

☒ OK To Use

AUDIT NAME

FY26 NMRE Monitoring: Delegated Functions (desk)

PASSING %

☐ Consumer linked to this audit☐ Staff Audit

SECTIONS			
Section			
NUMBERTITLE			
1	Information (Customer Services)		
SECTION QUESTIONS			
Questions			
1	A policy and/or procedure is in place for accessing the language needs of individuals served.	Mixed	N/A
2	Oral interpretation of all languages is available free of charge	Mixed	N/A
3	The following information is provided to all consumers within a reasonable time after notice of the consumer's referral: a. Names, group affiliation, website, specialty, cultural capability, non-English language spoken, accommodations for physical disabilities, locations and telephone numbers of current providers. This includes information about case managers, psychiatrists, therapists, etc. and any restrictions on freedom of choice among providers; b. Amount, scope, and duration of services available in sufficient detail to ensure that consumers understand the services to which they are entitled; c. Procedures for obtaining services including authorization requirements; d. Extent to which and how recipients may obtain benefits for out-of-network providers; e. Extent of and how after-hours crisis services are provided, including definitions and locations of emergency and post stabilization services and the right to access them;	Mixed	N/A
4	: f)Consumer rights and protections, including information about the right to a State Fair Hearing, the right to file grievances and appeals, the requirements and time frames for filing a grievance or appeal.	Mixed	N/A

the availability of assistance in the filing process, the toll-free numbers that consumers can use to file a grievance or an appeal by phone, and the fact that benefits can continue if requested by consumer pending a hearing decision;

g) Any cost-sharing and how to access any other benefits available under the state plan but not covered in contract;

h) Additional information is available upon request, regarding the PIHP operational structure and physician incentive plans;

i) Consumers are notified of their right to receive all required information at least once per year. Provider Member Handbook Annually

5	Written notice of a significant change in its provider network including the addition of new providers and planned termination of existing providers is provided to each beneficiary.	Mixed	N/A
6	Good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each beneficiary who received his or her primary care from, or was seen on a regular basis by, the terminated provider.	Mixed	N/A

#### SECTION QUESTIONS

Questions

#### NUMBERTITLE

2 Enrollee Rights and Protections- (Customer Service) FY26

#### SECTION QUESTIONS

Questions

1	The CMHSP maintains an office(s) of Enrollee Rights and Recipient Rights in compliance with federal and state statutes.	Mixed	N/A
2	Local communication with consumers regarding the role and purpose of the PIHP's Customer Services and Recipient Rights Office.	Mixed	
3	Consumers are allowed to choose their health care professional(s) to the extent possible and appropriate.	Mixed	N/A
4	Policies and member materials include the enrollee's right to be treated with respect and due consideration of his or her dignity and privacy.	Mixed	N/A

5	Policies and member materials include the enrollee's right to receive information about available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.	Mixed	N/A
6	A CMHSP not electing to provide, reimburse for, or provide coverage of, a counseling or referral service based on objections to the service on a moral or religious ground must furnish information about the services it does not cover as follows: • Inform the PIHP prior to any action • To potential enrollees, before and during enrollment; and • To enrollees, within 90 days after adopting the policy with respect to any particular service, with the overriding rule to furnish the information 30 days before the policy effective date.	Mixed	N/A
7	The CMHSP policies provide the enrollee the right to participate in the decisions regarding his or her healthcare, including the right to refuse treatment.	Mixed	N/A
8	The CMHSP policies and member materials will provide enrollees the right to be free from any form of coercion, discipline, convenience or retaliation.	Mixed	N/A
9	The CMHSP ensures that consumers are free to exercise their rights in a manner that does not adversely affect their services.	Mixed	N/A
10	The CMHSP has a written policy and procedure in place for when an ABD notice must be sent to a member due to a denial of payment for services rendered. The procedure should include the criteria for when an ABD notice for a denial of payment is sent, describe the coordination between the utilization management team and claims team, and delineate the responsibilities for which team will send the ABD notice to the member and ensure the ABD notice is mailed on the same date that the claim denial is determined.	Mixed	N/A

11	All documentation given to beneficiaries must be in easy to read font, and easy to understand language.	Mixed	N/A
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#### SECTION QUESTIONS

Questions

NUMBERTITLE

3 Customer Service Standards

#### SECTION QUESTIONS

Questions

1	Customer service is an identifiable function	Mixed	N/A
2	Customer service calls answers by a live voice., with TTY support; operates minimally 8 hours/ day, M-F; hours of operation publicized (normal business hours); phone numbers are displayed in agency brochures and public information material.	Mixed	N/A
3	Community Mental Health Handbook with provider list will be available to all consumers annually and upon request.	Mixed	N/A
4	Each customer service unit needs to have access to: CMHSP annual report, Current organizational chart, CMHSP board member list, meeting, minutes	Mixed	N/A
5	Role of Customer services and Recipient rights officer is delineated in policy and practice.	Mixed	N/A
6	Upon request, the customer services unit assists beneficiaries with the grievance, appeals and local dispute resolution processes and coordinates, as appropriate, with the Fair Hearing Officer and the local Office of Recipient Rights.	Mixed	N/A
7	Customer Service staff will be trained to welcome people to the public mental health system and/ or have knowledge and/ or have access of the following: <ul style="list-style-type: none"> <li>• Populations served</li> <li>• Service array</li> <li>• Person centered planning</li> <li>• Self-determination</li> <li>• Recovery and resiliency</li> <li>• Peer specialists</li> <li>• Grievance and appeals, fair hearings, local dispute resolution processes and recipient rights.</li> <li>• LEP and cultural competency</li> <li>• Information and referral about Medicaid covered services within the PIHP as well as outside to</li> </ul>	Mixed	N/A

Medicaid Health Plan, fee for service practitioners and the department of human services.

