POLICY TITLE: PROVIDER NETWORK AND CONTRACT MANAGEMENT	POLICY #4.2	REVIEW DATES	
Topic Area: Provider Network Management	**ISSUED BY:** Chief Executive Officer	11/21/13	2/1/2015
		2/29/16	12/16/2021
Applies to: LRE and all member CMHSPs			
	APPROVED BY: Chief Executive Officer		
Developed and Maintained by: CEO and Designee			
Supersedes: N/A	**Effective Date:** January 1, 2014	**Revised Date:** 12/16/2021	

I. PURPOSE

To assure that the provider network permits meaningful consumer choice, promotes the highest quality of services, and is compliant with contractual and regulatory requirements, and performance expectations of the Entity.

II. POLICY

Network Monitoring and Oversight

The Lakeshore Regional Entity (the "Entity") shall provide contractual oversight for all contracts within the Entity Region for all services related to Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Programs, the Healthy Michigan Program and Substance Use Disorder (SUD) Community Grant Programs. The Entity will monitor the performance, quality contractual compliance and compliance with State and Federal standards of each entity providing mental health and/or substance use disorder services to consumers within the Region.

CMHSP Members/SUDSPs unable to demonstrate acceptable performance shall be required to provide corrective action including but not limited to additional PIHP oversight and interventions and may be subject to sanctions imposed by the Entity.

Network Adequacy/Sufficiency

1. The Entity shall ensure an adequate and sufficient network of providers through a variety of mechanisms including, but not limited to, the development of a comprehensive list of all providers in the region, regular reviews of access and availability data, review of annual CMHSP Community Needs Assessments and Demand for Services data, review of utilization reports, and solicitation of stakeholder input.
2. Each CMHSP Member shall conduct a local assessment of community need consistent with the MDHHS Guidelines for Community Needs Assessment. This assessment shall

aid in informing decisions related to the sufficiency and adequacy of the provider network to address local needs and priorities. The assessment shall also determine whether services are available in accordance with MDHHS and Medicaid Provider Manual requirements.

3. Annually the Entity shall evaluate the needed and actual capacity of its provider network via a review of available data sources. The Entity shall consider, at a minimum, anticipated Medicaid enrollment, expected utilization, and required numbers and types of providers, number of network providers not accepting new beneficiaries, geographic location of providers and beneficiaries, the distance, travel time, and the availability of transportation including physical access for beneficiaries with disabilities. The Entity shall also consider the availability of local inpatient beds, crisis capacity, local alternatives to residential care, and regional alternatives to segregated day service in its decisions about network capacity and sufficiency. Consumer satisfaction with the existing service array shall also be reviewed and considered in this annual assessment.
4. Based on this analysis the Entity may redistribute resources per the Operating Agreement where necessary to ensure timely access and necessary service array to address consumer demands. The Entity will explore economies of scale in purchasing, rate setting, regional capacity development and other efficiencies. The Entity shall also annually produce a plan from its evaluation and findings and shall develop recommendations for network development.

<u>CMHSP Service Delivery System</u>

1. Development and management of the CMHSP Service Delivery System are functions delegated by the PIHP to the CMHSP Members. Contracts executed between CMHSPs and subcontractors shall be consistent in terms of provider expectations, though documents may differ among CMHSPs. CMHSP Members shall develop mechanisms for sharing application materials, provider monitoring/auditing reports, and provider training and credentialing when contracting with common providers in the region.
2. The Entity shall require each CMHSP Participant to have written policies and procedures and to maintain evidence of compliance with network development standards that meet state and federal requirements. This includes:
    a. Public, fair, and open processes for provider selection, provider qualification programs or other similar valid processes taking place on a regular or reoccurring basis.
    b. Consumer input in CMHSP provider selection processes where feasible, that includes new program development or service array expansion to meet local needs where indicated.
    c. Provider orientation and training for specific service delivery needs that meet

requirements and conforms with applicable best practices, and methods to identify new workforce training needs.

d. Verification of provider qualifications and credentials required for service delivery responsibilities.
e. An assigned individual at each CMHSP who is responsible to maintain compliance and consistency with standards and requirements in this area.
f. Compliance with State and Federal Procurement Guidelines.

3. Each CMHSP Member shall assign staff to carry out the network development and management functions delegated by the PIHP in a manner consistent with the standards and requirements established by MDHHS, the BBA and the Entity.

Provider Qualifications and Credentialing

The Entity shall ensure that CMHSP Members/SUDSP comply with all MDHHS guidelines and federal regulations related to credentialing, re-credentialing, and primary source verification of professional staff, as well as the qualifying of non-credentialed staff, and in accordance with the Entity policies and procedures. The Entity will monitor CMHSP/SUDSP credentialing and qualifying activities at least annually to ensure compliance with these standards.

Conflict of Interest

All CMHSP Members/SUDSPs will consistently function with integrity, in compliance with requirements of all applicable laws, utilizing sound business practices, and with the highest standards of excellence.

Payment Liability

The Entity shall ensure that CMHSP Members/SUDSPs comply with enrollee rights related to payment liability. Written agreements shall ensure that beneficiaries are not held liable when the PIHP does not pay the health care provider furnishing services under the contract.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to the Entity and its member CMHSPs.

IV. MONITORING AND REVIEW

This policy will be reviewed by the LRE CEO or designees on an annual basis.

V. DEFINITIONS

Agreement: Non-financial arrangements such as Data Use Agreements, Medicaid Health Plan Agreements.

Business Associate Agreement (BAA): The most common agreement between a Covered Entity and its third-party service provider is the BAA. BAA is more common terminology to healthcare providers than the term QSOA simply because a vast majority of Covered Entities

do not qualify as Part 2 Programs, and therefore, Covered Entities are using BAAs much more frequently than QSOAs. There are certain required elements of a BAA such as 1) establish permitted and required uses and disclosures of PHI by the Business Associate; 2) provide that the Business Associate will not use or further disclose the information other than as permitted by the BAA or as otherwise required by law; and 3) require the Business Associate to implement appropriate safeguards to prevent unauthorized use or disclosure of PHI.

CMHSP: Community Mental Health Service Program

Provider: Organizations and Individuals the LRE and/or CMHSP contract with to provide mental health and/or SUD services.

VI. RELATED POLICIES AND PROCEDURES

A. Quality Policies and Procedures
B. Compliance Policy and Procedures
C. Compliance Plan
D. General Management Policies and Procedures
E. Service Delivery Policies and Procedures
F. Care Coordination Policies and Procedures
G. Provider Network Policies and Procedures

VII. REFERENCES/LEGAL AUTHORITY

A. MDHHS Medicaid Managed Specialty Supports and Service Contract
B. Michigan Medicaid Provider Manual
C. MDHHS Provider Credentialing and Re-Credentialing Processes
D. MDHHS Quality Assessment and Performance Improvement Programs for Specialty Prepaid Health Inpatient Health Plans
E. Balanced Budget Act 438.214(b)(2) Provider Selection
F. Federal Procurement Guidelines
G. Procurement Policy

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
12/16/2021		CEO and Designees