COPPER COUNTRY MENTAL HEALTH SERVICES BOARD

POLICY AND PROCEDURE

DATE: March 27, 2019

RESCINDS: April 27, 2016

CATEGORY: Administration

SUBJECT: Contracting for Clinical Services

POLICY: It is the policy of the Copper Country Mental Health Services Board (CCMHS) that all contracts between the Board and organizational providers and independent (non-employee) providers comply with all applicable laws and regulations.

PURPOSE: This policy is written to address statutes, regulations and guidelines applicable when clinical services are provided through contracts with organizations and individuals. CCMHS cannot contract with persons or organizations who: are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department; or have been convicted of a felony; or have been convicted of a misdemeanor that has a direct relationship to the duties of the position, for example, a conviction of Medicaid fraud under $500 would exclude a person from positions which require working with Medicaid recipients (Section 1128(a) and (b) of the Social Security Act).

DEFINITIONS:

CREDENTIALING: The process of validating that the organizational provider is licensed or certified as necessary to operate in the State, and has not been excluded from Medicaid or Medicare participation and that the organization properly credentials their directly employed and subcontracted direct service providers. Credentialing includes verifying and evaluating the applicant for information including but not limited to: state licensure information; a copy of the facility's liability insurance declaration; additional requirements per Michigan Medicaid Provider rules; a current copy of accreditation status; and a signed and dated attestation of authorized representative for the facility attesting the information is accurate and complete. Organizational providers are providers with whom CCMHS contracts and that directly employ and/or contract with individual providers to provide healthcare services. Examples of organizational providers include, but are not limited to hospitals, residential providers, and vocational providers. (As defined by MDHHS Contract P.6.4.3.1)

DELIVERABLES: Services or work product to be performed including status reports, recommendations, analysis and other reports and documentation as required.

ORGANIZATIONAL PROVIDERS: Entities that directly employ and/or contract with individuals to provide health care services. Examples of organizational providers include, but are not limited to: Community Mental Health Services Programs; hospitals; nursing homes; homes for the aged; psychiatric hospitals, units and partial hospitalization programs; substance abuse programs; and home health agencies and specialized residential providers.

PRIVILEGING: The process of determining a health care professional's current skill and competence to perform specific diagnostic or therapeutic procedures that the professional requests to perform as a participant in or an affiliate of a healthcare facility or system. The result of privileging is that a practitioner is permitted by a healthcare organization or network to conduct those specific procedures. (American Managed Behavioral Healthcare Association)

PROVIDER: Any individual or entity that is engaged in the delivery of healthcare services and is legally authorized to do so by the State in which he or she delivers the services.

QUALIFIED BEHAVIORAL HEALTH PRACTITIONER: A person certified, licensed, registered, or credentialed by a governmental entity or professional association as meeting the education, experiential, or competency requirements necessary to provide mental health or alcohol and other drug services.

SANCTIONS: Actions including, but not limited to, a monetary penalty imposed on the contract provider; termination of the contract between CCMHS and the provider.

PROCEDURE:

I. AUTHORITY

A. The Executive Director or his designee has the sole authority to negotiate contracts between the Board and clinical service providers.

B. The contract will provide a limit on the total expenditures authorized thereunder during any one fiscal year. Should that limit provide for total payments to any one individual or organization in excess of $5,000, it will require approval by the Copper Country Mental Health Services Board in accordance with its By-Laws then in effect.

C. Upon execution by all parties, the signed original is returned to and retained by CCMHS and the provider keeps a copy.

II. CONTENTS OF CONTRACTS:

A. All contracts will be written using standardized templates and contain assurances found in standard boilerplate language including, but not necessarily limited to:

- Compliance with Applicable Laws, including but not limited to MCL 15.342 Public officer or employee - prohibited conduct; Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1973, and the Rehabilitation Act of 1973, and the Americans with Disabilities Act;
- Anti-Lobbying Act;
- Non-Discrimination;
- Debarment and Suspension;
- Federal Requirement: Pro-Children Act;
- Hatch Political Activity Act and Intergovernmental Personnel Act;
- Limited English Proficiency;
- Health Insurance Portability and Accountability Act;
- Byrd Anti-Lobbying Amendment;
- Davis-Bacon Act;
- Contract Work Hours and Safety Standards;
- Clean Air Act and Federal Water Pollution Control Act (for contracts in excess of $100,000).

B. Additional elements addressing:

- Duty to treat and accept referrals;
- Authorization requirements;
- Access standards and treatment time lines;
- Relationships with other providers;
- Reporting requirements;
- Provisions for the provider to participate in CCMHS's quality improvement and utilization review activities, as appropriate;
- Payment arrangements for services and withholds that may apply to provider failing to meet deliverables;
- Anti-delegation clause;
- Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements, if any.

