

IX. Network Management



A. ValueOptions' Network Management Department

As part of the efforts to develop a state-of-the-art behavioral health system in Texas, *ValueOptions* recognizes and acknowledges the provider network is not only crucial to the success of our program, but also constitutes one of the major customers. The network management functions are designed to provide a full range of services to participating providers.

The *ValueOptions* Network Management Department carries the primary responsibility for ensuring that a strong network of high-quality service providers is available and accessible to consumers. The department is the primary point of contact for providers with issues related to provider credentialing, service procurement, contract implementation, provider monitoring, and training/technical assistance. The key functions of the Network Management Department include:

- Network development:
 - Continuous analysis of service needs and gaps in current service network
 - Expansion of the provider network to fill service gaps and/or improve the delivery of care to consumers
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 - Credentialing and recredentialing of facilities, agencies, and practitioners
- Network management:
 - Maintaining ongoing communication with the provider network
 - Providing training and technical assistance to network providers
 - Monitoring provider and practitioner performance
 - Following up with corrective action and/or sanctions for non-compliance with requirements

B. Network Development

1. Overview

In developing the provider network, *ValueOptions* is committed to the following key principles:

- Network design and development should be driven by the needs of individual consumers and the community.
- Network development must be focused on building an integrated coordinated system of care through provider selection by an open and competitive process.
- Services provided through the network must be respectful and meaningful in the context of each consumer's cultural heritage and language.

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- The design of the network should promote the availability and accessibility of services to consumers, including the provision of services close to home and at times convenient for consumers.
- *ValueOptions* must be able to move quickly to expand the network to fill gaps in services, either by adding new providers, expanding existing provider agreements, or using provisional credentialing and single case agreements to expedite the provision of needed services to consumers.
- *ValueOptions* is committed to meeting the special challenges of rural areas by developing strategies to ensure that consumers who live outside of the metropolitan area have responsive services.

2. Planning and Procurement of Service Providers

An important function of the Network Management Department is to continuously assess the capacity of the provider network relative to consumers' needs. This assessment includes analyzing the number, type, and location of network providers, availability of a continuum of care, specialized services, and the ability of the network to meet accessibility standards for both crisis and routine care.

Network management staff review service utilization and accessibility data and obtain stakeholder input through a variety of processes. To identify gaps in the service network which need to be addressed through network development, the staff reviews data from grievances, appeals, and other quality management processes. *ValueOptions* has conducted a needs assessment and gap analysis during the

NorthSTAR proposal process. This review and identification of gaps continues as an ongoing process in conjunction with provider monitoring and network planning/development functions.

3. Provider Credentialing

Provider credentialing is central to the *ValueOptions* quality improvement philosophy. In collaboration with providers and consumers, credentialing criteria has been developed for network participation. The credentialing process is being implemented throughout the provider network. The

NorthSTAR standards are based on a credentialing system developed and tested for public sector individual practitioners and provider organizations, with consideration to existing Texas behavioral health provider requirements. Key elements of the *ValueOptions* credentialing system are:

- The system is designed to incorporate traditional and non-traditional providers (e.g., Community Support Services)
- A waiver process and provisional credentialing procedures maximize the number of providers available to *ValueOptions* consumers needing specialized services.
- Training and assistance is provided to network providers and potential providers through regular provider forums and other training sessions.

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4. Credentialing Committee

The development of credentialing standards and management of the credentialing process occur within the framework of

the National Credentialing Committee (NCC)

The NCC consists of representatives of all major clinical disciplines, participating providers, and representatives of major *ValueOptions* departments, including National Network Management and the Quality Management Departments. The NCC has decision-making authority for all credentialing and recredentialing. The NCC also makes decisions regarding provider sanctions and reports its activities to the

NorthSTAR Program Service Center Quality Management Committee.

5. Initial Credentialing Process

The *ValueOptions* credentialing process is designed to meet NCQA standards for individual practitioners and facilities. Minimum credentialing standards have been adopted for the

NorthSTAR Program, and an application process is in place to facilitate the credentialing process and verify the necessary information. Once a completed application packet is returned, the provider's credentials are compared with *ValueOptions*' NorthSTAR credentialing criteria for the level(s) of care offered by the provider. Providers which are accredited by a national accreditation body accepted by *ValueOptions* (JCAHO, CARF, COA, and AOA) will have their accreditation status and their standing with state and federal

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regulatory bodies verified as a precondition to full credentialing. Providers who are not nationally accredited will have a structured site visit to confirm they meet *ValueOptions*' credentialing standards.

