MENTAL HEALTH AND SUBSTANCE ABUSE MANAGED CARE NETWORKS
HOSPITAL INPATIENT PSYCHIATRIC CARE
APPLICATION FOR BCBSM PARTICIPATION

GENERAL INFORMATION

NOTE: DO NOT USE THIS APPLICATION FOR OWNERSHIP CHANGES. USE THE MORE ABBREVIATED "ADDENDUM" FORM INSTEAD.

I. BCBSM's Mental Health and Substance Abuse Managed Care Networks

BCBSM's Mental Health and Substance Abuse Managed Care (MHSAMC) networks are utilized by select BCBSM customer groups that have chosen a managed care program for their mental health and substance abuse benefits. For each of the two networks, all mental health and substance abuse care is currently managed (preauthorized) by vendor care managers. Members are subject to substantial out-of-network copayments, deductibles, and/or reduced benefits when they go outside of their designated mental health network without an authorization from the care manager. For some benefit plans, out-of-network referrals are not allowed. These networks include:

- State of Michigan Mental Health Case Management Program- This network is open to all qualified hospitals that provide inpatient (or partial) psychiatric care. It is currently used by Federal Employee Program (FEP) members, Ford Hourly National PPO Plan members, select MESSA members EDS, Blue Choice Point of Service (POS) and Chrysler Help Line serving Chrysler members (mental health)

The selection of network providers is based upon the provider's demonstrated commitment to appropriate, high quality, cost-effective care and their agreement to accept the applicable discounted MHSAMC network payment as payment in full for covered hospital services, except for applicable copayments and deductibles. In support of these commitments, network providers are required to meet guidelines relative to quality of care, cost control, appropriate utilization, access, and other standards.

Note: This application pertains only to the hospital's inpatient (and/or partial) psychiatric care program. If the hospital also offers outpatient psychiatric care, complete the application for Outpatient Psychiatric Care (OPC) facilities. If the hospital offers substance abuse services, complete the application for Substance Abuse facilities.
II. Hospital Qualifications Requirements for Inpatient Psychiatric Care

Psychiatric hospitals, acute care general hospitals with psychiatric care units, and hospital-based psychiatric day care (partial) units will be included in the networks. These facilities must have and maintain the following:

- An active Traditional Participating Hospital Agreement (PHA) with BCBSM.
- Full accreditation with no limitations for each site by either JCAHO or AOA.
- Compliance with BCBSM Psychiatric Severity of Illness/Intensity of Service Criteria.
- An appropriate and timely internal utilization program.
- Satisfactory utilization and audit history
- An effective and timely discharge planning program.
- Compliance with credentialing and recredentialing policies established by BCBSM.
- Psychiatric beds/units licensed by the state of Michigan.
- An established internal quality of care and improvement program.
- Professional liability insurance or funded self-insurance in the name of the hospital in the minimum amount of $1 million per occurrence and $3 million aggregate.

III. Hospital Reimbursement

For covered services, BCBSM will pay the lesser of the hospital’s charge or the BCBSM approved amount, less copayments and/or deductibles if applicable. The BCBSM approved amount for these networks is a hospital-specific per-diem for inpatient psychiatric care and/or partial hospitalization care. Please contact Provider Contracting for rate information before completing this application.

IV. Participation Agreement

The Mental Health and Substance Abuse Managed Care participation agreement will be sent to the hospital if/when the hospital is approved for participation. If, however, the hospital would like to review the agreement prior to submitting the application, you may request a sample copy from BCBSM.
MENTAL HEALTH AND SUBSTANCE ABUSE MANAGED CARE NETWORKS
HOSPITAL INPATIENT PSYCHIATRIC CARE
APPLICATION INSTRUCTIONS

Complete this application if the hospital was not previously in one of the MHSAMC networks and is
now interested in applying for network participation. If the application is being submitted in
conjunction with an ownership change, you may use the more abbreviated Addendum form, instead.