C. Provisions for the immediate transfer of people receiving services to a different provider if their health or safety is in jeopardy;

D. Termination clause, remedial actions clause and requirements to follow CCMHS standards;

E. Will not prohibit a provider from discussing treatment options with a person that may not reflect CCMHS's position or may not be covered by CCMH;

F. Will not prohibit a provider from advocating on behalf of the person receiving services in any grievance or utilization review process, or individual authorization process to obtain necessary health care services;

G. The frequency with which performance reports and other reporting documentation will be submitted;

H. Requirement for provider to meet Medicaid accessibility standards as established in Medicaid policy and the Michigan Department of Community Health (MDCH) contract;

I. Complete description of the scope of work, all expected deliverables, rates and terms of payments for such rates, and the contract period;

J. Any changes in rates or contract provisions are communicated to providers at least 30 days in advance, through written correspondence and may include a contract amendment;

K. Names of contact representatives for CCMHS and the provider;

L. Requirements for credentialing/re-credentials and privileging of providers, criminal background checks, and checks to ensure the provider has not been or is currently sanctioned by the Medicaid program;

M. Will prohibit the provider from employing individuals to provide services who are excluded from participation in Federal health care programs under either Section 1128 or 1128A of the Social Security Act;

N. Will require compliance with:

   a. all Recipient Rights provisions of the Michigan Mental Health Code and Administrative Rules;

   b. all other applicable policies and procedures of CCMHS.

O. Will prohibit the interests of the parties to be assignable;

P. Will prohibit actual or apparent conflicts of interest;

Q. Statement that CCMHS will be held harmless from any losses caused by the other party(ies) to the contract. Further,

MDHHS is not a party to the contract and therefore not a party to any employer/employee relationship with the provider;

R. Statement that the provider is responsible for the wages, employment taxes, insurance and workers' compensation coverage for the provider's employees;

S. Each provision of the contract will be deemed to be severable from all other provisions of the contract and, if one or more of the provisions are declared invalid, the remaining provisions of the contract will remain in full force and effect; and

T. The contract will be governed by Michigan Law, and will prohibit modifications except in writing.

III. REPORTING REQUIREMENTS

A. Documentation Requirements - CCMHS is required by NorthCare Network to have a documented process to monitor and verify that providers are providing services in accordance with those authorized in the IPOS, including amount, scope, duration, start and stop times, and that includes ensuring no overlap in services. Services must be clearly documented in the provider's record and must meet documentation standards.

CCMHS will give each provider instructions about how to fulfill this requirement.

B. Event Notification - In addition to other reporting requirements outlined in the contract, the provider will immediately notify CCMHS of the following events:

1. Any death of a person receiving services that occurs as a result of an employee's suspected action or inaction, or any death that is the subject of a recipient rights licensing or police investigation.

2. Relocation of a person's placement due to licensing issues.

3. An occurrence that requires the relocation of any provider's service site, governance, or administrative operation for more than 24 hours.

4. The conviction or adverse change in licensure or certification of the individual provider, organization or of any employee of the organization as soon as the provider is aware of or should have been aware of the change.

Notification of these events will be made telephonically or by other forms of communication to the contract manager or

management staff at CCMHS, who will in turn notify the NorthCare Network and/or MDHHS.

IV. CREDENTIALING AND RE-CREDENTIALING OF ORGANIZATIONAL PROVIDER

A. Credentialing Organizational Providers

1. Facilities and other organizational providers must credential staff according to their accreditation and contract with CCMHS. In addition, CCMHS verifies that the organizational provider is licensed or certified as necessary to operate in Michigan, and has not been excluded from Medicaid or Medicare participation relating to procurement and health care issues.

2. All organizational providers are expected to maintain compliance with the "Credentialing Program" Policy and Procedure, Paragraph II which addresses "Credentialing and Re-credentialing of Facilities and Other Organizational Providers."

    a. For providers of specialized residential services, CCMHS will also monitor: Michigan Department of Licensing and Regulatory Affairs (LARA) – michigan.gov/lara - to verify that the provider is licensed by MDHHS to provide specialized residential care in a licensed setting and to review on-line reports.

B. Deemed Status

CCMHS may recognize and accept credentialing activities conducted by another CMHSP for any provider that delivers healthcare services to both CCMHS and the other CMHSP. In such situations, CCMHS shall maintain copies of the credentialing CMHSP's decisions in the provider's contract file.

C. Notification of Adverse Credentialing Decision

An individual practitioner or organizational provider that is denied credentialing or re-credentialing by CCMHS will be informed of the reasons for the adverse credentialing decision in writing.

D. Appeal Process

If an organizational provider, group or individually licensed provider disagrees with a determination by CCMHS in the application process or during review of a provider's status, please refer to "Credentialing Program" Policy and Procedure, Paragraph VII, which addresses how the provider may proceed to have the matter reviewed at a higher level.

V. CREDENTIALING/RE-CREDENTIALING AND PRIVILEGING ORGANIZATIONAL PROVIDER'S EMPLOYEES

A. All organizational providers' employees who provide clinical services must be credentialed and privileged in the same manner or to the same degree as CCHMS practitioners and in accordance with CCMHS's credentialing and privileging policies.