- The Organization of the Public Mental Health System
- Balanced Budget Act (Managed Care rules) relative to the customer service functions and beneficiary rights and protections
- Community resources (e.g., Advocacy organization, housing options, schools, public health agencies)
- Public Health Code (for substance abuse treatment recipient if not delegated to the substance abuse coordinating agency).

#### SECTION QUESTIONS

Questions

NUMBERTITLE

4 Access System Standards

#### SECTION QUESTIONS

Questions

1	The Organization's Access System is available to all Michigan residents and is not restricted to individuals who live in a particular geographic region.	Mixed	N/A
2	CMHSP staff provides all individuals with a welcoming access experience.	Mixed	N/A
3	The Access system is available 24 hours a day, seven days per week.	Mixed	N/A
4	The Access System's telephone response system is answered by a live voice and demonstrates a welcoming atmosphere.	Mixed	N/A
5	For non-emergent calls, a person's time on-hold awaiting a screening does not exceed 3 minutes without being offered an option for callback or talking with a non-professional in the interim.	Mixed	N/A
6	Access System crisis/emergent telephone calls are immediately transferred to a qualified practitioner without requiring an individual to call back.	Mixed	N/A
7	All non-emergent callbacks occur within one business day of initial contact	Mixed	N/A
8	Individuals with routine needs are screened or other arrangements made within 30 minutes	Mixed	N/A

9	It is expected that the Access Center/Unit or function will operate minimally 8 hours per day M-F except for holidays	Mixed	N/A
10	Individuals who walk in to an Access System are provided a timely and effective response to their requests for assistance.	Mixed	N/A
11	he Access System has the capacity to accommodate individuals who have special access needs, i.e. LEP, Diverse Culture and demographic backgrounds, visual impairments, alternative needs for communication and mobility challenges.	Mixed	N/A
12	Individuals approaching the access system are informed of available service options and how to access services.	Mixed	N/A
13	Initial/provisional eligibility and level of care determination is made by conducting a professional screening	Mixed	N/A
14	The Access System shall address financial considerations, including COFR as a secondary administrative concern, only after any urgent or emergent needs of the person are addressed.	Mixed	N/A
15	Access System staff members provide applicants with a summary of their recipient rights, including their rights to a person-centered planning process and timely access to the pre-planning process.	Mixed	N/A
16	The Access System shall inquire as to the existence of any established medical or psychiatric advanced directives relevant to the provision of services.	Mixed	N/A
17	Access staff should assure an understanding of the problem from the point of view of the person who is seeking help, methods for determining urgent or emergent situation must incorporate, "caller or client-defined" crisis situations.	Mixed	N/A
18	Clinical Screening for eligibility results in a written (hard copy or electronic) screening decision which addresses each of the required elements, i.e. identification of presenting problem; initial identification of population group; legal eligibility and priority criteria; documentation of emergent or urgent needs and how they	Mixed	N/A

	<p>were immediately linked for crisis services; identification of screening disposition; rationale for system admission or denial.</p>		
19	The Organization has a regular and consistent outreach effort to commonly unserved and underserved populations.	Mixed	N/A
20	The Organization's medical director is involved in the review and oversight of Access System policies and clinical practices.	Mixed	N/A
21	The Organization shall assure coverage and provision of post stabilization services for Medicaid beneficiaries once their crises are stabilized.	Mixed	N/A
22	Individuals who are not Medicaid beneficiaries shall be referred back to the Access system for assistance.	Mixed	N/A
23	The Access system shall assure that applicants are offered appointments for assessments with mental health professionals of their choice within contract required standard time frames.	Mixed	N/A
24	Staff follows up to ensure the appointment occurred.	Mixed	N/A
25	The Access system shall provide information about other non-mental health community resources or services that are not the responsibility of the public mental health system to individuals who request it.	Mixed	N/A
26	The Access system shall provide information about Customer Services unit, peer supports specialists and family advocates; and local community resources, such as; transportation services, prevention programs, local community advocacy groups, self-help groups, service recipient groups and other avenues of support.	Mixed	N/A
27	The Access system shall provide beneficiaries information about the local dispute resolution process and the State Fair Hearing process. When an individual is determined ineligible for Medicaid specialty services and supports, he/she is notified both verbally and in writing of the right to request a second opinion; and/or file an appeal through the local dispute resolution process; or request a state Fair Hearing.	Mixed	N/A

28	The Access system shall schedule and provide for a timely second opinion, when requested, from a qualified health care professional within the network, or arrange for the person to obtain one outside the network at no cost. The person has the right to a face-to-face determination, if requested.	Mixed	N/A
29	The Access system shall provide individuals with mental health needs or persons with co-occurring SUD/MI with information regarding local CMH ORR. The access system shall provide individuals with co-occurring SUD/MI with information regarding PIHP SUD ORR.	Mixed	N/A
30	The Access system shall ensure the person and any referral source (with the person's consent) are informed of the reasons for denial, and shall recommend alternative services and supports or disposition.	Mixed	N/A
31	The Organization shall have mechanisms to prevent conflict of interest between the coverage determination function and access to, or authorization of, services.	Mixed	N/A
32	The Organization shall routinely measure telephone answering rates, call abandonment rates and timeliness of appointments and referrals.	Mixed	N/A
33	The Organization staff shall work within individuals, families, local communities, and others to address barriers to using the access system, including those caused by lack of transportation.	Mixed	N/A

