



# HURON BEHAVIORAL HEALTH OPERATIONAL POLICY

Policy #: **PM.1.01**  
Issue Date: **08/08/17**

Rev. Date:  
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**Title: Provider Network Policy**

**Prepared By: Executive Director**

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## **Purpose:**

To define the guidelines for the development and management of contracts with external providers and organizations (provider network) at Huron Behavioral Health (HBH).

## **Scope:**

This policy applies to all providers and organizations which Huron Behavioral Health (HBH) contracts with for services or goods.

## **Information:**

- HBH maintains a network of appropriate service providers supported by written agreements/contracts which is sufficient to provide adequate access to services covered under agreement with the Mid-State Health Network (MSHN) based upon:
  - The anticipated number of referrals
  - The expected utilization of services, including health care needs and local populations
  - The number and types of providers needed to furnish the medically necessary services
  - The geographic location of consumers and providers considering distance, travel time, transportation and physical access
- HBH conducts annual Needs Assessments in an effort to determine the county's population service needs and will develop or redistribute resources as necessary to accommodate the population needs and assure timely access and service array to address area needs.
- HBH will make good faith efforts to develop all contracts based on a consistent procurement method that is in accordance with requirements set forth by federal and state procurement regulations, the Michigan Mental Health Code, Michigan Department of Health and Human Services (MDHHS), the Balanced Budget Act (BBA), PIHP (Pre-paid Inpatient Health Plan) Mid-State Health Network (MSHN), governing authorities, and accrediting bodies. HBH staff will consistently function with integrity, in compliance with all applicable laws, utilizing sound business practices, and with the highest standards of excellence.
- Regarding common providers within the region, HBH will share information and reports with other CMHSPs (Community Mental Health Services Programs), as applicable.
- HBH will not discriminate against any provider or individual based on race, color, or national origin.
- Beginning with Fiscal Year (FY) 2017, the responsibility for managing the provider network management function was moved into the Finance Department. The Chief Financial Officer (CFO) has overall responsibility for this function and works with the Finance Coordinator/Contract Manager to develop, oversee, and manage contractual agreements maintaining compliance and consistency with applicable standards and requirements.

## **Policy:**

1. The Board of Huron Behavioral Health is authorized by MDHHS and the Mental Health Code to enter into subcontracts for mental health services. When entering such subcontracts, HBH will be consistent with MDHHS's Administrative Rules, the Mental Health Code, the MDHHS Contract, and other state and federal laws and regulations including title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and the Americans with Disabilities Act (ADA) of 1990.
2. In accordance with the Balanced Budget Act (42 CFR Part 400 (438.214)(c), HBH will establish uniform non-discrimination policies for its provider network, regarding provider selection and will not discriminate against particular providers that serve high-risk populations or specialize in conditions that require more costly

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treatment. HBH will ensure compliance with the PIHP's policies for nondiscrimination in the selection of network providers.

3. To the extent possible, HBH encourages open competition in the selection of contracted providers. Contracted providers are selected based upon their qualifications, capability, capacity, experience, stability, reputation, and financial aspects and must be credentialed and licensed as necessary (including primary source verification of professional staff) for the specific areas of service. This is accomplished by seeking proposals, obtaining open competitive bids, assessing best value for services provided, etc, using both competitive and noncompetitive negotiations as appropriate to secure the needed contracted services.
4. HBH excludes any providers during the selection process who have been debarred, suspended, excluded, or have any convictions relative to healthcare fraud in accordance with Social Security Act 1128 and 1128A.
5. If HBH denies/excludes an individual provider or group of providers from its service network, they will be notified of the reason for its decision in writing.
6. When HBH management determines that a mental healthcare service contract is needed as part of the annual assessment process, bids may be solicited from available competent, licensed practitioners or agencies in a public, fair, and open process. Whenever feasible, consumer input is solicited in the provider selection process, especially where new program development or service array expansion is indicated to meet community needs.
7. As deemed necessary to the situation and terms of the contract, provider orientation and training is provided for specific service delivery needs that meet requirements and conform to applicable best practices/methods. New providers are given HBH's "[Appeals and Grievances Procedure](#)" (RR.2.36) which defines grievance, appeal, fair hearing requirements and timeframes.
8. Licenses are confirmed to verify credentials prior to the issuance or renewal of contracts.
9. The Contract Manager will maintain a current list of active contracts with expiration dates and will assure that contracts requiring renewal will be generated prior to their expiration.
10. In accordance with the period defined in the contract, the Contract Manager and other executive and/or finance and clinical employees (as appropriate) will review the contracts for changes in costs, etc. and revise/amend as necessary. The review includes analyzing the costs of the contracted services for effectiveness and efficiencies. Since most HBH contracts are written for a one (1) year period, this is typically conducted annually.

