

Exhibit G – DSN Provider and Hospital Adequacy Reporting Requirements

1. DSN Provider Reports

- a. Contractor shall submit DSN Provider reports to OHA upon effective date of this Contract and upon any significant change of Contractor's services, benefits, services area, or payments.
- b. 42 CFR 438.206 "Availability of Services" and 42 CFR 438.207 "Assurances of Adequate Capacity and Services" require Contractor to ensure to OHA, with supporting documentation, that all services covered under this Contract are available and accessible to Members and that the Contractor demonstrates adequate Provider capacity.
- c. Contractor shall provide the following information of how Contractor requires and monitors adequate mental health Provider capacity. If any of the activities are subcontracted, describe how Contractor provides oversight and monitoring of the activities as well.
 - (1)
 - (a) How does Contractor or delegate(s) maintain a network of appropriate Providers to sufficiently provide adequate access to all services covered under this Contract including Special Health Care Needs?
 - (b) How does Contractor or delegate(s) monitor the network of appropriate Providers to sufficiently provide adequate access to all services covered under this Contract including Special Health Care Needs?
 - (2) If the network is unable to provide necessary services, covered under this Contract, to a particular Member, how does Contractor or delegate(s) provide adequate and timely services out of network for a Member, for as long as the Contractor or delegate(s) is unable to provide them within the network?
 - (3)
 - (a) How does Contractor or delegate(s) require Providers to meet OHA standards for timely access to routine, urgent and emergent care and services, taking into account the urgency of the need for services?
 - (b) How does Contractor or delegate(s) monitor compliance by Providers of timely access to care and services?
 - (c) How does Contractor or delegate(s) monitor availability of services when medically necessary routine, urgent and emergent services?
- d. What corrective actions has Contractor or delegate(s) taken if there was a failure to comply with any provision or timeliness of services during the prior year? If, any, what is the current status of the corrective action and compliance?
- e. In the current year, what is Contractor or delegate(s) doing to provide delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds?
- f. What does Contractor do to monitor subcontracted activities related to Provider capacity? Be specific to each activity subcontracted.

- g. Contractor shall submit a list of participating QMHP practitioners and participating facilities to include the following elements:

Practitioner List

Name
Agency/Location
Telephone Number
Non-English Language Spoken

Facility List

Name of Facility
Psychiatric Day Treatment Facility
Psychiatric Residential Treatment Services Facility

- h. **DSN Provider Report:**

Contractor shall submit the Provider Capacity Report to OHA in the electronic format of Microsoft Excel. The field types and sizes are required and may be submitted in an alternate format if Contractor obtains prior approval from OHA by contacting Contractor’s CCO Coordinator or designee.

Required Data Elements

Practitioner List

Name
Type of Provider
Address
Telephone Number
Non-English Language Spoken
Last Date Credentialed

Facility List

Name of Facility
Type of Facility
Address
Telephone Number
Last Date Credentialed

- i. **Community Social and Support Service Organizations Involvement Report:**

The following table details Contractor’s involvement with publicly funded health care and service programs. Include those publicly funded health care and service programs with which Contractor has involvement with.

Name of publicly funded program	Type of public program (i.e. county mental health dept.)	County in which program provides services	Description of the services provided in relation to Contractor's services	What has been the involvement of the public program in Contractor's operations (on the board, on Quality Assurance Committee, specify if subcontract, etc.)?

j. Provider Type and Provider Specialty Code Listing:

Contractor shall utilize 1) the Provider/ Type code table and 2) Provider specialty code table to specify the required information on Contractor's Provider Capacity Report file as outlined in Section 3, Required Data Elements, line number 9 of this Exhibit. Both forms can be obtained from your CCOC.

2. Hospital Network Adequacy

- a.** Contractor shall submit to its OHA by March 31, 2011, the Hospital Adequacy Report located at _____org. This Hospital Adequacy Report is an annual report of admissions and paid amounts from July 1 of every year to June 30 of every year, that details hospital admissions at Contracted Hospitals and hospital admissions at Non-Contracted Hospitals. The Hospital Adequacy Report will also include the Contractor's total outpatient costs at Contracted Hospitals and the Contractor's total outpatient costs at Non-Contracted Hospitals. OHA will review and analyze non-contracted claims by Contractor annually to determine if all hospital services are adequately represented.
- b.** Contractor and hospitals are expected to contract for an adequate hospital network for a full range of services reasonably expected to meet the needs of the Contractor's number and location of Members.

Definitions:

Contracted Hospital - in this Exhibit G means a hospital that is a Subcontractor.

Non-Contracted Hospital – in this Exhibit G means a hospital that is not a Subcontractor.

