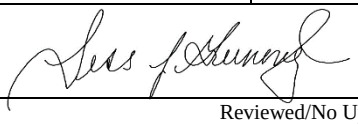
COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE POLICY AND PROCEDURES MANUAL				
Chapter **Program Quality**	**Section** **Provider Network Management**	**Chapter** **05**	**Section** **05**	**Subject** **08**
Subject **Provider Network Capacity and Analysis**	**Authorization** 		**Approved: 11/26/13** **Replaces: #03-01-09**	

Reviewed/No Updates: October 2022, October 2023

I. PURPOSE: To comply with the Balanced Budget Act (BBA) requirement, 42CFR section 438.206(b) (1) (I-V), 438.206(c) (1) (ii-iv) (2), 42 CFR Part 438.207 (b) (2), and Michigan Department of Health and Human Services (DHHS) contract requirements.

II. APPLICATION: Community Mental Health Authority (CMHA) personnel and Contracted Providers.

III. DEFINITIONS:

A. Sub-contract: A secondary contract in which CMHA originally contracted with in turn contracts with another individual or entity to provide all or part of the work or service.

B. Gap Analysis: Evaluating what standards or expectations exist for the agency against what the agency is actually doing. Where are the gaps between the standard and expectation and how will the agency respond to decreasing the gap between what is expected and provided. A gap analysis includes all aspects of the agency's functioning.

IV. POLICY: CMHA will assure that there is an adequate network of providers sufficient to:

A. meet the needs of the anticipated number of beneficiaries in the service area,

B. provide adequate access,

C. provide reasonable choice of provider, and

D. offer the full range of services covered by the benefit plan.

CMHA will comply with all regional provisions relating to Provider Network Management as directed by NorthCare policies.

V. PROCEDURE:

A. CMHA will perform a formal gap analysis to determine whether their panel of providers and/or contracted providers/sub-contractors is sufficient to meet the needs of the individuals served; this gap analysis will be performed once each fiscal year. Based on this analysis, CMHA will determine where there are specific gaps, if any, in service availability.

B. CMHA will assess beneficiaries' needs and assure adequate access to services in appropriate settings to meet those care needs, while planning for the expansion, adjustment, and improvement of their provider network, as deemed necessary. In addition, CMHA will assure that:

1) their providers and/or contract providers/sub-contractors respond to the cultural, racial, and linguistic needs (including interpretive services as necessary) of the service area; provide services with necessary and reasonable accommodations and furnished in a culturally competent manner;

2) services are accessible, considering travel time, availability of public transportation, and other factors that may affect accessibility; and, that the location of primary service providers is within 60 minutes/60 miles from beneficiary's residence for office or site-based services;

3) contract providers/sub-contractors do not segregate CMHA consumers in any way from other consumers receiving their services, and offer hours of operation to CMHA consumers that are no less than the hours offered other consumers receiving their services;

4) CMHA and/or contract providers/sub-contractors do not contract or employ providers previously or currently sanctioned or excluded from participation in federal health care programs under Section 1128 or 1128a of the Social Security Act;

5) contract providers/sub-contractors do not discriminate against particular providers that serve high-risk populations or who specialize in conditions that require costly treatment;

6) CMHA providers and/or contract providers/sub-contractors are regularly monitored to ensure all needed services are available and accessible to beneficiaries, and to determine whether provider capacity is sufficient in number, mix, and geographic distribution to assure adequate access to serve the expected beneficiary enrollment in CMHA's service area;

7) CMHA providers and/or contract providers/sub-contractors are responsive to individual needs, provide for clean and comfortable service facilities, have adequate hours, and appropriately address other quality of care issues; and

8) Corrective action is taken if there is failure to comply with applicable requirements for availability of services (42 CFR Part 438.206) or assurance of adequate capacity and services (42 CFR Part 438.207).

C. CMHA will consider the anticipated number of people who potentially could access services to include those who are General Fund and those who have Medicaid enrollment, expected utilization of services, numbers and types (in terms of training, experience, and specialization) of providers required, number of contract providers/sub-contractors who are not accepting new beneficiaries, geographic location of providers and beneficiaries, considering distance, travel time and transportation availability, including physical access for beneficiaries with disabilities.

D. Information for a gap analysis may come from a variety of sources, with the intent of obtaining a comprehensive overview of system needs. Such sources may include but are not limited to the following:

- Monthly Management Team Meetings
- Monthly Outpatient Department Meetings
- Monthly Community Services Department Meetings
- Annual Submission Requirement (i.e., PPG submission to DHHS)
- Customer Satisfaction Surveys

- Historical QI, TEDS, and Service Data
- Incidence and Prevalence Data
- CMHA Strategic Plan
- Productivity Reports
- Information as requested from contracted providers/sub-contractors
- Member data and Members served
- Occupancy rates of residential providers
- Provider Profiles, Numbers and Specialties
- Finances/budget
- New mandates
- Utilization Management
- Performance Indicators
- Penetration Rates
- ELMER reports
- Other information as deemed appropriate

E. CMHA's CEO, or designee, will ensure that all gaps in network of providers are reviewed by the Management Team. The Management Team will review on a monthly basis a report of the open, closed, and new consumers by provider for the current month and Year-To-Date. Any and all gaps in services or potential needs will also be addressed and a plan developed to address the gaps and/or needs. Any gaps/needs and plans will be made part of the meeting minutes.

F. As needed, CMHA's CEO, or designee, will present the identified need to the CMHA Board of Directors for discussion and action, if necessary.

G. Providers who enter into contract/sub-contract provider arrangements are required to comply with CMHA Policies and Procedures. In addition, all contracts, contract renewals, and performance monitoring will be submitted to CMHA's Credentialing & Privileging Committee for review and/or approval.

VI. REFERENCES AND LEGAL AUTHORITY: BBA 42 CFR section 438.206(b) (1) (I-V); BBA 42 CFR Part 438.206(c) (1) (ii-iv) (2)**;** BBA 42 CFR Part 438.207(b) (2); Medicaid Provider Manual**;** URAC Network Management Standards**;** PIHP/DHHS Contract, Sections 3.1 and 6.4**;** NorthCare Procurement Policy**;** NorthCare Selection Policy; NorthCare Network Capacity and Analysis Policy; CARF Behavioral Health Standards

VII. EXHIBITS: None