KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

PROVIDER MONITORING MATRIX

Acronym Key:

CVCRR =	Claims Verification/Clinical Record Review	QM =	Quality Management
KQIC =	KCMHSAS Quality Improvement Council	QMD =	Quality Management Department
MDHHS =	Michigan Department of Health and Human Services	QMR =	Quality Monitoring Reviews
NPDB =	National Practitioner Databank	RR =	Recipient Rights
OIG =	Office of Inspector General	SAM =	System Award Management
OPR =	Organizational Practices Review	UM =	Utilization Management/Clinical Practices
PNWG =	Provider Network Group	VDMS =	Verification of the Delivery of Medicaid Services

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 ▪ Driver's License ▪ Evidence of auto insurance	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, Grievance & Appeals, 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 ▪ Periodic Reviews ▪ Medical/Psychiatric ▪ Person Served Input Feedback ▪ Transfer & Discharge ▪ Inpatient Psychiatric Hospital Admission Core Elements of Claims Verification (as specified by MDHHS	Annually for contract providers, 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

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		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			
Organizational Practices Review (Mental Health)	QMR	▪ Accreditation/Certification ▪ Health & Safety ▪ Staff Training & Qualifications ▪ Outcomes/Performance Objectives ▪ Quality Improvement ▪ Person Served Involvement/Satisfaction ▪ Customer Services/Access to Care ▪ Administrative Compliance/Finance	Annually for contract providers, may complete an abbreviated review if overall rating of 90% or above is achieved; additional monitoring within year if overall rating is < 80%	▪ KCMHSAS policy exhibit 02.08B (Quality Monitoring Review) ▪ Organizational Practices Review Protocol	Organizational Practices Review 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 ▪ Current level of care to meet Level of Care guidelines and eligibility criteria	KCMHSAS Policy 30.01 (Utilization Management)	Utilization Management Utilization Management Plan	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 review 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	▪ 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

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Activity/ Review	Type	Scope of Review	Frequency	Procedures/ Protocols	Forms
	sanctions				
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 as needed	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 ▪ Recipient Rights Certification Review	Annually or based on MDHHS schedule	MDHHS Site Review Protocol, Technical Advisories, CMHSP Contract, Medicaid Provider Manual	MDHHS Site Review Report
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