#### SECTION QUESTIONS

Questions

NUMBERTITLE

5 CMHSP Provider Network- Sub Contracted providers

#### SECTION QUESTIONS

Questions

1	The CMHSP maintains a network of appropriate providers that is supported by contracts.	Mixed	N/A
2	The CMHSPs maintains and continually evaluates needed and actual service capacity of its provider network.	Mixed	N/A



3	<p>The network of providers is sufficient to provide adequate access to all services covered under the contract with the PIHP, based upon:</p> <ul style="list-style-type: none"> <li>• the anticipated number of referrals from the PIHP</li> <li>• the expected utilization of services taking into consideration the characteristics and health care needs of local populations;</li> <li>• the numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted services; and</li> <li>• the geographic location of providers and consumers, considering distance, travel time, the means of transportation ordinarily used by consumers, and whether the location provides physical access for people with disabilities.</li> </ul>	Mixed	N/A
4	Any changes in sub-contracted providers shall be reported to NMRE within 3 business days.	Mixed	N/A
5	Maintain a regular means of communicating and providing information on changes in policies and procedures to its providers.	Mixed	N/A
6	Provide a copy of the CMHSPs prior authorization policies to the provider when the provider joins the CMHSPs provider network.	Mixed	N/A
7	The CMHSP must notify providers of any changes to prior authorization policies as changes are made.	Mixed	N/A
8	Assure that services are accessible (60 minutes/60 miles), taking into account travel time, availability of public transportation, and other factors that may determine accessibility.	Mixed	N/A
9	Assure that network providers do not segregate Customers in any way from other people receiving their services.	Mixed	N/A
10	Does not discriminate against any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.	Mixed	N/A
11	If an individual or group of providers is excluded, CMHSP gives the affected providers written notice of the reason for its decision.	Mixed	N/A

12	Has written policies and procedures for selection and retention of providers.	Mixed	N/A
13	If the CMHSP is unable to provide necessary medical services covered under the contract to a particular consumer, the CMHSP adequately and timely covers these services out of network.	Mixed	N/A
14	The CMHSP coordinates with out-of-network providers with respect to payment and ensures the cost to the consumer is no greater than it would be if the services were furnished within the network.	Mixed	N/A
15	<p>Negotiate contracts between the CMHSP and providers based on a procurement method that meets state and federal standards and in accordance with PIHP policy.</p> <p>a. A procurement Process was used if the managing entity restricts or otherwise limits the number of providers who can participate in the program.</p> <p>1) Procurement for Selective Contracting:</p> <p>a) The CMHSP purchases services from a limited number of providers who agree to fulfill contractual obligations for an agreed upon price.</p> <p>b) The managing entity identifies the specific services to be provided.</p> <p>c) The managing entity seeks proposals/price bids, and awards the contracts to the best bidders.</p> <p>d) Contracts are let only with a sufficient number of providers to assure adequate access to services.</p>	Mixed	N/A
16	<p>Negotiate contracts between the CMHSP and providers based on a procurement method that meets state and federal standards and in accordance with PIHP policy.</p> <p>a. A procurement Process was used if the managing entity restricts or otherwise limits the number of providers who can participate in the program</p> <p>2) Procurement to Obtain Best Prices Without Selective Contracting:</p> <p>a) Utilizes "any willing and qualified provider"</p> <p>b) Bids are solicited and used to set prices for a service, and then contracts or provider agreements</p>	Mixed	N/A

	are offered to any qualified provider that is willing to fulfill the contract and meet the bid price.		
17	Negotiate contracts between the CMH and providers based on a procurement method that meets state and federal standards. A procurement Process was used if the managing entity restricts or otherwise limits the number of providers who can participate in the program 1)The service is available only from one source; 2) There is a public exigency or emergency, and the urgency for obtaining the service does not permit a delay incident to competitive solicitation; 3) After solicitation of a number of sources, competition is determined inadequate;4) The services involved are professional services (e.g. psychological testing) of limited quantity or duration; 5) The services are unique (e.g. financial intermediaries for consumers using vouchers or personal service budgets) and/ or the selection of the service provider has been delegated to the consumer under a self-determination program;6) Existing residential service systems, where continuity of care arrangements are of paramount concerns.	Mixed	N/A
18	The CMHSP manages procurement of local providers sufficient to fulfill all PIHP delegated activities and to meet identified needs, including recruitment of staff (or contracted) interpreters, translators, and bi-lingual/bi-cultural clinicians.	Mixed	N/A
19	The CMHSP has an established process for monitoring the performance of each subcontracted provider relative to the contract. The monitoring process will minimally assess performance and compliance indicators established by the PIHP, deemed status and reciprocity by other CMHSPs in the region.	Mixed	N/A
20	The CMHSP has established and implemented a local level process for soliciting network provider feedback and/or complaints.	Mixed	N/A