***Network Management and Monitoring Plan:***

The responsibility of assessing needs and deciding on purchase of services as a means of meeting those needs generally resides with various program and/or administrative staff. Several individuals and areas of responsibility within the agency may be involved in developing contracts and selecting providers and organizations using the following guidelines.

1. Program and administrative staff will evaluate a potential contract provider to ensure that sufficient financial and human resources are available and that they possess any required licenses or are otherwise legally authorized to deliver the purchased services.
2. HBH will establish a mechanism to ensure compliance and will:
  - Monitor providers regularly to determine compliance
  - Take corrective action if there is failure to comply
3. HBH will maintain a documented process for privileging/credentialing and re-privileging/re-credentialing that is aligned with the Pre-paid Inpatient Health Plan's (PIHP) privileging/credentialing policies. (See also "[Privileging Policy](#)" HR.1.01)
4. HBH will ensure the documented process for privileging/credentialing and re-privileging/re-credentialing of its direct and contract agency providers (individual or organization) is followed.
5. HBH will establish uniform provider selection policies/procedures for provider network that aligns with PIHP policies.

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6. HBH will not employ or contract with providers or organizations that have been excluded from participation in the federal healthcare programs.
7. HBH will develop a local network management and monitoring plan for the management of subcontracted providers. This plan will be aligned with the PIHPs regional network plan. HBH will adopt the network's management and monitoring plan which includes:
  - a. An assessment of the performance of the existing network
  - b. Results of a gap analysis and/or needs assessment which identifies deficits with respect to the capacity of the existing network
  - c. Goals for the network with respect to:
    - The contractual relationship between the agency and service providers, including those who are directly employed by the agency
    - The mechanisms for monitoring the operations and performance of the provider network
    - Methods for rewarding and sanctioning providers
8. If any contracts are terminated with providers who give direct care to HBH consumers, HBH will make a good faith effort to notify the consumer (in writing), of the termination of those services within fifteen (15) days of issuance/receipt of the termination notice.
9. If HBH cannot provide a particular medically-necessary service to a consumer as mandated to provide under contract, HBH will expeditiously develop a contract with an out-of-network provider to provide the needed service at no additional cost to the consumer.

**Definitions/Acronyms:**

ADA – Americans with Disabilities Act  
BBA – Balanced Budget Act  
CFO – Chief Financial Officer  
CFR – Code of Federal Regulations  
CMHSP – Community Mental Health Services Program  
COA – Council on Accreditation  
FY – Fiscal Year  
HBH – Huron Behavioral Health  
HIPAA - Health Insurance Portability and Accountability Act of 1996  
MDHHS – Michigan Department of Health and Human Services  
MSHN – Mid-State Health Network  
PIHP – Prepaid Inpatient Health Plan  
USC – United States Code

**Forms:**

N/A

**Records:**

Contracts are retained by the HBH Contract Manager for the life of the contracted period plus seven (7) years.

**Reference(s) and/or Legal Authority**

COA standards  
Michigan Mental Health Code  
MDHHS Procurement Technical Requirement (Contract Attachment P.6.4.1.1)  
ADA (28 CFR/42 U.S.C/Public Law 336) @ [www.usdoj.gov](http://www.usdoj.gov)  
42 CFR (438.6 – *Contract Requirements*) Balanced Budget Act of 1997 @ [www.cms.hhs.gov](http://www.cms.hhs.gov)  
Title VI of the Civil Rights Act of 1964 @ [www.usdoj.gov](http://www.usdoj.gov)  
Title IX of the Education Amendments of 1972 @ [www.dol.gov](http://www.dol.gov)

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Age Discrimination Act of 1975 @ [www.ed.gov](http://www.ed.gov)  
 Rehabilitation Act of 1973 @ [www.eeoc.gov](http://www.eeoc.gov)  
 Americans with Disabilities Act (ADA) of 1990. @ [www.usdoj.gov](http://www.usdoj.gov)  
 Health Insurance Portability and Accountability Act of 1996 @ <http://aspe.hhs.gov/admsimp/pl104191.htm>  
 Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 @ <http://www.hhs.gov/ocr/privacy/hipaa/administrative/enforcementrule/hitech/enforcementiftr.html>  
 Social Security Act 1128 & 1128A @ [http://www.ssa.gov/OP\\_Home/ssact/title11/1128.htm](http://www.ssa.gov/OP_Home/ssact/title11/1128.htm) & [http://www.ssa.gov/OP\\_Home/ssact/title11/1128A.htm](http://www.ssa.gov/OP_Home/ssact/title11/1128A.htm)  
[HR.1.01 Privileging Policy](#)  
[RR.2.07 Confidentiality and Disclosure of Information Procedure](#)  
[RR.2.36 Appeals and Grievances Procedure](#)

**Change History:**

Change Letter	Date of Change(s)	Changes
None		This policy was renumbered from originally released policy. Was RM.1.01. For previous versions of this policy or for complete history of changes, see Controlled Documentation Manager (or designee).