MCCMH MCO Policy 3-006

Chapter: **PROVIDER NETWORK MANAGEMENT**
Title: **NETWORK MONITORING AND OVERSIGHT**

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Proposed by: Traci Smith 10/29/2026
Chief Executive Officer Date

Approved by: Al Lorenzo 10/29/2026
County Executive Office Date

I. ABSTRACT

This policy establishes the standards of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, for the management and oversight of its network.

II. APPLICATION

This policy shall apply to all contract network providers of MCCMH.

III. POLICY

It is the policy of MCCMH that all network providers comply with applicable standards, regulations, and laws as well as the designated MCCMH practices described herein.

IV. DEFINITIONS

Prescribers: Behavioral health practitioners credentialed to prescribe medications (MD, DO, NP, PA);

Non-prescribers: Behavioral health practitioners who are credentialed to provide therapy services or case management services. Therapists must hold a license (LPC, LLPC, LMSW, LLMSW, LLP, LP, TLLP. MCCMH also classifies organizational providers as inpatient, residential, or ambulatory providers. A practitioner or provider is assigned to the category that reflects the service and credential information maintained in MCCMH records.

V. STANDARDS

A. MCCMH maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of persons served in its service area.

B. MCCMH utilizes standards regarding time and distance for provider agencies as established by the Michigan Department of Health and Human Services (MDHHS). MCCMH continuously monitors its network and evaluates maximum time and distance, timely appointments, language preferences, cultural competency, and physical accessibility. MCCMH includes information regarding language and accessibility in the provider directory to ensure individuals served have adequate access.

C. MCCMH establishes and maintains a written numerical adequacy standard for each practitioner type (prescriber, therapist, and case manager).. Annually, MCCMH collects the required data to conduct an assessment of practitioner and provider availability, conducts quantitative and qualitative analyses of this data and reports findings to Executive Leadership. MCCMH adjusts its practitioner network to provide the types and number of practitioners necessary to meet the needs of members within defined geographical areas.

D. MCCMH shall give assurances to MDHHS and provide supporting documentation to demonstrate its capability to serve the expected enrollment in its service area, in accordance with MDHHS' Network Adequacy Standards for access to care.

E. MCCMH shall submit assurances of adequate capacity to MDHHS annually and any time there is a significant change, including changes in services, benefits, geographic service area, composition of or payments to provider network, or enrollment of a new population in its network.

F. Prospective providers requesting to participate in MCCMH's network must complete and submit initial documentation for consideration. MCCMH responds to such requests with a written determination based on the provider's ability to meet contractual requirements and the needs of the network. MCCMH's procurement practices are described further in MCCMH Policy 3-020, "Procurement of Services."

G. When prospective providers are approved for further consideration, MCCMH sends the provider an organizational credentialing application. Organizational Credentialing standards and processes are described further in MCCMH Policy 8-010, "Organizational Credentialing and Re-Credentialing."

H. Once an official contractual relationship begins between MCCMH and a contracted provider, the provider must be able to provide the services delineated in their executed contract.

I. Newly contracted providers must attend an initial onboarding session. During their onboarding session, providers receive instruction and training on various areas of service delivery within MCCMH's network.

    1. Providers are reviewed at regular intervals after their initial onboarding to monitor appropriate completion of documentation and submission of claims.

    2. MCCMH provides support during these reviews to ensure providers are able to meet contractual requirements and expectations.

J. MCCMH ensures that there are sufficient Indian Health Care Providers (IHCP) participating in the provider network to ensure timely access to services for Indian beneficiaries who are

eligible to receive services. If timely access to covered services cannot be ensured due to few or no IHCPs, MCCMH shall allow Indian beneficiaries to access out-of-state IHCPs; or show good cause for disenrollment from both MCCMH and Michigan Department of Health and Human Services' (MDHHS) managed care program.

1. MCCMH shall permit Indian beneficiaries to obtain services covered under the Contract from out-of-network IHCPs from whom the beneficiary is otherwise eligible to receive such services.

2. MCCMH shall permit an out-of-network IHCP to refer an Indian beneficiary to a network provider.

K. Providers within MCCMH's network must provide formal notice to MCCMH any time they become unable to provide a contracted service or if there is a change in their capacity to provide a contracted service. Examples of scenarios include, but are not limited to:

1. Temporary staff-shortages;

2. A weather-related closure of any contracted site;

3. Being unable to accept new referrals; and/or

4. Health-related concerns.

L. When a contracted provider agency is unable to meet the needs of the individuals it serves, the agency must provide prompt, written notice to those individuals and their legal representatives. Written notice must include:

1. The reason(s) the person's request or needs cannot be met by the agency at this time;

2. The anticipated timeframe until the issue can be resolved;

3. Names and contact information for the person to contact for assistance;

4. Names and contact information for the person to contact if they would like to file a grievance; and

5. Names and contact information for other MCCMH contracted agencies that provide the services and supports the person may need.