21	The CMHSP shall have an effective provider appeal process to promptly and fairly resolve disputes, including a secondary level review by NMRE.	Mixed	N/A
22	The CMHSP has a process for ensuring that contractual providers comply with all applicable requirements concerning the provision of culturally competent services	Mixed	N/A
23	Provider performance reports are available for review by individuals, families, advocates, and the public.	Mixed	N/A
24	The entire service array for individuals with developmental disabilities, mental illness, or a substance abuse disorder, including 1915(i)SPA services, are available to consumers who meet medical necessity criteria.	Mixed	N/A
25	At the time of enrollment and re-enrollment, CMHSPs must search the OIG exclusion database to ensure contractor and any individuals with ownership or control interests in the provider entity have not been excluded from participating in federal health care programs.	Mixed	N/A
26	The CMHSP does not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or 1128A of the Social Security Act.	Mixed	N/A
27	Verification that providers have not been previously sanctioned by Medicaid program.	Mixed	N/A
28	Has written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with the PIHP's standards	Mixed	N/A
29	The CMHSP utilizes standardized template(s) for contracts and monitoring as is applicable.	Mixed	N/A
30	CMH has monitoring process and results that all Group Homes were reviewed for current fiscal year and any necessary corrective actions plans were completed.	Mixed	N/A
31	Disclosure of Ownership Monitoring • The CMHSP ensures that its providers and contractors submit full disclosures identified in 42 CFR Part 455 Subpart B. Disclosures include:	Mixed	N/A

	<ul style="list-style-type: none"> <li>• Name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include primary business address, every business location, and P.O. Box location.</li> <li>• Date of birth and Social Security number of each person with an ownership or control interest in the disclosing entity.</li> <li>• Other tax identification number (in case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five percent or more interest.</li> </ul>		
32	<p>Disclosure of Ownership Monitoring</p> <ul style="list-style-type: none"> <li>• Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with an ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or</li> <li>• control interest as a spouse, parent, child, or sibling.</li> <li>• The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.</li> <li>• The name, address, date of birth, and Social Security number of any managing employee of the disclosing entity</li> </ul>	Mixed	N/A
33	<p>Disclosure of Ownership Monitoring</p> <ul style="list-style-type: none"> <li>• The identity of any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider, and has been convicted of a criminal offense related to that person's involvement in any program described under sections 1128(a) and 1128(b)(1),</li> <li>• (2), or (3) of the Social Security Act, or had civil money penalties or assessments imposed under section 1128A of the Act since the inception of those programs</li> </ul>	Mixed	N/A
34	Time of Disclosure	Mixed	N/A

	<p>The CMHSP has a process to obtain disclosure from its providers/contractors at any of the following times:</p> <ul style="list-style-type: none"> <li>• When the provider or disclosing entity submits a provider application.</li> <li>• Upon execution of the provider or disclosing entity agreement.</li> <li>• During recredentialing or re-contracting</li> <li>• Within 35 days of any change in ownership of a disclosing entity.</li> </ul>		
35	<p><b>Monitoring Provider Networks</b> The PIHP must search the OIG exclusions database monthly to capture exclusions since the last search and at any time providers enroll, reenroll, or submit new disclosure information.</p>	Mixed	N/A
36	<p><b>Reporting Criminal Convictions</b> The CMHSP has a policy and process to identify and notify the MDHHS BHDDA Division of Program Development, Consultation and Contracts when any disclosures are made by providers with regard to:</p> <ul style="list-style-type: none"> <li>• The ownership or control by a person that has been convicted of a criminal offense described under sections 1128(a) and 1128(b)(1)(2), or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act.</li> </ul>	Mixed	N/A
37	<p><b>Oversight</b> There is a written agreement with each provider entity that specifies the activities and report responsibilities delegated to the subcontractor, including contract language that requires the provider entity to disclose to the PIHP any criminal convictions described under 1128 (a) and 1128 (b)(1)(2), or (3) of the Act, or that have had civil monetary penalties or assessments imposed under section 1128 A of the Act.</p>	Mixed	N/A
38	<p>The CMHSP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.</p>	Mixed	N/A

39	Corrective Action: If the CMHSP identifies deficiencies or areas for improvement, the CMHSP and the subcontractor take corrective action.	Mixed	N/A
40	Security The CMHSP has a process/procedure for securely storing Disclosure of Ownership PII information.	Mixed	N/A

## SECTION QUESTIONS

Questions

NUMBER TITLE

6 Service Authorization and Utilization Management

## SECTION QUESTIONS

Questions

1	<p>A utilization management program is in operation. The written program description includes:</p> <ul style="list-style-type: none"> <li>• procedures to evaluate clinical necessity, and the process used to review and approve the provision of clinical services,</li> <li>• mechanisms to identify and correct under-utilization as well as over utilization, and</li> <li>• preauthorization, concurrent and retrospective procedures.</li> <li>• Arbitrary denial or reduction of the amount, duration or scope of a required service solely because of a consumer's diagnosis, type of illness or condition is prohibited.</li> <li>• CMHSP must assure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.</li> </ul> <p>Any service limits are appropriate and restricted to criteria such as medical necessity or for utilization control, if the services furnished can be expected to achieve their purpose.</p>	Mixed	N/A
2	<p>Initial approval or denial of requested service:</p> <ul style="list-style-type: none"> <li>• Initial assessment for and authorization of psychiatric inpatient services</li> <li>• Initial assessment for and authorization of psychiatric partial hospitalization services</li> <li>• Initial and ongoing authorization of services to individuals receiving community-based services</li> </ul>	Mixed	N/A

