Centennial Care Reporting Instructions

Provider Network Development and Management Plan and Evaluation - Report #49

Related Contract Requirements

1. Section 4.8 – General Requirements
2. Section 4.21 – Reporting Requirements
3. Section 7.3.5 – Liquidated Damages/Penalties Chart

Attestation and Penalties

The MCO shall ensure that all data is accurate and appropriately formatted in the report prior to submitting the report. Per Section 7.3 of the contract, failure to submit accurate reports and/or failure to submit properly formatted reports in accordance with the contract may result in liquidated damages of $5,000 per report, per occurrence.

The MCO shall include a signed attestation with each report. Failure to submit a signed attestation form by the report due date will result in the entire report being late. Per Section 7.3 of the contract, failure to submit timely reports in accordance with the contract may result in liquidated damages of $1,000 per report, per calendar day. The $1,000 per day damage amounts will double every ten calendar days.

Instructions

The managed care organization (MCO) is required to submit to the New Mexico Human Services Department (HSD) an annual Provider Network Development and Management plan. The MCO must submit the Provider Network Development and Management Plan and Evaluation annually on February 1st and should describe the plan and activities of the upcoming year and include its evaluation.

An electronic version of the Provider Network Development and Management Plan must be submitted to HSD and shall be submitted via the State's secure DMZ FTP site. The date of receipt of the electronic version will serve as the date of receipt for the plan. The MCO shall submit the electronic version of the report with the following file name: MCO Name.HSD49.CY14.v1. Please change the calendar year (e.g., CY14) and the version number (e.g., v1) as appropriate.

Provider Network Development and Management Plan

Minimum Requirements for Provider Network Development and Management Plan

The Provider Network Development and Management Plan must be sufficient to ensure that all medically necessary covered services are accessible and available. At a minimum, the plan must include the following:

a) A summary of the total number of providers with signed contracts;

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b) Current number of providers with signed contracts, by geographic location in the State (urban/rural/tribal) and by the following provider categories:

i. Physical Health

- PCPs
- Pharmacies
- FQHC
- RHC
- Cardiology
- Certified Nurse Practitioners
- Certified Nurse Midwives
- Dermatology
- Dental
- Endocrinology
- ENT
- Hematology/Oncology
- I/T/U
- Neurology
- Neurosurgeons
- OB-Gyn
- Orthopedics
- Pediatrics
- Physician Assistant
- Podiatry
- Rheumatology
- Surgeons
- Urology

ii. Behavioral Health

- Freestanding Psychiatric Hospitals
- General Hospitals with psychiatric units
- Partial Hospital Programs
- Accredited Residential Treatment Centers (ARTC)
- Non-Accredited Residential Treatment Centers (RTC) and Group Homes (GH)
- Treatment Foster Care I & II (TFC I & II)
- Core Service Agencies (CSA)
- Community Mental Health Center (CMHC)
- Indian Health Service and Tribal 638s providing BH services
- Outpatient Provider Agencies
- Agencies providing Behavioral Management Services (BMS)
- Agencies providing Day Treatment Services
- Agencies providing Assertive Community Treatment (ACT)
- Agencies providing Multi-Systematic Therapy (MST)
- Agencies providing Intensive Outpatient Services
- Methadone Clinics
- FQHCs providing BH Services

- Psychiatrists
- Psychologists (including prescribing psychologists)
- Suboxone certified MDs
- All other licensed Independent Behavioral Health practitioners
- (LISW, LPCC, LMFT, CNS & CNP with psychiatric certification, independent practices and groups)

iii. Long-Term Care

- Assisted Living Facilities
- Personal Care Service Agencies (PCS) - Delegated
- Personal Care Service Agencies (PCS) - Directed
- Nursing Facilities

c) Number of providers projected to furnish required covered services, by geographic location in the State (urban/rural/frontier) and by provider category (as noted in item b. above) (based upon, at a minimum, the anticipated member enrollment including expected growth);

d) Projected expected utilization of covered services taking into consideration the characteristics and health needs of member population including: 1) current unmet need and 2) future needs related to membership growth;

e) Projected number and types of providers required to furnish covered services;

f) Description of monitoring activities to ensure that access standards are met and that members have timely access to services;

g) Description of current network gaps and the methodologies used to identify them;

h) Description of remediation and quality improvement activities to address network gaps, barriers to those interventions and target timeframes for implementation and completion; and

i) Description of ongoing activities for provider development and expansion taking into account provider capacity, network deficiencies, service delivery and future needs relating to grown in members and long-term needs.

Provider Network Development and Management Plan Evaluation

Minimum Requirements for Provider Network Development and Management Evaluation Report

At a minimum, the Provider Network Development and Management Evaluation must address the following:

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a) The status of implementing the Provider Network Development and Management Plan, including timeframes for meeting identified targets;

b) A description of the outcome measures and evaluation of the plan;

c) The most significant barriers to efficient network development;

d) Identified gaps;

e) Measures taken and interventions to address identified gaps;

f) Lessons learned and successes; and

g) A description of any modifications to the current year's plan based upon the MCO's evaluation.