NORTHCARE NETWORK

Provider Manual

Mental Health Service & Support Providers

NorthCare Network

Website: www.northcarenetwork.org

FY24 October 1, 2023 – September 30, 2024

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Welcome

We are pleased to provide you with the NorthCare Network Provider Manual. This Manual, along with NorthCare Policies, Procedures, and Plans, contains core information necessary to fulfill obligations as a provider serving residents across the Upper Peninsula of Michigan. A separate SUD Operations Manual is also maintained for providers serving individuals with substance use disorders. Both manuals and all NorthCare policies and plans can also be found at www.northcarenetwork.org. Network Providers are required to review and refer to resources on our website at time of contract, when notice of new or revisions is received, and as necessary. Each Network Provider will be emailed notice of any new or revised policy, procedure, or plan and will be responsible for informing staff within your organization of these changes. We ask that you update your contact information with NorthCare's Provider Network Specialist as needed, to ensure proper and timely notice is received by your organization. We welcome you to the NorthCare Behavioral Health Provider Network and ask you to work with us to continue to assure the most effective, best value services for our members.

About NorthCare Network

Under contract with the Michigan Department of Health and Human Services (MDHHS), NorthCare Network operates as the Specialty Prepaid Inpatient Health Plan for persons enrolled in Medicaid living in any of the 15 counties in Michigan's Upper Peninsula. NorthCare partners with local substance use disorder providers, community providers, and the five Community Mental Health Service Providers (CMHSPs) to ensure the delivery of a comprehensive array of specialty mental health and substance use disorder services and supports for adults with serious mental illnesses (SMI), children and adolescents with serious emotional disturbances (SED), persons with intellectual/developmental disabilities (I/DD), and persons with substance use disorders (SUD). In addition, NorthCare manages behavioral health services for individuals, age 21 and older, with both Medicare and Medicaid who are enrolled in the MI Health Link Program as well as the SUD Block Grants, and PA2 Liquor Tax Funds for the region.

NorthCare Network has about 80,000 Medicaid covered lives in its region and manages approximately $130 million in Medicaid revenue annually. NorthCare Network is governed by a 15-member board of directors with representation from across the Upper Peninsula.

NorthCare's efforts are framed by the core values of providing services that foster consumer inclusion, trauma informed, recovery, independence, and freedom in the community. Care will be coordinated to include both physical health as well as behavioral health goals and consideration will be given to other social determinants of health. NorthCare will hold true to its mission to be accountable stewards of public funds.

Mission, Visions, and Values

Mission

NorthCare Network ensures that every eligible recipient receives quality specialty mental health and substance use disorder services and supports through responsible management of regional resources.

Vision

NorthCare Network envisions a full range of accessible, efficient, effective and integrated quality behavioral health services and community-based supports for residents of Michigan's Upper Peninsula.

Values

- We believe in respect, consumer empowerment, person centered care, self-determination, full community participation, recovery, and a culture of gentleness.
- We also endorse effective, efficient community-based systems of care based on the ready availability of a competent workforce and evidence-based practices.
- We believe in services that are accessible, accountable, value based, and trauma informed.
- We support full compliance with state, federal and contract requirements, and responsible stewardship.
- The right care, at the right time, for the right cost, and with the right outcome.

Questions, Concerns, Contact Information

NorthCare Network wants to be as responsive and accessible to its Providers as possible. If you, as a NorthCare Network Provider, have any questions please don't hesitate to contact the appropriate office and/or staff at the number or address listed below. NorthCare Network maintains office hours between 8:00 a.m. and 5:00 p.m. ET Monday through Friday.

NorthCare Network 1230 Wilson Street Marquette, MI 49855 www.northcarenetwork.org 1-888-333-8030 Fax 1-906-232-1070	
Access Unit 1-888-906-9060 906-225-4433 Hospital Continued Stay Review 906-936-6864	
Chief Executive Officer	Megan Rooney mrooney@northcarenetwork.org 906-936-6845
Senior Clinical Director	Bob Wedin rwedin@northcarenetwork.org 906-936-6858
SUD Clinical Director	Tami LeBlanc tleblanc@northcarenetwork.org 906-936-6847
SUD Services Director	Sara Sircely ssircely@northcarenetwork.org 906-936-6844
Compliance Privacy Officer	Stacy Coleman scoleman@northcarenetwork.org 906-936-6843
Provider Network Specialist	Karena Grasso kgrasso@northcarenetwork.org 906-205-2838
Customer Services/SUD Recipient Rights	Stacey Coleman scoleman@northcarenetwork.org 906-225-7254 or 1-888-333-8030

NorthCare Network Responsibilities

NorthCare Network is responsible for the operation of the 1115 Behavioral Health Demonstration Waiver, the Healthy Michigan Plan, and SUD Community Grant Programs, and relevant approved Waivers within its designated service area and to ensure a comprehensive array of specialty mental health and substance abuse services and supports is available. NorthCare Network is also responsible for development of the service delivery system and the

establishment of sufficient administrative capabilities to carry out the requirements and obligations of the MDHHS/PIHP contract. If NorthCare Network elects to subcontract, NorthCare shall comply with applicable provisions of federal procurement requirements, as specified in the MDHHS/PIHP Contract Procurement Technical Requirements. NorthCare Network is responsible for complying with all reporting requirements as specified in their contract with the MDHHS.