	<ul style="list-style-type: none"> <li>• Grievance and Appeals, Second Opinion management, coordination and notification</li> </ul> <p>Communication with consumers regarding UM decisions, including adequate and advance notice, right to second opinion and grievance and appeal</p>		
3	Local-level Concurrent and Retrospective Reviews of Authorization and Utilization Management decisions/activities to internally monitor authorization decisions and congruities regarding level of need with level of service are consistent with PIHP policy, standards and protocols.	Mixed	N/A
4	Mechanisms are in effect to ensure consistent application of review criteria for authorization decisions; Review decisions are supervised by qualified medical professionals.	Mixed	N/A
5	Procedures - Prospective (preauthorization), concurrent and retrospective procedures are established and include: Review decisions are supervised by qualified medical professionals.	Mixed	N/A
6	<p>Decisions to deny or authorize service in an amount, duration or scope that is less than requested are made by a health care professional who has the appropriate clinical expertise in treating the consumer's condition or disease;</p> <ul style="list-style-type: none"> <li>• The CMHSP provides Medicaid consumers with written service authorization decisions no later than 14 calendar days following receipt of a request for service authorization, unless the PIHP has authorized an extension;</li> <li>• and the CMHSP provides Medicaid consumers with written service authorization decisions no later than 72 hours following receipt of a request for expedited service authorization, if warranted by the consumer's health or functioning, unless the PIHP has authorized an extension.</li> </ul> <p>Reasons for decisions are clearly documented and available to the recipient.</p>	Mixed	N/A
7	The involved provider is informed verbally or in writing of the action if a service authorization request was denied or services were	Mixed	N/A



	authorized in an amount, duration or scope that was less than requested.		
8	Inpatient Screening tool:  Utilized meets standard and is completed 100%	Mixed	N/A
9	When inpatient hospitalization has been denied, a second opinion must be offered.	Mixed	N/A
10	Program, contact, individual, and date and time of appointment of alternative services documented on form.	Mixed	N/A
11	Emergency Services Staff available 24 hours.	Mixed	N/A
12	Appropriate follow up care/ discharge planning arranged	Mixed	N/A
13	All disposition decisions are made within three hours of request.	Mixed	N/A
14	Emergency Services procedure/ process minimally meets the requirements	Mixed	N/A
15	Comprehensive Provider ES workers conduct the pre-admission screening utilizing local procedures.	Mixed	N/A
16	Clinical necessity is documented on local ES screening forms.	Mixed	N/A
17	Authorization of necessary services (number of units of inpatient care) is made based on the MDHHS Medicaid Provider Manual and MCG Indicia.	Mixed	N/A

#### SECTION QUESTIONS

Questions			
18	MCG Indicia tool is utilized when issuing Adverse Benefit Determination.	Mixed	N/A
19	MCG Indicia tool is utilized during ES to assist LOC determination/ disposition.	Mixed	N/A
20	The CMH defines "emergency medical condition" as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:	Mixed	N/A

	<p>a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.</p> <p>b. Serious impairment to bodily functions.</p> <p>c. Serious dysfunction of any bodily organ or part.</p>		
21	<p>The CMH defines “emergency services” as covered inpatient and outpatient services that are as follows:</p> <p>a. Furnished by a provider that is qualified to furnish these services under Title 42.</p> <p>b. Needed to evaluate or stabilize an emergency medical condition.</p>	Mixed	N/A
22	<p>The CMH defines “poststabilization care services” as covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the member’s condition.</p>	Mixed	N/A
23	<p>The CMH has Emergency and Potabilization services policy that adequately addressed definition, coverage and payment, requiremetns, and rules for emergency and post stabilization services.</p>	Mixed	N/A

## NUMBERTITLE

## 7 Grievance and Appeal

SECTION QUESTIONS			
Questions			
1	G&A Poster and brochures are available in lobbies.	Mixed	N/A
2	There are publicized and available appeal mechanisms for providers and consumers.	Mixed	N/A
3	Notification of a denial is sent to both the consumer and the provider. This notification of a denial includes a description of how to file an appeal.	Mixed	N/A
4	Incentives are not present for the denial, limitation or discontinuation of services to any consumer	Mixed	N/A
5	<p>Consumers are provided with written adequate notice of action regarding authorization of services:</p> <p>at the time of the decision to deny payment for a service (on the same date the action takes effect);</p>	Mixed	N/A

	at the time of the signing of the individual plan of services/ supports; within 14 calendar days of the request for a standard service authorization if the decision will deny or limit services; and within 72-hours of the request for an expedited service authorization if the decision will deny or limit services.		
6	The advanced and adequate notice letter template from the PIHP/MDCH Contract is used to ensure consistency across the region.	Mixed	N/A
7	The adequate and advance notices meet the language and alternative format needs of the consumer.	Mixed	N/A
8	Consumers are provided with written adverse benefit determination within 10 calendar days before the intended action will take effect, when an action is being taken to reduce, suspend or terminate previously authorized services.	Mixed	N/A
9	Consumers are given reasonable assistance to complete forms and to take other procedural steps to file a grievance, appeal and/ or State Fair Hearing request. This includes but is not limited to providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	Mixed	N/A
10	A copy of grievance, appeal and fair hearing requirements and time frames are given to each provider when they join the provider network.	Mixed	N/A
11	A local appeal process has been established for Medicaid consumers to appeal action, and consumers are informed of the availability of this process.	Mixed	N/A
12	An expedited appeal process has been established for Medicaid consumers to appeal an action, and consumers are informed of the availability of this process.	Mixed	N/A
13	If a request for an expedited resolution of an appeal is denied, the CMHSP: •Transfers the appeal to the standard resolution time frame. •Initiates reasonable efforts to provide prompt oral notice of the denial.	Mixed	N/A

