:

1. H0032 must be authorized and reported for all new enrollees to the IRS program (new, is defined as an individual who has not been authorized for any service in over 90 days). The H0032 code will be authorized for a maximum of 2 encounters.
2. H0031 must be authorized and reported for all new enrollees to the IRS program (new, is defined as an individual who has not been authorized for any service in over 90 days).
3. As applied to the IRS service array the H2015 code is specifically designed to capture those activities completed by Peer (non-certified) who is in the process of obtaining his/her Peer Certification.

Supports Coordination/Case Management may not be reported for the time other Medicaid-covered services (e.g., medication reviews, skill building) are occurring. Only in cases where a per diem is being paid for a service-e.g. CLS and Personal Care-it is acceptable to report units of supports coordination or case management for the same day.

A combination of codes will be utilized to provide services to those receiving Integrated Recovery Supports. Each of the identified codes will be “associated” and will “count” toward an organizational budget, a specific cap number has not been identified in this agreement as with previous agreements. Authorizations for Integrated Recovery Supports will include this “package” and will be determined based on needs identified in the Individual Plan of Service and prior service utilization. The KCMHSAS budgeting is based on historical utilization. It is expected that the provider will monitor service utilization and conduct its own utilization management activities. Cap or adjustments may be implemented if necessary based on service utilization and budget parameters.

Modification(s) may be made to Program and/or Service Activity Codes without formal amendment to the Agreement. Changes to codes will be conveyed in writing from KCMHSAS to the Provider. All services must be delivered and documented according to applicable sections of the MDHHS Medicaid Provider Manual.

Attachment C
(From KCMHSAS Policy and Procedures)

KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

ADMINISTRATIVE POLICY 02.08

<table>
<tr><td colspan="2">Subject: Provider Network Monitoring</td><td colspan="2">Section: Provider Network Management</td></tr>
<tr><td colspan="3">Applies To:
☒ KCMHSAS Staff ☒ KCMHSAS Contract Providers</td><td>Page:
13 of 24</td></tr>
<tr><td colspan="4">Approved:

(Jeff Patton, Chief Executive Officer)</td></tr>
<tr><td>Revised:
03/07/2016</td><td colspan="2">Supersedes:
01/01/2014</td><td>First Effective:
12/20/2004</td></tr>
</table>

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	QMR	▪ Accreditation/Certification ▪ Health & Safety	Annually for contract providers, per discretion of	▪ KCMHSAS policy exhibit 02.08B (Quality	Organizational Practices Review

Activity/ Review	Type	Scope of Review	Frequency	Procedures/ Protocols	Forms
(Mental Health)		▪ Staff Training & Qualifications ▪ Outcomes/Performance Objectives ▪ Quality Improvement ▪ Person Served Involvement/Satisfaction ▪ Customer Services/Access to Care ▪ Administrative Compliance/Finance	PNWG may complete an abbreviated review if overall rating of 90% or above is achieved; additional monitoring within year if overall rating is < 80%	Monitoring Review) ▪ Organizational Practices Review Protocol	Report
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	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
		▪ Autism Waiver ▪ 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 D

INTERIM BEHAVIORAL ASSESSMENT AND TREATMENT PLAN

CONSUMER:
KCMHS CASE #:
DATE OF BIRTH:
CASE MANAGER:
DATE OF REPORT:
AUTHOR:
==

Presenting Problem: (Brief synopsis of history—presenting situation/problem—Treatment history/issues. Hint: If the PASN treatment hx. or integrated summary is thorough, can just cut and paste here.)

ASSESSMENT/ANALYSIS

(HINT: Goal of this section is to provide your "best Guess" of what happens prior to the behavior—what causes the behavior--for example, internal stimuli, fantasies, external provocation, lack of attention, etc.)

DEFINITIONS OF TARGET BEHAVIORS

(Hint—Identify the target behaviors—elopement? Health and safety?) Examples:

1. **Physical aggression towards others** is defined as hitting, charging at, slapping, pushing, scratching, biting or kicking others.
2. **Elopement** is defined as exiting the apartment and leaving the apartment building without staff.
3. **Tantrum behavior** is defined as engaging in more than one challenging behavior such verbal agitation, threatening others, yelling, slamming doors, or physically acting out others and/or objects.

REINFORCERS (what does the individual like? What motivates them positively) For Example:

- Movies
- One on one staff attention
- Outings with staff
- Edibles including cheese, popcorn, candy, and pop
- Music
- Going outdoors

BEHAVIOR TREATMENT PLAN

GOAL OF PLAN

The goal of this plan is to increase appropriate replacement behaviors and decrease challenging behaviors through consistent implementation of proactive and reactive strategies.

PROACTIVE PROCEDURE Hint—what proactive things will work with client? What things will help stop the behavior before it occurs? Below are some samples

- Staff will provide __________ with social praise and/or an item from his menu of reinforcers for appropriately responding to events/situations and in the absence of target behaviors.

- The activity or situation should dictate the schedule of reinforcement. For example, when __________ is engaging in an activity that requires effort, the reinforcement schedule should be richer (i.e., every three to ten minutes, depending on the situation).

- During downtime, while he is engaged in a preferred activity or if he is in a low demand situation, the reinforcement schedule can be every fifteen to sixty minutes.

REACTIVE PROCEDURE What happens after the behavior—how do you want others to respond…(here's where you would put in applicable restrictions, such as 24 hour staff supervision in the community; placement in a restricted, fenced setting, etc.

Reminder: Any medications used for the purpose of Behavior Control –not to manage an Axis I symptoms—must come through the BTC.

DATA COLLECTION

Staff will document all episodes of targeted behaviors on the respective data sheets.. I&A reports will be completed per KCMHSAS and agency guidelines.

Staff Name, licensure, date
Agency.

MAJOR HINT: when done entering info in this form, TAKE OUT THE BLUE HINTS.

DRAFT