SUBJECT PIHP Network of Service Providers		**CHAPTER** 01	**SECTION** 06	**SUBJECT** 02
CHAPTER Administration	**SECTION** Provider Network			
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I. APPLICATION:

☒ PIHP Board ☒ CMH Providers ☒ SUD Providers
☒ PIHP Staff ☒ CMH Subcontractors

II. POLICY STATEMENT:

It shall be the policy of the Region to ensure a comprehensive network of specialized services and supports is in place which has the capacity to provide services of sufficient amount, scope, and duration to meet the needs of all eligible persons requiring specialty benefit mental health and substance use disorder services.

III. DEFINITIONS:

A. Code of Federal Regulations (CFR): The codification of the general and permanent rules published in the federal Register by the departments and agencies of the Federal Government– for the purposes of this policy, specifically 42CFR438 – Managed Care.
B. Provider: CMHSP and SUD Providers, individual or corporation; any CMHSP subcontracted provider / practitioner, individual or corporation.

IV. STANDARDS:

A. Network Management Program: The PIHP shall maintain a network management plan that delineates the framework of its network management program. The plan shall be updated whenever necessary to reflect current functionality and/or changing rules and regulations imposed upon the PIHP.

B. Network Management Delegation: The PIHP is delegating the management of its local sub-panel of mental health service providers to each CMHSP and directly manages a network of SUD Providers. The PIHP shall ensure through its Provider contracts that it remains accountable for any PIHP functions and responsibilities that it delegates.

1. Before the delegation, the PIHP shall evaluate the prospective Provider's ability to perform the activities to be delegated.
2. The PIHP has in writing what specifies the activities and report responsibilities delegated to the Provider.

C. Network Services: The PIHP shall ensure (and each CMHSP shall assure the PIHP) that all services covered under the state plan, HSW, and additional (B) (3) services listed in the Michigan Department of Health and Human Services (MDHHS) Contract are available and geographically accessible to all beneficiaries of the PIHP.

D. Network Sufficiency: The PIHP shall ensure (and each CMHSP shall assure the PIHP) of service sufficiency and availability – that a sufficient service delivery network is available, which meets the following requirements:

1. A network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under contract.
2. Maintain a policy that ensures parties that are declined as part of the network are provided written notice of the reason why.
3. Address the following in maintaining and monitoring its provider network:
   a. The anticipated Medicaid enrollment.
   b. The expected utilization of services, taking into consideration the characteristics and healthcare needs of the specified populations in the PIHP's catchment area.
   c. The numbers and types of providers required to furnish the contracted Medicaid services.
   d. The numbers of network providers not accepting new Medicaid referrals; and any capacity limitations that may exist in the network.
   e. The geographic location of providers and Medicaid beneficiaries considering distance, travel, time, the means of transportation, ordinarily used by Medicaid beneficiaries within the region, and whether the location provides physical access to persons with disabilities.
4. Maintain sufficient capacity to provide a "second opinion", as defined in the CFR, from a qualified health care professional within the network, or arranges for the Medicaid beneficiary to obtain one outside the network.
5. Necessary services, covered under the MDHHS/PIHP or PIHP/CMHSP contract are obtained should sufficient capacity not exist within the local network to provide adequate and timely services.
6. If unable to provide necessary medical services covered under the contract to a particular beneficiary, to adequately and timely cover these services out of network for the beneficiary, for as long as the entity is unable to provide them within the network.
7. Since there is no cost to the beneficiary for the PIHP's in-network services, there may be no cost to beneficiary for medically necessary specialty services provided out of network.
8. Demonstrate that its organizational providers are credentialed as required by CFR §438.214 and the Medicaid Provider Manual.
9. Ensure that each subcontracted provider complies with the following requirements:
   a. Timely access. Require its providers to meet PIHP standards for timely access to care and services, taking into account the urgency of the need for services.
   b. Offer hours of operation that are no less than the hours of operation offered to commercial plan enrollees, or comparable Medicaid fee-for-service providers.

10. Establish mechanisms to ensure compliance by subcontracted providers (i.e. contract monitoring).

E. The PIHP shall ensure (and each Provider shall assure the PIHP) that service delivery meets the following requirements:

1. Providers may not bill individuals for the difference between the provider's charge and the PIHP's payment for services. Providers shall not seek nor accept any additional payment for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the beneficiary would owe if the PIHP provided the services directly.
2. To promote the delivery of services in a culturally competent manner to all enrollees; including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.
3. To provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities. To immediately accommodate individuals who present with limited English proficiency and other linguistic needs, diverse cultural or demographic backgrounds, visual impairments, alternative needs for communication and mobility challenges.
4. Provide appropriate and timely notification of any changes to the composition of the network that negatively affect access to care and maintain procedures to address related changes.
5. Review and monitoring of MDHHS network adequacy standards.

F. Network Credentialing: The PIHP shall establish a network-wide uniform credentialing policy.

1. The PIHP shall ensure (and each Provider shall assure the PIHP) that each is following a documented process for credentialing and re-credentialing of its direct (practitioner) and contract agency sub-panel providers (organization – applicable to CMHSPs only).
2. The PIHP shall establish uniform policies and procedures for the provider network. Each Provider shall ensure compliance with these network selection policies, and the development of local procedures on its implementation.
3. The PIHP and Providers (and their networks where applicable for each CMHSP) may not employ or contract with providers excluded or sectioned from participation in Federal Healthcare Programs as verified monthly through both MDHHS Office of Inspector General (OIG) AND through the MDHHS sanctioned Provider List.

G. Provider Registry: Providers must register with the PIHP any Medicaid state plan, HSW, or additional (B)(3) service it provides directly or through an approved contracted sub-panel provider, as specified in the Medicaid Provider Manual, Mental Health and Substance Abuse Chapter, Section .1.4 Providers must update their own directory or the PIHP whenever substantial changes occur (e.g. address, scope of program, program additions, program deletions, etc.), according to the format

specified by the PIHP. In turn, the PIHP shall be the responsible entity to update the PIHP's provider registry with MDHHS.

H. Provider Enrollment: Providers must ensure they are e enrolled with the PIHP as required and specified in the PIHP Credentialing and Privileging Policy. Credentialing of contracted provider organizations must be re-credentialed at least every two (2) years to maintain enrollment in the PIHP Provider Network.

I. CMHSP Special Program Approval:

Each CMHSP must obtain and maintain PIHP (and MDHHS) specific approval for certain programs prior to service delivery and claims submission into to the PIHP, in order to be reported as a Medicaid cost. Programs requiring **special approval** are:

a. Assertive Community Treatment (ACT) Program
b. Clubhouse Psychosocial Rehabilitation Programs
c. Crisis Residential Programs
d. Day Program Sites
e. Drop-in Programs
f. Home-Based Services
g. Intensive Crisis Stabilization
h. Wraparound

V. PROCEDURES:

PIHP

1. Maintains network management plan for the regional network and updates as necessary.
2. Coordinates CMHSP Special Program Approval enrollment including initial and renewal applications and service agency profiles (including revisions as appropriate) and submits to MDHHS.
3. Coordinates and submits to MDHHS CMHSP Special Program Approval enrollment MDHHS required reports.
4. Monitors, no less than annually, the overall performance and compliance of each Provider, as required by the CFR and MDHHS contract, providing a summary report to the PIHP Board on each Provider performance, including any delegated functions.
5. Notifies the MDHHS within seven (7) days of any significant changes to its provic affects adequate capacity and services of the network.

CMH

1. Submits timely information to the PIHP regarding CMHSP Special Program approval for initial or updated enrollment information and reporting.