	<ul style="list-style-type: none"> <li>•Provides follow-up written notice to consumer within 2 calendar days.</li> <li>•Consumers are given 60 calendar days from the date of the notice of action to request a local appeal.</li> </ul>		
14	Receipt of each grievance and appeal is acknowledged.	Mixed	N/A
15	A written notice of the disposition of a grievance and appeal is provided and reasonable efforts to provide oral notice of an expedited resolution is made.	Mixed	N/A
16	Oral requests for a local appeal of an action are accepted and confirmed in writing (unless the consumer requests expedited resolution for which oral response is allowed).	Mixed	N/A
17	Maintain a log of all requests for appeal to allow reporting to the PIHP Quality Improvement Program, that ensures individuals who make the decisions on appeal were not involved in the previous level review or decision-making	Mixed	N/A
18	Maintain a log of all grievances to allow reporting to the PIHP Quality Improvement Program that ensures individuals who make the decisions I were not involved in the previous level review or decision-making.	Mixed	N/A
19	<p>9.19- The content of notices of disposition includes an explanation of the results of the resolution and the date it was completed. When the appeal is not resolved wholly in favor of the consumer, the notice of disposition must also include:</p> <ul style="list-style-type: none"> <li>• the right to request a state fair hearing, and how to do so;</li> <li>• the right to request to receive benefits while the state fair hearing is pending, if requested within 10 days of the mailing the notice of disposition, and how to make the request; and the consumer may be held liable for the cost of those benefits if the hearing decision upholds the action.</li> </ul>	Mixed	N/A
20	Medicaid consumers are informed of their right to access to the State Fair Hearing process for appeal of actions, including the 120-calendar day deadline (from the date of notice of an action) for filing a request.	Mixed	N/A

21	CMHSP provides acknowledgement of grievance and appeals, Adequate and Advance Notice and disposition of grievance and appeal notices within time frames specified by and according to NMRE Medicaid Beneficiary Appeals and Grievances Policy.	Mixed	N/A
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SECTION QUESTIONS			
Questions			
22	Medicaid consumers are informed of the reinstatement of benefits after appeal, if the appeal is overturned. If the appeal is overturned at the local level, benefits must be reinstated within 72 hours. If the appeal is overturned at the SFH level, benefits must be reinstated immediately.	Mixed	N/A
23	CMHSP provides all beneficiary documentation in easily understood language and font.	Mixed	N/A
24	There is evidence of quarterly submission of ABD and G&A reports to PIHP for review.	Mixed	N/A

## NUMBERTITLE

## 8 Coordination of Care/Integration of Behavioral and Physical Health Services

SECTION QUESTIONS			
Questions			
1	CMHSP staff pro-actively assume responsibility for engaging the inpatient team during consumer's hospital stay. This includes participating in team meetings and initiating discharge planning with staff, consumer, family/guardian and community resources.	Mixed	N/A
2	CMHSP has developed service coordination agreements with each of the pertinent public and private community-based organizations and providers to address issues that relate to a shared consumer base.	Mixed	N/A
3	The CMHSP has procedures to ensure that coordination occurs between primary care physicians and the CMHSP and/or its network. Procedures ensure that the services the CMHSP furnishes to the beneficiary are coordinated with the services the beneficiary receives from other MCOs and PIHPs.	Mixed	N/A

## SECTION QUESTIONS

Questions			
4	CMHSP utilized Standardized ROI (MDHHS 5515) for care coordination.	Mixed	N/A
5	MDHHS 5515 ROI lists Physician /PCP name, address, and contact.	Mixed	N/A

## NUMBERTITLE

## 9 Consumer Involvement

SECTION QUESTIONS			
Questions			
1	The CMHSP provides meaningful opportunities and supports for consumer involvement in service development, service delivery, and service evaluation activities.	Mixed	N/A
2	Development of local activities designed to engage consumers, and other stakeholders, including members of the general public, in decision-oriented activities throughout the CMHSP, including its subcontractors	Mixed	N/A
3	Training and orientation of customers, to participate actively in Advisory Groups, task forces, working committees.	Mixed	N/A
4	If LTSS are provided under the contract between the PIHP and the CMH, the CMH must establish and maintain a member advisory committee. The member advisory committee will include at least a reasonably representative sample of the LTSS populations, or other individuals representing those enrollees, covered under the contract with the CMH.	Mixed	N/A

SECTION QUESTIONS			
Questions			
5	Consumers, family members, advocates, and the public are invited to participate in the evaluation of provider performance with regard to consumer-driven services.	Mixed	N/A

## NUMBERTITLE

## 10 Provider &amp; Staff Credentialing

SECTION QUESTIONS			
Questions			
1	The CMHSP follows a documented process consistent with State policy for credentialing and re-credentialing of providers who are employed by or have signed contracts or participation agreements with the CMHSP.	Mixed	N/A