NorthCare Network is organized around the essential administrative functions of a PIHP. These functions support the development of the service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of MDHHS/PIHP Contract. These seven functions are:

- Access Assurance
- Customer Services
- Financial Management
- Management Information Systems
- Organizational Structure
- Provider Network Services
- Quality Assessment & Performance Improvement
- Program Integrity
- Service & Utilization Management

NorthCare utilizes a regional approach to assist in achieving contract requirements through regional committees. Regional committees are comprised of staff from Member CMHSPs, interested consumers and stakeholders. Providers interested in participating on a NorthCare committee are encouraged to contact NorthCare.

Provider Responsibilities

In addition to specific responsibilities outlined in other sections of this manual and NorthCare Policies, Network Providers are required to report any material changes to information that was submitted as part of the Provider Panel and Credentialing application process. All information must be reported within five (5) business days of the provider becoming aware of the information to NorthCare's CEO and/or Network Management Designee. Changes are to be sent to pnm@northcarenetwork.org and include, but are not limited to:

a) Any action against any of its licenses.
b) Any action against its accreditation status.
c) Any changes in ownership, business address, or phone number.
d) Any legal or government action initiated that could materially affect the rendering of services in connection with this agreement.
e) Any legal action commenced by or on behalf of a NorthCare member against Provider.
f) Any initiation of bankruptcy or insolvency proceedings with regard to Provider.

g) Discovery that a claim, suit or criminal or administrative proceeding is being brought against the Provider relating to the Provider's malpractice, compliance with applicable laws, including any action by licensing or accreditation authorities and exclusions from government programs (i.e., Medicare/Medicaid);
h) Expiration of required professional liability insurance coverage (must be reported within 30 days prior to the expiration of such coverage).
i) Any changes in demographic information such as change of address, name change, coverage arrangements, tax identification number, National Provider ID Numbers (NPI), hours of operation, etc.
j) Expiration of professional license/certification, DEA certificate, CDS (Controlled Dangerous Substance) Certificate, board certification, and malpractice insurance. Current copies must be submitted within five (5) days of expiration. Failure to comply may result in sanctions.

Provider Coverage During Absences

A Network Provider must contact NorthCare Network's Provider Network Specialist 906-205-2838, to discuss alternative Provider coverage arrangements in any situation when the Provider is unable to directly provide the contracted service for a consumer at any time. Notification is required regardless of the reasons for utilizing an alternative provider (i.e. coverage while on vacation).

Obligation to Report/Duty to Warn

NorthCare Network and Network Providers must comply with all applicable state and federal child abuse, adult protective service and other reporting laws. It is the Provider's responsibility to understand and comply with the federal and state professional and legal requirements. The duty to warn may override the usual right to confidentiality of which an individual is assured when speaking to a clinician. This applies to any NorthCare Network Provider who receives information during assessment or treatment. In a life-threatening situation, relevant clinical data or history may be released. If a Provider believes that a consumer represents a threat to others, the provider must attempt to warn the potential victim(s) in a timely manner. It is preferable to contact the police, but the provider should warn the intended victim by telephone, in accordance with applicable law, if that is the best way to assure the victim(s) safety. It is important to understand reporting laws as some state laws protecting "privileged" communications between clinicians and patients may prohibit making such reports and individuals receiving substance use disorder services are covered under more restrictive laws.

Access to Services- Mental Health

Each CMHSP completes their own access screening for specialty supports and services. The Access system functions as the front door for obtaining behavioral health services and provides an opportunity for callers to be

heard, understood and provided with options for treatment. The Access system is available, accessible, and welcoming to all Michigan residents on a telephone and a walk-in basis.

Access system staff shall first determine whether the presenting mental health/substance use disorder need is emergent or routine and address emergent need first. Individuals presenting with real and imminent danger to self or others and/or require immediate diagnosis and treatment are considered an emergent situation and are immediately transferred to a qualified provider without requiring an individual to call back.

Individuals are screened for eligibility. If these individuals are found ineligible for specialty mental health services, they are referred to appropriate, less restrictive, and cost-effective services which satisfy the standard for medical necessity. The Access Center routinely updates a list of referral information for mental health Providers throughout the region. Individuals who are denied an intake assessment at the CMHSP are given an appropriate referral and verbally informed about the right to request a second opinion. When an initial assessment is denied, an adverse benefit determination notice must also be given which includes specific contact information and instructions on appeal rights. Written information about second opinions is provided along with the adverse benefit determination.