Please print (in ink) or type the requested application information in the space provided. Where
applicable, attach complete copies of all documents requested (indicated in bold). Return the
completed application, along with the requested attachments to:

MHSAMC Inpatient Psychiatric Care Program
Provider Contracting - B715
Blue Cross Blue Shield of Michigan
27000 West 11 Mile Road
Southfield, MI 48034
Fax: 248-448-7888

Please be certain the application is complete and all requested attachments are enclosed at the
time of submission to BCBSM. Refer to the checklist attached. Incomplete applications will be
returned to you. This will significantly delay the review process.

Upon receipt of the application, we will send you a letter of acknowledgment. It takes
approximately 4-8 weeks for an application to be evaluated. After we review the application and
accompanying documentation, we will most likely contact the designated representative of the
hospital to set up an appointment for an on-site visit. The on-site visit includes a review of a
sample of medical records to evaluate the applicant's compliance with BCBSM requirements, as
outlined in this application. If the hospital is approved for MHSAMC program participation, the
appropriate participation agreement will be offered. If the hospital is not approved, we will send
notification in writing indicating the reason(s) for the denial.

The hospital may not submit claims and is not eligible for reimbursement unless and until
participation is granted by BCBSM and both parties sign the appropriate Mental Health and
Substance Abuse Managed Care Network participation agreement. If the hospital is approved and
offered a participation agreement, it will be asked to retain the agreement for its records and return
the signed Signature Document to BCBSM. The countersigned copy of the Signature Document
will be returned to the hospital, generally, within 10-14 days of our receipt of the signed Signature
Document. The hospital's effective date for participation in the BCBSM MHSAMC program will be
30 days from the date the Signature Document is received by BCBSM. It is not retroactive to the
date we received the application.

Upon completion of the application and contracting process, the hospital will be provided with the
appropriate BCBSM provider manual(s) and will be added to our mailing list for the appropriate
BCBSM provider publication (e.g., The Record). It is the Hospital's responsibility to be familiar with
and to adhere to all BCBCM billing and benefit requirements. It is also the responsibility of the
hospital to ensure the hospital's billing department (or billing agency) is compliant with all BCBSM's
billing requirements.

Please direct questions regarding completion of the application to Barbara Milke, Provider
Contracting, at (248) 448-7894 or via Email at BMilke@BCBSM.com.
Mental Health and Substance Abuse Managed Care Networks
Inpatient Psychiatric Care Application

☐ The hospital would like to apply for participation in one of BCBSM’s mental health and substance abuse managed care (MHSAMC) networks

1.0 General Information:

1.1 Tax Name (This is name on file with the IRS and maybe different from the hospital’s business name)
_________________________________________________________________

1.2 Business Name (This is name used when doing business, or the DBA. It will be used for directories)
_________________________________________________________________

1.3 Hospital’s primary site address (Main Campus)

Site Address___________________________________________________________

City_______________________ State_________ Zip Code__________

1.4 Hospital’s address for inpatient psychiatric services, if different from above address

Site Address ______________________________________________________

City_______________________ State_________ Zip Code__________

1.5 Inpatient Psychiatric Care Program Telephone Number (for directory) _______________________

1.6 Hospital’s address for partial hospitalization psychiatric services, if different from above address

Site Address ______________________________________________________

City_______________________ State_________ Zip Code__________

1.7 Partial Psychiatric Program Telephone Number (for directory)___________________________

1.8 Hospital’s Web site address (if applicable) _________________________________

1.9 Date hospital began/will begin admitting patients for psychiatric care (MM/DD/YR) ________
2.0 **Ownership and Administration**

2.1 Is the hospital's board of directors responsible for the operations of the psychiatric care unit and partial hospitalization services?
   
   Yes____ No______

2.2 If the answer was "no" to 2.1 please provide an explanation below:
   
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

3.0 **Accreditation**

3.1 Check the hospital's applicable accreditation agency:

   □ JCAHO - Joint Commission on the Accreditation of Healthcare Organizations.
   □ AOA - American Osteopathic Association

3.2 What is the date of the hospital's most current accreditation survey report? (MM/DD/YY)?

   ________________________________

4.0 **Licensure**

4.1 Indicate below the type of current Michigan license(s) held by the hospital. For each license checked, please attach a current copy.