M. It is the responsibility of MCCMH to ensure that the needs of all persons served are met. When contracted providers send out notices of their inability to meet the needs of its persons served, MCCMH must also receive notification from the provider agency.

1. Notification must include the reason for the notices(s) and the number of individuals involved.

2. Notice to MCCMH can be mailed, faxed, emailed, or dropped off at MCCMH's offices to the attention of the Network Operations Division and/or the Substance Use Division.

3. Large volume notices should be summarized on a Microsoft Excel spreadsheet.

N. Failure of provider agencies to comply with applicable federal, state, county, and local laws, administrative directives, guidelines and/or policies will result in sanctions as outlined in the MCCMH contract which may include recommendation for contract termination.

O. MCCMH shall notify MDHHS within seven (7) days of any changes to the composition of the provider network that negatively affects access to care.

VI. PROCEDURES

A. Continued Access to Care

1. Authorized services will continue at a provider agency regardless of staff availability or employment status. Should a staff member assigned to provide authorized services to a person served leave the provider agency/position, the provider agency must ensure that the person served is reassigned to appropriate staff and no gaps in services occur.

2. Should a provider agency discontinue its contract with MCCMH, the agency will work with all individuals funded by MCCMH to schedule an appointment with an MCCMH directly operated clinic, or MCCMH contracted provider, prior to the end of their contract period to transfer services. The agency will continue to provide services until the date of the individual's appointment with their new provider or the last date of authorized services specific to said agency. The agency will also obtain a release of information for the new provider and share any pertinent information regarding the individual's treatment (including but not limited to assessments, diagnoses, treatment plans, and authorized services) to ensure continuity of care.

3. MCCMH provides written notice of the termination of a behavioral healthcare agency to affected persons served at least 30 calendar days prior to the effective date of termination or 15 calendar days after receipt or issuance of the termination notice. Notice must include:

    a. The provider's name;

    b. The effective termination date; and

    c. Procedures for selecting another provider.

4. MCCMH shall provide notification of provider termination to persons served by mail, fax, email, or on its website if it informs individuals that the information is available online. MCCMH mails notification to persons served who do not have fax, email, or internet access.

5. The provider terminating a contract with MCCMH may provide written notice of the termination to persons served during scheduled visits or appointments. When delivered in-person, the individual signs the notice of termination to indicate receipt and provides a copy to MCCMH.

6. Upon the termination of an agency's contract, MCCMH ensures that persons served are

transitioned to another agency within the MCCMH network to continue services as outlined in the individual plan of service (IPOS).

7. Should an individual practitioner leave a contracted agency, the contracted agency is responsible for ensuring the individual served is transferred to another practitioner to continue services as outlined in their individual plan of service (IPOS).

B. Network Availability Analysis

MCCMH completes a quantitative and qualitative analysis at least annually for each practitioner and organizational provider category defined in this policy. The analysis compares actual availability of the numeric and geographic distribution with each approved standard, identifies the data source and measurement period, and reports the count or numerator and denominator, calculated result, threshold, and whether the standard was met. Prescribing and non-prescribing practitioner results are identified separately where applicable.

Before reporting results, MCCMH validates the source data, category assignments, calculations, and geographic method. The analysis identifies data limitations and explains how they affect interpretation. It compares results with the prior period when comparable data are available and identifies material changes in member needs, service capacity, or geographic access.

When a standard is not met, the data is presented to MCCMH Executive Leadership by the Chief Network Officer and/or Director of Substance Use Services including the affected practitioner or provider category and geographic area, the likely causes and effect on persons served, and recommendations for remediation. MCCMH Executive Leadership then works to determine an appropriate corrective action plan. The Chief Networks Officer and the Director of Substance Use Services will implement corrective action plans as outlined by MCCMH Executive Leadership.

VII. REFERENCES / LEGAL AUTHORITY

A. 42 CFR 438.68

B. 42 CFR 438.206

C. 42 CFR 438.07

D. MDHHS Network Adequacy Standards – Medicaid Specialty Behavioral Health Services

E. MCCMH MCO Policy 2-100, "Integration of Care"

F. MCCMH MCO Policy 3-020, "Procurement of Services"

G. MCCMH MCO Policy 8-010, "Organizational Credentialing and Re-Credentialing"

VIII. EXHIBITS

A. MDHHS Time and Distance Standards

B. MCCMH Provider Termination Procedure

Annual Revision Attestation/Revision History

Revision #	Review Date	Revision Summary/Policy Update Notice Date	Reviewer/Department