Access to Services – Substance Use

NorthCare Access operates the access center for individuals seeking substance use treatment.

Customer Services

NorthCare Network and Network Providers must convey an atmosphere that is welcoming, recovery based, and trauma informed. Opening the door in this manner will assure consumers have the ability to lead, control, and exercise choice over, and determine their own path of recovery. Telephone calls to the customer services unit shall be answered by a live voice during business hours.

A welcoming philosophy is based on the core belief of dignity and respect for all people while in turn following good business practice. It is important for the system to understand and support the individual in seeking treatment by providing an environment including actions and behavior that foster entry and engagement throughout the treatment process and supports recovery.

Customer Services functions are mandated by the Michigan Department of Health and Human Services (MDHHS) and Standards in the Balanced Budget Act (BBA). The MDHHS PIHP Customer Services Standards can be found at CUSTOMER SERVICES STANDARDS (michigan.gov)

The NorthCare Customer Service Policy outlines requirements for the Customer Services unit at NorthCare and Network Providers.

Customer Education and Marketing

All customer educational materials (both written and on the NorthCare website) and other general written communication must be accurate, in plain language (7th grade reading level)

and clearly represent the activities/services provided by NorthCare and Network Providers. Documents, as appropriate, will indicate that they were paid for with funds from MDHHS.

All providers shall abide by:

- The Balanced Budget Act (BBA)
- MDHHS/PIHP Contract Customer Service Standards
- Accreditation Standards, as applicable

Rights and Protections of Individuals Served

Enrollee/Recipient Rights and Protections are delineated in the legal authorities noted below and the requirements of the rights of individuals receiving mental health specialty supports and services and substance use disorder services. These rights include, but are not limited to ensuring that:

- Recipients are free from abuse, neglect, and other rights violations;
- Rights under the balanced budget amendment, Michigan Mental Health Code, Michigan
- Public Health Code, and Administrative rules are protected;
- When there is reason to believe a recipient's rights have been violated, staff report to the proper agency; and,
- Each Member CMHSP has an office of recipient rights that is approved by the State of
- Michigan.

All providers shall abide by:

- Sections 4, 4a, 7, and 7a of the Mental Health Code and corresponding Administrative
- Rules in their entirety.
- Enrollee Rights and Protection as noted in Subpart C, 42 CFR 438.100.
- Enrollee Communications as noted in Subpart 42 CFR 438.102
- Grievance System as noted in 42 CFR § 438.400 et seq

Grievances and Appeals

The Grievance and Appeal processes are intended to facilitate NorthCare Network and its Providers' compliance with the grievance and appeals process required by the state of Michigan and the federal government for Medicaid consumers. (This process is outlined in the MDHHS/PIHP Appeal and Grievance Resolution Processes Technical Requirement found at Appeal-and-Grievance-Resolution-Processes-Technical-Requirement.pdf (michigan.gov) and NorthCare policies. The grievance system divides beneficiary complaints into two categories, those challenging an adverse benefit determination and those challenging anything else. A challenge to an adverse benefit determination is called an appeal. Any other type of complaint or expression of any type of dissatisfaction is considered a grievance.

Medicaid beneficiaries must receive due process whenever benefits are denied, delayed, suspended, reduced, or terminated. Due Process includes: (1) prior written notice of the

adverse action (2) a fair hearing before an impartial decision maker (3) continued benefits pending a final decision, and (4) a timely decision, measured from the date the complaint is first made.

Medicaid beneficiaries have rights and dispute resolution protections under federal authority of the Social Security Act, including:

- State fair hearings through authority of 42 CFR 431.200 et seq.
- Local appeals through authority of 42 CFR 438.400 et seq.
- Local grievances through authority of 42 CFR 438.400 et seq.

Medicaid Beneficiaries, as public mental health consumers, also have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, (hereafter referred to as the 'Code") Chapters 7,7A, 4 and 4A, including:

- Recipient Rights complaints through authority of the Mental Health Code (MCL 330.1772 et seq.)
- Medical Second Opinion through authority of the Mental Health Code (MCL 330.1705)

Education

Recipients will be informed of their rights as outlined by the Michigan Administrative Rules 325.14301-14306 and as indicated in the NorthCare policy Enrollee/Recipient Rights & Protections. Recipients will be provided assistance in understanding their rights and with all procedural steps required to register a rights complaint or grievance.

All staff must have training in the full extent of recipients' rights within 30 days of hire and annually thereafter. Additional training and updates will be conducted as needed. Any major change in policy or in forms requires staff training before implementation.

