

<b>CHELAN-DOUGLAS RSN/PIHP POLICY AND PROCEDURE MANUAL</b>		Chapter:	1.6.3
Title:	INTRODUCTION AND ADMINISTRATIVE POLICIES	Page:	1 of 3
		Date Effective:	July 1, 2004
Subject:	Access Standards: Availability of Services	Date Revised:	October 23, 2006 January 12, 2012
		Authorizing Signature:	

**AUTHORITY:** Guiding Principle(s): Consumer Focused, Holistic/  
Humanitarian, Accessible, Normalizing/Non-Stigmatizing,  
Responsive, Effectively Managed  
Chelan-Douglas Regional Support Network/Prepaid Inpatient  
Health Plan contracts  
42 CFR 438.206(b)(1)(i)-(v),(2),(3),(4)  
State Quality Strategy Doc Sec V and VIII

**SCOPE:** This policy applies to Chelan-Douglas Regional Support  
Network/Prepaid Inpatient Health Plan (CDRSN/PIHP) and its  
contractors (agencies/providers), and subcontractors (referred  
to as contractors or agencies or providers throughout this  
policy).

**PURPOSE:** This policy describes the monitoring responsibilities of the  
CDRSN/PIHP in developing and maintaining contracted  
providers adequate to provide services within the provider  
network.

**DEFINITIONS:** “Penetration Rate” means: The percentage of Medicaid  
individuals using publicly funded mental health services out of  
the total population of Medicaid eligible’s.

“Provider” means: A term that indicates a contracted agency  
that provides mental health services within the RSN/CDRSN/  
PIHP. May also refer to a facility or an individual.

“Second Opinion” means: An opinion obtained from an  
additional health care professional prior to the performance of a  
clinical service or a related clinical procedure. May relate to a  
formalized process, either voluntary or mandatory, which is used  
to help educate a consumer regarding treatment alternatives  
and/or to determine medical necessity.

**POLICY:** The CDRSN/PIHP maintains and monitors a network of  
appropriate providers that is supported by written agreements  
and is sufficient to provide adequate access to all services

covered under the contract. In establishing and maintaining the network, the CDRSN/PIHP considers the following:

1. The anticipated Medicaid enrollment for the CDRSN/PIHP catchments area. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the CDRSN/PIHP.
2. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services. The number of network providers who are not accepting new Medicaid patients.
3. The geographic location of providers and Medicaid enrollees, considering distance, travel time, at the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.

The CDRSN/PIHP is obligated to cover—and does cover--through out-of-the network contracted providers any necessary services covered under contract but not available through the network. The CDRSN/PIHP adequately and timely covers these services when unable to provide them through a network provider.

The CDRSN/PIHP requires the out of network providers to coordinate with the CDRSN/PIHP, with respect to payment and ensure the cost to the enrollee is no greater than it would be if the services were furnished within the network.

**PROCEDURE:** Within available resources the CDRSN/PIHP is responsible for carrying out various service area planning activities which will provide context and data to determine if there is an appropriate and adequate number and type of providers, based on multiple planning factors and planning models. If the State has established any explicit standards for provider network adequacy, ration of providers to enrollees, etc. the standards will be included in the analysis. The analysis will be based on benchmarking processes, data, and other reasonable sources of information and guidelines.

The analysis of the CDRSN/PIHP's network capacity to serve the Medicaid beneficiaries in a given area includes the CDRSN Governing Board, CDRSN Advisory Board, Quality Management Oversight Committee, CDRSN Provider Network Directors, and other community stakeholders.

In the circumstance where CDRSN/PIHP contracted network provider is unable to provide covered services to a particular enrollee, the contracted provider is responsible to secure and be financially responsible for the provision of the covered services with an out-of-network professional mental health provider with the expertise to address the specific need or needs for as long as the CDRSN/PIHP provider network is unable to provide the necessary services.

In the event a contracted provider utilizes an out-of-network and/out-of-area provider to meet a particular need of an enrollee, the provider will document the need to address this circumstance, how, who, when, where, etc. And, written agreements between CDRSN/PIHP for this circumstance will be developed and attached for reference and assurance to reviewers that the CDRSN/PIHP has addressed this need and to ensure that any costs to the enrollee is no greater than it would be if the services were furnished with the provider network.

The CDRSN/PIHP will ensure contracted provider agency compliance through Contract Audits, reviews, and analysis. The CDRSN Quality Management Plan identifies the Quality Management Oversight Committee as the central entity to review and make recommendations to the CDRSN/PIHP.

SEE ALSO: Glossary of Terms and Acronyms