The following benchmarks will be monitored and evaluated to assess the adequacy of a hospital network:

- a.** A minimum of 90% of Contractor's total inpatient admissions (excluding all outpatient services) shall be provided in hospitals under contract with the Contractor.
- b.** A minimum of 90% of Contractor's total dollars paid for all outpatient services (excluding amounts paid for inpatient admissions) shall be provided in hospitals under contract with the Contractor.

In those instances where the percentage of Non-Contracted Hospital services are below the benchmarks or the OHA review of the Contractor's annual report of hospital admissions by DRG indicates Contractor's hospital network is not adequate, OHA shall determine if the Contractor and hospital(s) have both made a good faith effort to contract with each other.

The determination of good faith shall consider the following:

- a.** The amount of time the Contractor has been actively trying to negotiate a contractual arrangement with the hospital(s) for the services involved;
- b.** The payment rates and methodology the Contractor has offered to the hospital(s);
- c.** The payment rates and methodology the hospital has offered to the Contractor;
- d.** Other hospital cost associated with non-financial contractual terms the Contractor has proposed including prior-authorization and other utilization management policies and practices;
- e.** The Contractor's track record with respect to claims payment timeliness, overturned claims, denials, and hospital complaints;
- f.** The Contractor's solvency status; and
- g.** The hospital(s)' reasons for not contracting with the Contractor.
- c.** If OHA determines that the Contractor has made a good faith effort to contract with the hospital, OHA shall modify the benchmark calculation, if necessary, for the Contractor to exclude the hospital so the Contractor is not penalized for a hospital's failure to contract in good faith with the Contractor.
- d.** If OHA determines that the Contractor did not make a good faith effort, to negotiate and enter into reasonable contracts, OHA may invoke the following remedies (until such time that the Contractor achieves the benchmarks and/or provides documentation to OHA that is has an adequate hospital panel):
 - (1)** Monthly reporting;
 - (2)** Partial withholding of CCO Payments (to be returned retroactively to the Contractor upon achieving compliance or termination/non-renewal of the contract); and finally,
 - (3)** Termination or non-renewal of this Contract.

Exhibit H – Physician Incentive Plan Regulation Guidance

1. Background/Authority:

This Contract requires that Contractor complies with the requirements set forth in 42 CFR 422.208 and 422.210 by disclosing information about Practitioner Incentive Plans (PIP) to OHA. If Contractor utilizes compensation arrangements placing physicians or Physician Groups at Substantial Financial Risk (as defined in this Exhibit) Contractor must also assure provision of adequate PIP Stop-loss Protection and conduct beneficiary surveys.

These Contract requirements implement federal law and regulations to protect Members against improper clinical decisions made under the influence of strong financial incentives. Therefore, it is the financial arrangement under which the physician is operating that is of interest and potential concern. Consequently, Contractors must report on the “bottom tier” - that is, the arrangement under which the participating physician is operating. The reporting requirement is imposed on Contractors because that is the entity or Physician Group with which OHA has a contractual relationship and the entity, which is ultimately responsible, under the statute, for making sure that adequate safeguards are in place.

A Physician Incentive Plan (PIP) is defined as "any compensation to pay a physician or Physician Group that may directly or indirectly have the effect of reducing or limiting services furnished to any Member". The compensation arrangements negotiated between Subcontractors of an Managed Care Organization (MCO) (e.g., physician-hospital organizations, IPAs) and a physician or group are of particular importance, given that the compensation arrangements with which a physician is most familiar will have the greatest potential to affect the physician's referral behavior. For this reason, all Subcontracting tiers of the Contractor's arrangements are subject to the regulation and must be disclosed to OHA.

Note that PIP rules differentiate between Physician Groups and Intermediate Entities. Examples of Intermediate Entities include Individual Practice Associations (IPAs) that contract with one or more Physician Groups, as well as physician-hospital organizations. IPAs that contract only with individual physicians and not with Physician Groups are considered Physician Groups under this rule.

2. Surveys:

Contractor shall conduct a customer survey of both Members and disenrollees if any physician or Physician Groups in the Contractor's network are placed at Substantial Financial Risk for Referral Services, as defined by the Physician Incentive Regulations. If a survey is required it must be conducted in accordance with Section 7, of this Exhibit H.

3. Disclosure to Members:

At Member's request, Contractor must provide information indicating whether it or any of its contractors or Subcontractors use a PIP that may affect the use of Referral Services, the type of incentive arrangement(s) used, and whether PIP Stop-loss Protection is provided. If Contractor is required to conduct a survey, it must also provide Members with a summary of survey results.

4. Monitoring:

- a. Contractor shall file the CMS PIP Disclosure Form (OMB No. 0938-0700).
- b. CMS PIP Disclosure Form (OMB No. 0938-0700), is subject to review by OHA and subject to correction/clarification.