2	CMHSP assures that all individuals, whether employed or contracted by the CMHSP, as identified in MDHHS/PIHP contract P.7.1.1 are credentialed; whether employed or contracted by the CMHSP	Mixed	N/A
3	The CMHSP's Policy reflects the scope, criteria, timeliness and process for credentialing and re-credentialing providers.	Mixed	N/A
4	Policy/Procedure does not discriminate against a provider solely on the basis of license, registration or certification, or against a provider who serves high-risk populations or specializes in conditions that require costly treatment.	Mixed	N/A
5	Providers excluded from participation under either Medicaid or Medicare will not be considered for employment or contracting.	Mixed	N/A
6	Policy/Procedure includes a statement that PIHP retains the right to approve, suspend or terminate a provider selected by that entity.	Mixed	N/A
7	CMHSP policies and procedures will designate an individual staff person/entity (e.g., a credentialing committee), responsible for oversight of the credentialing process and delineate its role.	Mixed	N/A
8	An individual credentialing/re-credentialing file is maintained for each credentialed provider.	Mixed	N/A
9	Credentials are verified, by primary source, prior to employment. This includes criminal background and central registry checks (CR if working with minors/children) for any staff having direct access to consumers served.	Mixed	N/A
10	<p>Prior to employment, the CMHSP verifies that the individual is not included in any excluded or sanctioned provider lists. This verification process shall also occur at the time of re-credentialing or contract renewal.</p> <p>The CMHSP shall search the OIG exclusions database monthly to capture exclusions and reinstatements that have occurred since the last search, or at any time providers submit new disclosure information</p>	Mixed	N/A

11	<p>The CMHSP follows written procedures to determine whether:</p> <ul style="list-style-type: none"> <li>• Physicians and other licensed healthcare professionals are qualified to perform their services</li> <li>• Non-licensed providers of care or support are qualified to perform their jobs</li> </ul>	Mixed	N/A
12	<p>The CMHSP's policy and procedures for re-credentialing require, at a minimum:</p> <ul style="list-style-type: none"> <li>• Re-credentialing at least every two years</li> <li>• An update of information obtained during the initial credentialing.</li> <li>• A process for ongoing monitoring, and intervention when appropriate, of provider sanctions, complaints, and quality issues pertaining to the provider, which must include, at a minimum, a review of: <ul style="list-style-type: none"> <li>o Medicare/Medicaid sanctions.</li> <li>o State sanctions or limitations on licensure, registration, or certification.</li> <li>o Beneficiary concerns, which include grievances (complaints) and appeals information.</li> <li>o CMHSP quality issues</li> </ul> </li> </ul>	Mixed	N/A
13	<p>The CMHSP has a policy and procedures to address granting of temporary or provisional credentials and the policy and procedures require that the temporary or provisional credentials are not granted for more than 150 days and at a minimum:</p> <p>1. A provider must complete a signed application that includes the following items:</p> <ul style="list-style-type: none"> <li>· Lack of present illegal drug use</li> <li>· Any history of loss of license and/or felony convictions</li> <li>· Any history of loss or limitation of privileges or disciplinary action</li> <li>· Summary of the providers work history for the prior five years</li> <li>· Attestation by the applicant of the correctness and completeness of the application.</li> </ul>	Mixed	N/A
14	<p>2. CMHSP must conduct primary source verification of the following:</p> <ul style="list-style-type: none"> <li>· Licensure or certification</li> <li>· Board certification, if applicable, or the highest level of credential attained</li> </ul>	Mixed	N/A



	<ul style="list-style-type: none"> <li>documentation of graduation from accredited school;</li> <li>Medicare/Medicaid sanctions</li> </ul> <p>3. Credentialing determinations will be made and communicated to the applicant Provider within thirty-one (31) days of receipt of a completed application and all supporting documentation.</p>		
15	<p>The CMHSP's processes require that an individual file be maintained for each credentialed provider and each file include:</p> <ul style="list-style-type: none"> <li>The initial credentialing and all subsequent re-credentialing applications.</li> <li>Information gained through primary source verification.</li> </ul> <p>Any other pertinent information used in determining whether or not the provider met the CMHSP's credentialing standards.</p>	Mixed	N/A
16	<p>The CMHSP's policy and procedures require that, at a minimum include:</p> <p>1. A written application that is completed, signed and dated by the provider and attests to the following elements:</p> <ul style="list-style-type: none"> <li>Lack of present illegal drug use</li> <li>Any history of loss of license and/or felony convictions</li> <li>Any history of loss or limitation of privileges or disciplinary action</li> <li>Attestation by the applicant of the correctness and completeness of the application.</li> </ul> <p>2. A summary of the provider's work history for the prior 5 years</p>	Mixed	N/A
17	<p>The CMHSP's policy and procedures require that, at a minimum include:</p> <p>Verification from primary sources of:</p> <p>A. Licensure or certification</p> <p>B. Board certification, if applicable, or the highest level of credential attained</p> <p>C. Documentation of graduation from an accredited school</p> <p>D. National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or in lieu of, all of the following must be verified:</p> <ul style="list-style-type: none"> <li>Minimum 5-year history of professional liability claims resulting in a judgment or settlement</li> <li>Disciplinary status with regulatory board or agency; and</li> </ul>	Mixed	N/A