   Psychiatric Care License ________________
   Psychiatric Partial Hospitalization License ________________

4.2 Indicate below the number of beds or treatment positions the hospital is licensed for:

<table>
<thead>
<tr>
<th>Type of beds</th>
<th>Number of Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric inpatient beds - adult</td>
<td></td>
</tr>
<tr>
<td>Psychiatric inpatient beds - minor</td>
<td></td>
</tr>
<tr>
<td>Psychiatric partial hospitalization treatment positions- adult</td>
<td></td>
</tr>
<tr>
<td>Psychiatric partial hospitalization treatment positions - minor</td>
<td></td>
</tr>
</tbody>
</table>
5.0 **Liability Insurance**

5.1 Does the hospital carry professional liability insurance in a minimum amount of $1 million per occurrence and $3 million per aggregate?
- Yes
- No

5.2 If the hospital's professional liability insurance is provided by a commercial insurance carrier or if it is self-funded, attach a copy of the Face Sheet or Declaration Sheet of the insurance contract or self-funding trust agreement (which indicates the name and location of the facility and the coverage amounts).

5.3 Does the hospital require all professional (clinical) staff not covered under the hospital's professional liability policy to carry individual policies in the same $1 million/$3 million minimum amount of coverage?
- Yes
- No (Explain: ____________________________________________)

5.4 If some or all of the professional (clinical) staff are not covered under the hospital's policy, does the hospital maintain copies on file of the professional staff's individual professional liability insurance policies or other proof of insurance?
- Yes
- No

5.5 Does the hospital require all clinical staff not covered under the hospital’s insurance coverage to carry individual insurance policies in an appropriate amount of coverage?

Yes _____  No _____

6.0 **Psychiatric Care Utilization Evaluation**

A utilization evaluation system can result in improved client care and improved planning for more appropriate, effective, and efficient use of the hospital’s resources and must include the following for the hospital’s psychiatric care program:

- The program must provide in writing a utilization evaluation system designed to review the appropriateness of admissions to the program, lengths of stay, discharge practices, use of services, quality, timeliness and completeness of client records, and any other factors that may contribute to the effective utilization of program resources.

- Utilization evaluation must be administered by a committee that is representative of all disciplines providing direct and indirect client services.

- Two levels of evaluation activity are required; concurrent evaluation and retrospective evaluation studies. Concurrent evaluation uses open cases to examine client records. Retrospective evaluation studies examine services provided so patterns of care can be analyzed. These findings serve as the basis for further program planning and development.

- Written utilization evaluation findings and recommendations must be made available to administrative and treatment staff for study and appropriate action.
6.1 Attach copies of policies and procedures pertaining to utilization review and program evaluation.

6.2 Attach minutes from the last two quarterly utilization review meetings.

6.3 Attach a copy of the most recent retrospective evaluation study.

6.4 Attach a copy of the clinical admission, continued stay and discharge criteria for inpatient and/or partial psychiatric care program.

6.5 What was the average length of stay for the past year?
   Inpatient psychiatric care program _____________________
   Partial hospitalization psychiatric care program _____________________

6.6 What was the number of admissions for the past year?
   Inpatient psychiatric care program ______________________
   Partial hospitalization psychiatric care program ______________________

6.7 What was the average census for the past year?
   Inpatient psychiatric care program _____________________
   Partial hospitalization psychiatric care program _____________________

6.8 What was the average patient-to-staff ratio for the past year?
   Inpatient psychiatric care program _____________________
   Partial hospitalization psychiatric care program _____________________

7.0 Staffing

Each program must include a multidisciplinary staff consisting of a board-certified psychiatrist, a fully licensed psychologist and a MSW certified social worker. Additionally, limited licensed psychologists, licensed professional counselors, certified nurse practitioners and licensed marriage and family therapists may be included on staff. All professional staff must hold a Michigan license that is the permanent license that can be obtained in that discipline. The hospital must maintain proof of current licensure, registration or certification for all clinical staff.