6. Recredentialing

ValueOptions requires practitioners undergo recredentialing every three years. Organizational providers must be recredentialled every three years. The recredentialing process begins approximately six months prior to the expiration of the initial credentialing. Providers are sent a recredentialing application that must be completed in full, signed, and returned to *ValueOptions* with all verifications attached. Credentialing information that is subject to change must be reverified from primary sources during the recredentialing process. Providers who are not nationally accredited must undergo a structured site review to ensure conformity with *ValueOptions* standards. This includes a review of clinical record-keeping practices at each site.

7. Credentialing of Independent Practitioners

The initial credentialing process includes primary source verification of the following information, at a minimum, to assure each provider file contains:

- A current valid license to practice as an independent behavioral healthcare provider at the highest level certified or approved by the state
- A copy of a valid DEA (Drug Enforcement Agency) or CDS (Controlled Dangerous Substances) certificate, as applicable
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline, and licensure of the practitioner
- Board certification, if designated by the practitioner on the application
- Work history
- History of professional liability claims that result in settlements or judgments paid by or on behalf of the practitioner.
- In addition, the following are queried for each practitioner to verify malpractice and sanction activity:
 - Information from the State Board of Licensure or Certification; the National Practitioner Data Bank; and the Office of Inspector General (LEIE).

The application process includes a statement by the applicant regarding:

- The reasons for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and/or felony convictions
- History of loss or limitation of privileges or disciplinary activity

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- Current malpractice insurance coverage
- An attestation as to the correctness and completeness of the application.

8. Recredentialing of Independent Practitioners

Quality of care issues and provider performance are considered when conducting network provider recredentialing. Decisions regarding credentialing are used to improve the effectiveness and efficiency of *ValueOptions*' provider network and are based, in part, on provider profiling of trended data such as patient treatment and outcome information.

Recredentialing is the process for the periodic re-verification of credentials. The recredentialing process looks for changes in the practitioner's licensure, sanctions history, board certification, clinical privileges status, competence or health status that may affect the practitioner's ability to perform services. Recredentialing is implemented every three years for independent practitioners.

The recredentialing process includes review of the following data:

- Member complaints
- Information from quality improvement activities
- Utilization management indicators

ValueOptions relies on Care Managers and our Provider Quality Program (PQP) to identify and document quality of care issues and to measure provider-specific access, clinical indicators, utilization patterns, and patient satisfaction.

To ensure the quality and safety of care between recredentialing cycles, ValueOptions has an ongoing monitoring system. The system includes timely monitoring of sanctions against providers and monitoring of member complaints.

9. Credentialing and Recredentialing of Organizations

In order for a facility or organizational provider to participate in *ValueOptions* network, the organization must be accredited by one of the following entities:

- The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO)
- Council on Accreditation (COA)
- Council on the Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association (AOA)

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Facility or organizational providers not accredited by an accepted entity must submit to a site visit by *ValueOptions*. *ValueOptions* recredentials organizational providers every 3 years.

10. Site Visits for Practitioners

To ensure the quality of the offices and facilities where *ValueOptions* members receive services, structured site visit reviews are conducted for all practitioner office sites that meet the established threshold for member complaints or when quality of care issues are identified. The review process includes an assessment of:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space
- Availability of appointments
- Adequacy of treatment record keeping
- Maintaining Health Insurance Portability and Accountability Act (HIPAA) Standards

The Texas Service Center uses the opportunities presented by the site visits to bring providers in a given demographic area together for provider education events. This enhances the opportunity to improve network communication and optimizes our opportunity to influence provider quality of care.

Each office/facility's results are compared against performance expectations. Offices/facilities that do not meet performance expectations must develop a corrective action plan. The office/facility must implement the plan within six (6) months of the initial visit. *ValueOptions* conducts revisits at least every six (6) months until the performance standards have been met.

11. Provider Appeals

Appeal of Credentialing Decisions

If a practitioner, agency, or facility disagrees with a *ValueOptions* credentialing decision, an appeal may be filed. Appeals must be submitted in writing and must include a careful explanation of the reasons the provider believes the credentialing decision to be in error along with relevant supporting documentation to:

Provider Appeals Committee *ValueOptions*
NorthSTAR Service Center 1199 S. Beltline, Suite 100 Coppell, Texas 75019

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The Provider Appeals Committee (PAC) is a national function that can support or overturn the decision of the NCC or can request additional information. The decision of the PAC will be communicated in writing within 10 working days after the Committee's decision. The decision of the PAC is final. The PAC operates under the *ValueOptions* Corporate Quality Improvement Committee.

