Community Mental Health Affiliation of Mid-Michigan

AFFILIATION POLICY	
Policy #: A0.5	SUBJECT: Provider Network Management
Issued and overseen by: The PHP's Contract Network Administrator	
Scope: All members of the Community Mental Health Affiliation of Mid-Michigan	

Action	Effective Date
Approved by PHP CEO	6/1/02

Subsequent Review Dates (Reviewed by Issuing Party)					

I. Policy/Standards/General Practice:

It is the policy of the Affiliation to utilize sound contracting practices to develop and manage a quality provider network with the composition, structure, capacity and characteristics necessary to ensure sufficient availability of providers and afford the consumer the opportunity for provider choice and consideration.

Standards:

A. Members of the Affiliation shall not discriminate against applicants, bidders and/or contractors on the basis of race, age, sex, religion, national origin, height, weight, sexual preference or marital status.

B. All provider applicants shall be required to submit a complete application for certification to be eligible to participate in the provider network. An applicant shall meet minimum qualifications and legal and program requirements to provide the services he or she is contracted to provide. The submission of an application for enrollment in the provider network neither guarantees nor obligates the affiliate member to contract with the Service Provider

C. A comprehensive background investigation, including criminal background, will be conducted prior to contract award, and annually thereafter, on all members of the provider network. The affiliated agency shall only credential and grant privileges to qualified providers. Qualified providers shall possess the same qualifications as the Affiliation internal provider network. Providers who appear on the Sanctioned Providers List shall be disqualified from providing services to Medicaid beneficiaries. The Sanctioned Providers List shall be reviewed at least annually to ensure no current Affiliation network providers are named.

D. Service needs shall be assessed on an ongoing basis to assure the necessity of procurement. Assessments may be based on the size and service needs of the population, likelihood of cost savings, financial options, utilization projections, availability of qualified service providers, performance standards, and MDCH contract requirements, among other indicators.

E. The provider network shall have sufficient capacity to meet the demand for care for each specialty service and support. Services shall be provided with consideration given to limited-English proficiency, cultural competence and accommodation of physical and communication limitations. A roster of resources shall be maintained by each member of the Affiliation to ensure that the needs for interpreter and translator services can be reasonably accommodated.

F. The development and management of the provider network will reflect the input of individual, family and stakeholder groups. These parties will play an integral role in monitoring provider performance. If the CMH is unable to provide necessary services to a particular consumer, the CMH shall adequately and timely cover these services out-of-network for the consumer for as long as the entity is unable to provide them within the

network. Out-of-network providers must meet minimum qualifications and legal and program requirements to provide the services he or she is to provide. The CMH ensures that the out-of-network services shall not incur additional cost to the consumer.

G. Each member of the Affiliation will utilize open-enrollment, single source procurement, competitive contracting, Request for Proposal (RFP) or Request for Quote (RFQ) when procuring services.
H. Each member of the Affiliation reserves the right to accept, reject or negotiate and amend any proposal/bid submitted when it is in the best interest of the agency to do so.
I. All provider contracts will contain, as applicable, language relevant to:
    1. Specification of service area/population
    2. Payment rates for all services being purchased
    3. Specifications for submitting clean claims/invoices
    4. Payment schedules, including the contractor's responsibility for payment timeliness
    5. Provider's financial risk (if any)
    6. First and third party liability and provider responsibility for collections (including provision that Medicaid beneficiaries have no first party liability)
    7. Incentive systems (if any)
    8. Requirements concerning Medicare/Medicaid dual eligibles
    9. Maximum lag between service date and claims submission date
    10. All reporting requirements
    11. Sanctions
    12. Employment of individuals with disabilities
    13. Conducting criminal background checks on all employees that have direct consumer contract
    14. Compliance with Recipient Rights provisions and guidelines as specified in Mental Health Code.
J. Orientation for network providers will occur at the time the contract is executed. A Provider Manual that includes policies, procedures and other information pertinent to the provision of contract services and contract execution will be distributed to all members of the provider network and reviewed during orientation. This information will include policies for services specific to children, persons with substance abuse disorders and older adults as applicable. Ongoing training will be offered as determined by the agency.
K. The Provider Manual will include policies and procedures that require provider compliance as a condition of initial contract award and of continued participation and compensation.
L. Providers will be monitored on an ongoing basis to assure quality of care, customer satisfaction and contract compliance and evaluated to determine "best value" in terms of price and quality.
M. The CMH will 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 consumer who received his or her primary care from, or was seen on a regular basis by, the terminated Provider, irrespective of the reason or cause for termination.
N. The Provider Network Management Committee will be responsible for overseeing contract and network development and management, including timely execution of contracts. The Provider monitoring of this committee shall include, but not be limited to, review and analysis of data and finance reports, as well as functional integration of utilization management and other practice information. Additionally, the committee shall ensure consumer, family and stakeholder involvement in the development of the provider network, and develop remedies for compliance or performance problems within the provider network.
O. The Chairperson of the Provider Network Management Committee shall serve as the single point of responsibility to ensure consistency relative to network contract development, execution and on-going contract management.
P. Specific measures will be established by each member of the Affiliation to ensure there is no conflict of interest in the selection, management and monitoring of any network provider.
Q. Dispute and appeal mechanisms shall be implemented by the Affiliation to assure due process is afforded to all network providers and applicants.

II. Definitions

Additional definitions may be found in the Affiliation Definition Document.

Best Value:	The highest level of quality at the lowest price.
Credentialing:	The process of reviewing and verifying the credentials of contract service providers and staff to include licensure, registration and/or certification conveyed by legal authority, academic record and degree, specific clinical training and/or experience, and professional affiliation.
Facility:	A hospital, institution or program that has entered into an agreement as an independent contractor with the agency to provide services.
Privileging:	The process of granting permission to individuals to perform certain professional duties within a defined scope of service, based on a determination of competency and verification of credentials.
Qualifications:	The individual's knowledge, training, experience, education and applicable licensure, registration, and/or certification to perform a specific function, responsibility or service.
Request for Proposal (RFP):	A bid process utilized by the agency to solicit competitive proposals from community providers to address a specific service need. The bidder is requested to provide a proposed set of activities addressing the need, the price for providing the services, information regarding the proposed qualifications, and capacity of the bidder to provide the services.
Request for Quote (RFQ):	A competitive bid process utilized by the agency to procure the purchase of services, which includes requesting information from prospective bidders about their ability to provide services and the price of those services.
Single Source Procurement:	A noncompetitive process for the solicitation and/or selection of providers.

III. Compliance Monitoring:
(Applies to this policy and all related procedures)

1. Compliance with this policy is ensured, across the Affiliation, by each affiliate's Contract Manager.
2. As applicable, the cross-affiliation Provider Network Management Committee is charged with providing guidance relative to compliance with this policy across the Affiliation.

IV. References

Technical Issues Advisory: "Procurement and Selective Contracting Under Managed Care", Department of Community Health, 1997.

"Application for Participation as a Prepaid Health Plan", Department of Community Health, January 2002.

V. Attachments

Provider Network Application