7.1 Name of the hospital’s psychiatric care program medical director:
7.2 Attach evidence that the psychiatric care program medical director is board certified in psychiatry.

7.3 For treating psychiatrists (other than the medical director) attach evidence that they are board eligible or board certified in psychiatry.

7.4 Attach a roster of all clinical staff and indicate full time equivalents.

7.5 Attach copies of current state of Michigan licensure or certifications for each clinician.

7.6 For certified social workers, attach a copy of their Masters degree in social work.

7.7 For clinical nurse practitioners, attach a copy of their American Nurses Association (ANA) certification as a nurse practitioner in either Adult Psychiatric and Mental Health Nursing or Child and Adolescent Psychiatric and Mental Health Nursing.

8.0 Policies and Procedures

8.1 Attach copies of all policies and procedures pertaining to the following services:

- Psychosocial intake assessment
- Psychiatric evaluation
- Medication review
- Individual psychotherapy
- Family psychotherapy
- Group psychotherapy

8.2 Attach copies of all patient treatment/activity schedules

9.0 Contact Person for Application

9.1 Please give the following information for a contact person for any questions BCBSM may have regarding this application:

Name: ________________________________________________________

Title: _________________________________________________________

Telephone number: ____________________________________________

Email: ________________________________________________________
10.0 Attestation

I certify by my signature below that:

- I have reviewed the information in this application and to the best of my knowledge it is a complete and accurate representation of this hospital’s psychiatric care operations.
- I understand that BCBSM may choose to do an onsite survey after review of this application to verify program compliance and to verify the accuracy of any information provided.
- All licenses for this hospital are current and valid in Michigan.
- All licenses and certifications for clinical staff who provide psychiatric care for this hospital are current and valid.
- The hospital’s accreditation and insurance coverage is current and valid.
- The enclosed policies and procedures have been implemented and are enforced by this hospital.
- The hospital maintains financial records that conform with generally accepted accounting principles and practices.
- I understand the effective date of participation, if granted, will be 30 days from the date the signed agreement’s Signature Document is received by BCBSM and is not the date the application was sent or received.

Note: This application must be signed by the person who is responsible for the overall administration of the hospital and/or for the administration of its psychiatric care services.

Authorized hospital representative

By X___________________________________________
(signature - required)

Name _____________________________________________
(print or type)

Title _____________________________________________
(print or type)

Date _____________________________________________

Return completed application with all attachments to:

MHSAMC Inpatient Psychiatric Care Program
Provider Contracting Mail Code B715
Blue Cross Blue Shield of Michigan
27000 West 11 Mile Road
Southfield, MI 48034
Checklist for Application Attachments

- Current state of Michigan psychiatric care license and/or psychiatric partial hospitalization license, as applicable.
- Copy of the Face Sheet or Declaration Sheet of the insurance contract or self-funding trust agreement (which indicates the name and location of the facility and the coverage amounts).
- Copy of policies and procedures pertaining to utilization review and program evaluation.
- Copy of minutes from the last two quarterly utilization review meetings.
- Copy of the most recent retrospective evaluation survey.
- Copy of the clinical admission, continued stay and discharge criteria for each program.
- Evidence that the psychiatric care program medical director is board certified in psychiatry.
- Evidence of treating psychiatrists' board eligibility or board certification in psychiatry.
- Copy of roster of all clinical staff with full time equivalent indicated.
- Copy of current state of Michigan licensure or certifications for each clinician.
- Copy of Masters degree in social work for certified social workers.
- Copy of clinical nurse practitioners’ American Nurses Association certificate for Adult Psychiatric and Mental Health Nursing, or Child and Adolescent Psychiatric and Mental Health.
- Copy of policy and procedures for psychosocial intake assessment, psychiatric evaluation, medication review, individual, family and group psychotherapy
- Copy of all patient treatment/activity schedules.