Provider Appeals Related to Credentialing, Sanctions, or Terminations

Providers have the right to appeal any adverse NCC decision regarding network participation. *ValueOptions* has established a Provider Appeals Committee (PAC) to hear provider appeals. This committee is comprised of representatives of major clinical disciplines, network providers and clinical representatives from within *ValueOptions*, none of whom compete with the appealing provider. Members of the PAC must not have participated in the original NCC decision under review.

Providers are given written notice of the NCC's decision, the reason for the decision, and of their right to appeal the decision along with an explanation of the applicable appeals procedures. Providers have 30 days from the date of the NCC's notice to file a written request for an appeal.

The request for an appeal should include an explanation of the reasons the provider believes the NCC reached a decision to be in error and include supporting documentation. The PAC will review the explanation provided by the provider, the information previously reviewed by the NCC, and any additional information it determines to be relevant. The PAC will support, modify or overturn the decision of the NCC. Additionally, the PAC may request additional information from the provider in order to make a determination or decision. The PAC provides written notification of its decision to the provider within 14 business days after its record is complete, with an explanation of the decision, along with appeal rights and fair hearing rights.

Fair Hearing Process

Providers may request a second level of appeal or a Fair Hearing when the PAC denies credentialing, recredentialing, issues a sanction or disenrolls a provider from the network based on issues related to competence or professional conduct. A request for a Fair Hearing must be made within 30 days of the date of the PAC's notification. The provider will receive written notice of the place, time and date of the Fair Hearing, which date shall not be less than 30 days after the date the request for appeal is received from the provider.

Additionally, the provider will receive an explanation of the hearing procedures, and a list of witnesses, if any, expected to testify on behalf of *ValueOptions*. The chair of the PAC will identify peer reviewers who will participate as the Fair Hearing panel, assuring representation of the discipline of the provider requesting the appeal. These peers will not

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have any economic interest adverse to the provider, nor will they have participated in the decisions of the PAC or NCC.

One member of the Fair Hearing panel will be selected to act as the hearing officer and will preside over the Fair Hearing. Both *ValueOptions* and the provider will make reasonable efforts to establish a mutually agreed upon date for the hearing. Both *ValueOptions* and the provider have the right to legal representation at the Fair Hearing. The provider will receive a written recommendation from the panel within 15 business days after the Fair Hearing. The Fair Hearing process as set forth above is subject to applicable state and federal law.

12. Out-of-Network Providers

It may sometimes be necessary to utilize the services of a provider who is not currently a

NorthSTAR Program network provider. *ValueOptions* will ensure the identified provider is qualified to perform the required services by contacting the provider for a limited amount of credentialing information. Network staff works with the provider to negotiate a single (or multi-) case agreement. *ValueOptions* conducts periodic analysis of the use of out-of-network providers to identify issues such as access to services and cultural competency. When necessary, the process of bringing additional providers into the network is initiated.

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Network management is the process by which *ValueOptions* educates providers regarding *ValueOptions* expectations and monitors network capacity to ensure that the network includes sufficient qualified providers to serve the number and needs of consumers. Network management also includes the identification of system barriers to care and the rapid initiation of procurement or corrective actions to address these barriers. The major activities include providing education and training to network providers, monitoring provider compliance with credentialing standards and contract requirements, and providing a primary point of contact for information, assistance, and problem-resolution for network providers.

1. Ongoing Communication with Provider Network

The success of *ValueOptions*' partnership with its network providers is dependent on regular, frequent communication. Communication may occur in the form of structured provider forums, special training sessions, or meetings with one or more provider agencies. Site visits and frequent one-to-one contact between *ValueOptions* and provider agency staff also provide opportunities for dialogue. *ValueOptions* is committed to disseminating written information to providers on a regular basis via newsletters, policy updates, and general informational memos.

ValueOptions' expectations of providers are contained in this Provider Manual, which is updated as necessary to include current policies and expectations. Policy changes are communicated to providers in writing; whenever possible, providers are given 30 days notice of policy changes. When necessary, ad hoc training sessions are provided to assist providers in understanding and implementing changes in policy and procedure.