B. Prior to a contract for services being enacted, the provider will attest in writing to CCMHS that services under the contract will only be provided by practitioners who meet all required credentialing, licensure, and/or certification.

C. Thereafter, at the time of the annual site review, the reviewer will verify appropriate proof of credentialing, licensure, and/or certification as a part of the site review process.

VI. BACKGROUND CHECKS

A. All contract providers of clinical services must conduct and/or undergo criminal background checks and a driving record check if providing transportation to persons receiving services, in the same manner or to the same degree as CCHMS employees in accordance with the CCMHS's Background Check policy. This includes fingerprinting for any person who has regular access to a person residing in a licensed adult foster care home operated by CCMHS, or to the person's property, financial information, medical records, treatment information, or any other identifying information.

B. Prior to a contract for services being enacted, the provider will attest in writing to CCMHS that services under the contract will only be provided by practitioners who meet all required background checks.

C. Thereafter, at the time of the annual site review, the reviewer will verify appropriate proof of background checks.

VII. TRAINING REQUIREMENTS

A. All contract providers of medical or clinical services must receive initial and ongoing training updates that, at a minimum, includes:

1. Rights of the person served.
2. Person- and family-centered services.
3. Prevention of workplace violence.
4. Confidentiality requirements.
5. Cultural competency.

6. Expectations regarding professional and ethical conduct.
7. Reporting of incidents and adverse events.
8. Advanced directives/crisis planning.
9. Regulatory management/compliance efforts.
10. Information about the grievance system, including the person's right to file grievances, timeframes, availability of assistance and contact information.

VIII. RECIPIENT RIGHTS

All contract providers who are allowed/required by contract to establish their own rights system will require that the provider's Recipient Rights Officer, Advisor and Alternate attend and successfully complete the Basic Skills Training programs offered by the MDHHS's Office of Recipient Rights within three (3) months of hire. In addition, every three (3) years during their employment, the Rights Officer/Advisor and any alternate(s) must complete a Recipient Rights Update Training as specified by the MDHHS.

IX. ANNUAL EVALUATION AND SANCTIONS

A. The performance of all providers (organizational and individual) is assessed at least annually to determine compliance with contract requirements and whether or not the contract will be renewed.

B. CCMHS will require a written Plan of Correction within thirty (30) days, for any areas of non-compliance, including credentialing and re-credentialing, background checks and driving record checks for individuals who transport persons receiving services. See CCMH Policy and Procedure entitled "Contract Oversight, Monitoring and Evaluation" for specific procedures.

C. In addition to termination as a result of being included on an Exclusions Database, providers may be removed for expiration of licenses and/or other adverse changes in licensure or certification status. Please refer to "Credentialing Program" Policy and Procedure, paragraph VI, for information.

D. CCMHS may immediately suspend, pending investigation, the participation status of a contract provider who, in the opinion of the Medical Director or Associate Director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to health, welfare, or safety of persons served. An immediate referral will be made to the Office of Recipient Rights in such an event.

X. COMMUNICATION WITH PROVIDERS

A. Whenever possible, persons receiving services from a provider will be given written notice of any change regarding the names, locations, telephone numbers of, and non-English languages spoken by contract providers at least thirty (30) days before the intended effective date of change.

B. CCMHS will make a good faith effort to give written notice of termination of a contracted provider within fifteen (15) days after receipt or issuance of the termination notice, to each person who received primary care from, or was seen on a regular basis by, the terminated provider.

C. New contract providers are directed to the Agency's Provider Manual on the website at www.cccmh.org/agency-information for policies, procedures and general information. A copy of the Provider Manual will be mailed upon request.

D. When changes are made to any policies, rules/regulations or procedures that affect providers, the providers are informed by e-mail and the changes are included in the Provider Manual on the website.

E. Providers with questions regarding the Provider Manual or contract provisions may contact a CCMHS representative.

F. Providers are encouraged to participate on Agency committees that address how CCMHS and its providers can provide the best services. Providers with suggestions and guidance information about how to improve services can contact CCMHS' Customer Services Coordinator.

G. CCMHS will maintain ongoing communication with its providers regarding changes that impact compliance.

CROSS REFERENCE:

- CCMHS Policy – Contract Provider Oversight, Monitoring and Evaluation
- CCMHS Policy - Procurement and Provider Selection
- CCMHS Policy – Credentialing Program
- CCMHS Policy – Clinical Privileging of Individual Practitioners
- CCMHS Policy – Background Checks
- NorthCare Network Policy – Procurement of Goods and Services
- NorthCare Network Policy – Provider Communication
- NorthCare Network Policy – Provider Oversight, Monitoring & Evaluation

- NorthCare Network Policy – Selection Policy
- Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 10
- Social Security Act-Section 1128(a)& (b)& Section 1902(a)(39)
- 42 CFR 438.214 Provider Selection