	<ul style="list-style-type: none"> <li>• Medicare/Medicaid sanctions</li> </ul> <p>E. If a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements for (A), (B) and (C) above.</p> <p>Copies of all documentation kept in employees' or contractors' file</p>		
18	The CMHSP's credentialing policy was approved by the CMHSP's governing body and identifies the CMHSP administrative staff member responsible for oversight of the process.	Mixed	N/A
19	The CMHSP's program for staff training includes: training for new personnel related to their responsibilities, program policy, and operating procedures methods for identifying staff training needs in-service training, continuing education and staff development activities	Mixed	N/A
20	The CMHSP validates, and re-validates at least every two years, that an organizational provider is licensed as necessary to operate within the State and has not been excluded from Medicaid or Medicare.	Mixed	N/A
21	If the CMHSP accepts the credentialing decision of another CMHSP for an individual or organizational provider, it maintains copies of the current credentialing CMHSP's decision in its administrative records.	Mixed	N/A
22	The CMHSP's policy and procedures address the requirement for the CMHSP to inform an individual or organizational provider in writing of the reasons for the CMHSP's adverse credentialing decisions	Mixed	N/A
23	The CMHSP's policy and procedures address the CMHSP's appeal process (consistent with State and federal regulations) that is available to providers for instances when the CMHSP denies, suspends, or terminates a provider for any reason other than lack of need.	Mixed	N/A
24	The CMHSP has procedures for reporting, to appropriate authorities (i.e., PIHP, MDCH, the provider's regulatory board or agency, the Attorney General, etc.), improper known organizational provider or	Mixed	N/A

individual practitioner conduct which results in suspension or termination from the CMHSP's provider network. The procedures are consistent with current federal and State requirements, including those specified in the MDCH Medicaid Managed Specialty Supports and Services Contract.

25	CMHSP must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.	Mixed	N/A
26	The CMHSP has a process or policy to ensure use of student interns is in compliance with the Provider Qualifications Chart.	Mixed	N/A

#### SECTION QUESTIONS

Questions

NUMBERTITLE

11 Quality and Compliance

#### SECTION QUESTIONS

Questions

1	CMHSP accreditation status is current and without provisions.	Mixed	N/A
2	<p>The CMHSP has a process in place for carrying out corporate compliance activities across the service area, including the following:</p> <ul style="list-style-type: none"> <li>• written policies, procedures, and standards of conduct that articulates the organization's commitment to comply with all applicable Federal and State standards, and to guard against fraud and abuse;</li> <li>• designation of a compliance officer and a compliance committee accountable to senior management, focused on regulatory identification, comprehension, interpretation, and dissemination;</li> <li>• training of the compliance officer, committee members and the organization's employees on the compliance policies and procedures;</li> <li>• provision for internal monitoring and auditing to assure standards are enforced, identify high risk compliance areas and where improvements must be made;</li> </ul>	Mixed	N/A

	<ul style="list-style-type: none"> <li>• provision for prompt response to detected offenses, and for development of corrective action.</li> </ul>		
3	<p>Procedures and a mandatory compliance plan are in place at each CMHSP to guard against fraud and abuse consistent with the NMRE Compliance Plan. This includes:</p> <ul style="list-style-type: none"> <li>• CMHSP follows established disciplinary guidelines for their respective employees who have failed to comply with the standards of conduct, policies, and procedures, federal and state law, or otherwise engage in wrongdoing.</li> <li>• The CMHSP informs, in writing, the NMRE Chief Executive Officer (CEO) of any notice to, inquiry from, investigation by any Federal, State, or local human services, fiscal, regulatory, investigatory, prosecutory, judicial, or law enforcement agency and/or advocacy organization regarding the rights, safety, or care of a recipient of Medicaid services</li> <li>• The CMHSP CEO/ED shall report violations to external parties as required per DCH contract and/or NMRE/CMHSP contract.</li> </ul> <p>CMHSP staff with knowledge of activities or omissions that may violate laws and regulations must report them to MMRE/CMHSP compliance.</p>	Mixed	N/A
4	The CMHSP has written procedures for reporting to the PIHP any suspicion or knowledge of fraud or abuse within the Medicaid program.	Mixed	N/A
5	The CMHSP has a process to collect information about the nature of fraud and abuse complaints, the name of the individuals or entity involved in the suspected fraud or abuse, including name, address, phone number and Medicaid identification number and/or any other identifying information, the type of provider, approximate dollars involved, and legal and administrative disposition of the case including actions taken by law enforcement officials to whom the case has been referred.	Mixed	N/A
6	The CMHSP has an established quality improvement program and plan consistent with the NMRE QAPIP.	Mixed	N/A

7	<p>The CMHSP has processes for reporting and analyzing adverse events and risk factors. This includes:</p> <ul style="list-style-type: none"> <li>• critical events</li> <li>• risk events</li> <li>• events requiring immediate notification to MDHHS</li> <li>• emergency physical intervention.</li> </ul> <p>Data on all types of incidents is monitored, reviewed and reported through a quality assurance process. The CMHSP process includes analysis of any identified patterns or trends, the completion of identified actions, and recommended prevention strategies for future risk reduction.</p>	Mixed	N/A
8	<p>Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care.</p> <p>For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.</p>	Mixed	N/A
9	<p>Provider has taken timely actions on sentinel events per MDHHS timeliness guidelines.</p>	Mixed	N/A

#### SECTION QUESTIONS

Questions

#### SECTIONS

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