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2. Training and Technical Assistance

One of the primary roles of the Network Management

Department is to provide training, technical assistance, and continuing education to our provider network. During the initial phase of network implementation, training focuses around basic orientation to *ValueOptions*' expectations and operational procedures, including:

- Orientation to *ValueOptions*
- NorthSTAR program
- Managed care concepts
- Operational procedures for eligibility screening, enrollment, disenrollment, service authorization, and claims submission
- Management of consumer access to care and coordination of care standards and procedures
- Performance requirement for crisis case management and physician services
- Reduction of unnecessary use of emergency rooms and urgent care centers

Ongoing training needs are identified by providers, community stakeholders, consumers, and *ValueOptions* staff based on provider profiling and monitoring activities and includes a range of clinical, cultural, and administrative best practices.

3. Provider Profiling and Monitoring

Provider profiling and monitoring are key components of the *ValueOptions* quality program. ***Provider profiling*** is the process of reviewing and analyzing provider performance against both *ValueOptions* and provider-generated performance standards. *ValueOptions* uses the Practitioner Quality Profile (PQP) to assess provider performance in order to ensure continuous quality improvement. ***Provider monitoring*** is the process of assessing provider compliance with relevant ADHS/DBHS policies and rules, reviewing quality of care incidents, and ensuring utilization management activities are adopted and followed. *ValueOptions* utilizes various methods and tools to monitor provider compliance, including:

- Consumer satisfaction surveys
- Provider surveys
- Care management staff input
- Complaint and grievance information
- Site visits
- Review of provider utilization and service data
- Medical record review (which is required by NCQA and QISMC)

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When performance problems are identified, *ValueOptions* works with providers to develop corrective action plans, which will result in improved performance on relevant performance measures.

4. Corrective Action Plans and Sanctions

ValueOptions' preferred approach in working with provider non-compliance with quality standards or contract requirements is to address the correction of problems through education, training, and technical assistance. When remediation attempts are not successful, *ValueOptions* may levy sanctions based on the severity of the problem and the frequency or duration of its occurrence. Sanctions may vary from verbal or written consultation to suspension or termination of contract. Provider sanctions are reviewed and must be approved by the *ValueOptions'* NCC. Sanctions may be appealed by the provider to the NCC.

D. Provider Sanctions

Though *ValueOptions* is able to resolve most provider quality issues through consultation and education, occasionally further action is necessary to ensure quality service delivery and protection of consumers. The NCC may impose provider sanctions for issues related to quality of care or contract compliance. **The *ValueOptions* NorthSTAR program complies with all local, state, and federal reporting requirements regarding professional competence and conduct to ensure the highest quality of care for consumers.** The following is a list of sanction options available to the NCC:

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1. Individual Practitioner – Sanctions

Type Definition

CONSULTATION A call is placed to the practitioner notifying him/her of the alleged improper action to include an explanation of possible sanctions if corrective actions are not taken. The call is documented in writing to include the date and subject for consultation and a copy of the consultation is placed in the practitioner's file. Educational materials are sent via certified mail to ensure the practitioner receives the information to correct the behavior addressed.

WRITTEN A written notice is sent to the practitioner warning him/her of an alleged

WARNING improper action that has been reported or discovered. An explanation is given of possible sanctions if corrective actions are not taken. A copy of the letter is put into the practitioner's file, and educational materials are sent via certified mail. Corrective action is monitored as necessary.

MONITORING The practitioner is given written notice sent via certified mail that he/she is being placed on probation and given an explanation of possible sanctions if corrective actions are not taken. The written notice includes the date and circumstances of the alleged improper action. Normally the practitioner has previously been given a consultation and/or written warning. A copy of the letter is placed in the practitioner's file. Probation can continue up to 180 days from the date of notification at which time the practitioner continues to be considered in the network, but is monitored closely to include supervision and/or treatment record review. Appropriate educational materials are sent via certified mail.

SUSPENSION The practitioner is given written notice via certified mail of the alleged improper action for which he/she is being placed on suspension. A copy of the letter is placed in the practitioner's file. The suspension can continue for a period of 14 days during which time an investigation may take place to verify the improper action. This investigative period can be extended by the NCC and is only used for serious infractions that are probable cause for termination.

TERMINATION The practitioner is given written notice sent via certified mail that he/she is being terminated from the network for an alleged improper action. A copy of the letter is put in their file. Consumers in care are notified and given assistance for referral to a new practitioner for continuing care as necessary.

