

CHELAN-DOUGLAS RSN/PIHP POLICY AND PROCEDURE MANUAL		Chapter:	1.6
Title:	INTRODUCTION AND ADMINISTRATIVE POLICIES	Page:	1 of 5
		Date Effective:	July 1, 2004
SUBJECT:	MENTAL HEALTH PROVIDER NETWORK: PROVIDER SELECTION	Date Revised:	November 20, 2006
		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 438.214(a),(b)(1)(2)(c)(d)(e)  
438.12(a)(1)(2),(b)(1)(2)(3)  
438.218; 438.224  
State MHD Quality Strategy Doc Sec X

**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 role and responsibilities of CDRSN/PIHP contractors.

**DEFINITIONS:** “Arm’s Length” is a phrase that can characterize the working relationship between two individuals or entities who establish protocols for working together to avoid dual relationships and/or conflict of interests.

“Credentialing” means: A process of review to approve a provider who applies to participate in a health plan. Specific criteria and prerequisites are applied in determining initial and ongoing participation in the health plan.

“Delegation” refers to a formal process by which a managed care organization gives another organization the authority to perform certain functions on its behalf, such as credentialing, utilization management, and quality improvement. Although a managed care organization can delegate the authority to perform a function, it cannot delegate the responsibility for assuring the function is performed appropriately. (NCQA source)

“Dual Relationship” means: The assumption, by the professional, of

more than one role in relationship to a subcontractor, which places either the CDRSN/PIHP or the sub-contractor at increased risk of harm, fraud and abuse, or exploitation. The power differential which can exist in potential dual relationship situations comes from the potential to serve as a “change agent or influence agent” to facilitate some change in behavior or action on the part of either party to the relationship. Differences in relationship power also places the CDRSN/PIHP in a position where there is the potential to misuse power and thus cause harm to the sub-contractor.

“Dual Role Conflict” refers to the assumption by the professional of multiple role relationships with entities, which place the entity or the CDRSN/PIHP at risk of risk of harm, fraud and abuse, or exploitation.

“Practitioner” means: A term that indicates an individual clinician under contract with the CDRSN/PIHP or its agent to provide mental health services to eligible enrollees.

“Provider” means: A term that indicates a contracted agency that provides mental health services within the CDRSN/PIHP delivery network. The term can also be used to refer to a facility, or an individual. In a more generic context, the term “provider” refers to a physician, hospital, group practice, nursing home, pharmacy, or any individual or group of individuals that provides a health care service.

Enrollees with “special health care needs” means: All persons who meet the Access to Care Standard for mental health treatment meet the definition of individuals with special health care needs.

**POLICY:** The CDRSN/PIHP maintains a network of Community Mental Health Agencies (CMHSs) that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. The CDRSN/PIHP complies fully with their State MHD Contract which specifies the CDRSN/PIHP will contract only with licensed providers who have been credentialed by the State MHD.

The CDRSN/PIHP implements written policies and procedures for selection and retention of providers from the State credentialed ‘pool’ of licensed providers and practitioners in composing the CDRSN/PIHP provider network for their service area.

The CDRSN/PIHP will develop a capacity management plan biennially and track and monitor the plan annually in order to plan ongoing development of mental health services throughout the region by the completion of the Capacity management report.

The CDRSN/PIHP will terminate its contract with a provider if the Mental Health Division notifies the regional support network of a provider's failure to attain or maintain licensure or certification, if applicable.

The CDRSN/PIHP does not discriminate for participation, reimbursement, or indemnification of 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 certifications. (BBA 438.120) This BBA requirement is mitigated only by the necessity of the CDRSN/PIHP to follow the guidelines set by the State MHD Contract.

#### PROCEDURE:

1. The CDRSN/PIHP follows the uniform credentialing and re-credentialing process established by the State, as per BBA regulations which require the State to establish a uniform credentialing and re-credentialing policy.
2. The CDRSN/PIHP follows a documented process for credentialing of providers who have signed contracts or participation agreements with the CDRSN/PIHP.
3. Provider selection policies and procedures, consistent with the following specifics, do not discriminate against particular practitioners that serve high risk populations, or specialize in conditions that require costly treatment.
  - a) If the CDRSN/PIHP declines to include individual or groups of providers in its network, it will give the affected providers written notice of the reason for its decision. The CDRSN/PIHP will notify the MHD 30 days in advance of public notice before it terminates any of its CMHA subcontracts. If the CDRSN/PIHP terminates a CMHA contract in less than 30 days, the CDRSN/PIHP will notify as soon as there is a determination to terminate the subcontract and in advance of the public notice. (Quality Strategy Doc., pg 23.)
  - b) In all contracts with health care professionals, the CDRSN/PIHP complies with the requirements in this section, BBA 438.214.
  - c) The above requirements may not be construed to require the CDRSN/PIHP to contract with providers beyond the number necessary to meet the needs of its enrollees; nor preclude the CDRSN/PIHP from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; nor preclude the CDRSN/PIHP from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.
4. The CDRSN/PIHP may 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, entitled, “Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs.”

5. The CDRSN/PIHP will comply with any additional requirements established by the State.
6. Consumer, stakeholder and provider representation will form a work group to map current services and develop a set of factors (to include but not limited to a.) waiting lists, b.) timely access to intake assessments c.) MHCP caseloads d. Availability of complete service package of service modalities, and e.) consumer complaints) that will be trended across time to indicate need for additional network capacity, new services and/or additional service locations. The Capacity management report shall be completed by June first of each year and submitted to the Quality Management Oversight Committee for review and action as needed.
7. The CDRSN/PIHP shall submit to the state in a state approved format at the time of waiver renewal or in the event of substantial change in the service package;(such as changes in PIHP services, benefits, geographic service area, payments or the enrollment of a new population in the PIHP) a report that demonstrates that the CDRSN/PIHP offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of enrollees for the service area.

Choice of mental health care provider: The contracted mental health agency must ensure that each consumer who is receiving non-emergency community mental health rehabilitation services has a primary care provider who is responsible to carry out the individualized service plan. The mental health prepaid health plan must allow consumers, parents of consumers under the age of thirteen, and guardians of consumers of all ages to select a primary care provider from the available primary care provider staff within the mental health prepaid health plan.

1. For an enrolled client with an assigned case manager, the case manager is the primary care provider;
2. If the consumer doesn't make a choice, the mental health prepaid health plan or its designee must assign a primary care provider no later than fifteen (15) working days after the consumer requests services;
3. The mental health prepaid health plan or its designee must allow a consumer to change primary care providers in the first ninety days of enrollment with the mental health prepaid health plan and once during a twelve-month period for any reason;
4. Any additional change of primary care provider during the twelve-month period may be made with the documented justification at the consumer's request by:

- a) Notifying the mental health prepaid health plan (or its designee) of his /her request for a change, and the name of the new primary care provider requested and;
  - b) Identifying the reason for the desired change.
5. A consumer whose request to change primary care providers is denied may submit a grievance with the plan, or request an administrative hearing.

SEE ALSO: Glossary of Terms and Acronyms