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2. Agency Providers – Sanctions

Type Definition

CONSULTATION A call is placed to the head (e.g., CEO) of the organization notifying him/her of an alleged improper action with includes an explanation of possible sanctions if corrective actions are not taken. The call is documented in writing to include the date and subject for consultation and a copy of the consultation is placed in the Facility/Program file. Appropriate educational materials are sent via certified mail.

WRITTEN A written notice is sent to the head (e.g., CEO) of the organization

WARNING notifying him/her of the alleged improper action that occurred. An explanation is given of possible sanctions if corrective actions are not taken. A copy of the letter is put into the Facility/Program file, and appropriate educational materials are sent via certified mail.

MONITORING The head (e.g., CEO) of the organization is given written notice sent certified mail that the Facility/Program is being placed on probation and given an explanation of possible further sanctions if corrective actions are not taken. The written notice includes the date and circumstances of the alleged improper action. Normally, the organization has previously been given a consultation and/or written warning regarding the allegation. A copy of the letter is placed in the Facility/Program file. Probation can continue up to 180 days from the date of notification at which time the organization continues to be considered in the network, but is monitored closely to include administrative audits and/or clinical treatment record review. Appropriate educational materials are sent via certified mail.

SUSPENSION A suspension can be imposed when deemed appropriate based on quality of care concern(s). The head (e.g., CEO) of the organization is given written notice via certified mail of the specific concern(s) deemed to warrant suspension. A copy of the letter is placed in the Facility/Program file. The suspension can continue for a period of 14 days during which time an investigation may take place to verify the improper action. This investigative period can be extended by the NCC and is only used for serious infractions that are probable cause for termination.

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3. Provider Appeals of Sanction Decisions

Providers who are terminated or otherwise sanctioned involving network participation have the right to appeal under the provider appeals process mentioned in section B, number eleven named, "Provider Appeals".

E. Special Program Requirements

Providers who receive funds for programs or services, which have special reporting or service coordination requirements, must comply with those requirements. Unless notified otherwise, providers should continue the procedures in place prior to the transition to *ValueOptions*. As new or revised procedures are implemented, providers are advised of them in writing.

F. Provider Responsibilities for Notification

Providers must notify *ValueOptions*

NorthSTAR Service Center in writing within 24 hours upon the occurrence of any of the following:

- Revocation, suspension, restriction, termination or voluntary relinquishment of any of the license, authorizations or accreditations required by our Provider Agreement
- Any legal action pending for professional negligence which may reasonably be considered to be a material loss contingency, and the final disposition of the action
- Any indictment, arrest or conviction for a felony or for any criminal charge related to an individual's or a facility's professional practice
- Any lapse or material change in professional liability insurance coverage
- Restriction, suspension, revocation or voluntary relinquishment of medical staff membership or clinical privileges at any healthcare facility

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G. Resource Information for Providers

This guide identifies key points of contact for providers who wish to contact *ValueOptions*.

RESOUCE INFORMATION GUIDE	PHONE
ValueOptions' NETWORK MANAGEMENT: • Contract issues • Credentialing and re-credentialing • Policies and Procedures • Processing changes to provider data • Network design and development	1-888-800-6799 TDD: 1-888-800-6792
ValueOptions' ENROLLEE AND PROVIDER SERVICE: • Claims inquiries (paper and EMC) • Consumer enrollment/eligibility inquiries or problems • Provider questions, inquiries, or problems • Complaints, grievances and appeals • Covered services and Consumer benefits • Requests for forms	1-888-800-6799 TDD: 1-888-800-6792
ValueOptions' ACCESS LINE: • Access to care • Screening and referral • Service authorization • Continuing stay reviews	1-888-800-6799 TDD: 1-888-800-6792
ValueOptions' EDI HELP LINE	1-888-247-9311
ValueOptions' COMPLAINT AND GRIEVANCE COORDINATOR • Functions as a liaison for all Providers and Consumers in the concerns they might experience with our Program • Reports directly to the Quality Management Department, in order to ensure that our Quality Program includes the action steps necessary to proactively resolve these issues.	1-888-800-6799 TDD: 1-888-800-6792
ValueOptions' Fax Line for Assessment Forms	1-877-888-6444

	Member Help Line	Provider Help Line	Precertification
• Texas Health Network	1-888-302-6688	1-888-834-7226	1-888-302-6167
• Americaid	1-800-600-4441	1-800-600-4441	1-800-600-4441
• Parkland	1-888-627-2277	1-888-627-2277	
NHIC		1-800-925-9126 (for claims inquiries)	