Advance Directives

NorthCare shall provide adult consumers receiving specialty services with written information on advance directives policies and a description of applicable state law and their rights under applicable laws. Providers of mental health services are further responsible to assist a consumer if the consumer decides to develop an Advance Directive for Mental Health Care. Providers are responsible for following the NorthCare Advance Directive/Durable Power of Attorney/Plan for Difficult Times Policy and to ensure their staff are adequately trained regarding such. Providers must ensure that all adult consumers are asked at intake if they have an advance directive and document this in a prominent part of the record. If a consumer requests further information they must be provided with information and/or shall be provided referrals to appropriate sources to assist them when they wish to create an advance directive.

The NorthCare Network website (www.northcarenetwork.org) and the MDHHS websites (www.michigan.gov/mdhhs) have detailed information about Advance Directives and several forms that may be accessed by individuals or the staff working with them.

Consumer Satisfaction

The Provider shall cooperate fully in NorthCare Network's implementation of (1) quantitative and qualitative member assessments of experience with services, including consumer satisfaction surveys and other consumer feedback methodologies; and (2) studies to regularly review outcomes for Medicaid recipients as a result of programs, treatment, and community services rendered to individuals in community settings.

Financial Management

Participating Provider Payment Methodology and Fees

MDHHS provides NorthCare Network with the state and federal share of Medicaid funds as a capitated payment based upon a per eligible per month methodology. NorthCare Network sub-capitates for shared risk with the Member CMHSPs using an actuarially sound methodology.

Claims Processing and Encounter Reporting

NorthCare Network reports encounter data to MDHHS for all services provided. Encounter data is collected for every service provided through accounts payable claims or service activity logs (SALs). Claims are adjudicated on a monthly basis. NorthCare Network is responsible for complying with all reporting requirements as specified in the MDHHS/PIHP Contract; therefore, Network Providers are responsible for ensuring that documentation is completed, supports the service provided, and signed timely per the NorthCare consumer record SOP. Member CMHSPs are responsible for ensuring receipt of sub-contract provider invoices and that claims data is entered into ELMER within 15 days of the month following the service. Member CMHSPs are responsible for monitoring the completion of all required Quality Improvement (QI) fields for every individual served.

Coordination of Benefits

NorthCare is responsible to ensure that Medicaid is the "Payer of Last Resort." Network Providers are required to identify and seek reimbursement from all other Third-Party Payers before Medicaid. It is expected that complete and accurate Coordination of Benefits for Third Party Liability (TPL) is conducted for all individuals served. TPL refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan or commercial carrier, automobile insurance, and worker's compensation) or program (e.g., Medicare) that has liability for all or part of a recipient's covered benefit. Member CMHSPs are responsible for verification of and the accurate and timely recording of Medicaid Benefits and all Third-Party Payers in the ELMER (Electronic Medical Record System) Insurance and Demographic section of each individual's electronic health record. The Member CMHSP shall collect any payments available from other health insurers including Medicare and private health insurance for services provided to its individuals in accordance with Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D, MA and the Michigan Mental Health Code

and Public Health Code section 226a as applicable. Member CMHSPs shall use the ELMER Electronic Billing system to process TPL claims for all applicable services on a regular monthly schedule and ensure accurate and timely balance billing to all consumers when an "Ability to Pay" exists.

Restrictions on billing of consumers

An Ability to Pay (ATP) amount shall be assigned and collected in accordance with the Michigan Mental Health Code (MMHC) Chapter 8, sections 330.1800 - 330.1842. The Ability to Pay shall be assigned during the initial intake process, annually thereafter and as an individual's financial circumstances change. For Medicaid beneficiaries with a monthly deductible, the Member CMHSP shall collect the ATP when Medicaid is not effective (until the deductible is met). Consumers will never be charged for services provided when no ATP has been assigned and will never be charged more than the assigned ATP, even when the service charge is more than the ATP. When multiple consumers from the same family are being treated within the same month, only one family member will be charged the assigned ATP.

Appeal Procedures

As part of the ATP process, individuals shall be informed of their right to appeal the assigned ATP amount in accordance with the Michigan Mental Health Code sections 330.1832 – 330.1834.

Individuals shall be informed that, under section 8 of the Michigan Mental Health Code, if they believe that the income figure being utilized to determine their ability to pay is not appropriate to their current income status or does not appropriately reflect their ability to pay, they may request the MDHHS or CMHSP to make a new determination of ability to pay, and the MDHHS or CMHSP shall be required to do so. The new determination of ability to pay should be based on the responsible party's current annualized Michigan taxable income. If this is not available, other documentation of income as described in section 8 shall be used. A new determination of ability to pay shall not be for an amount greater than the original determination.

Information Management

Electronic Health Record

Network Providers are required to maintain the confidentiality, integrity, and availability of electronic protected health information (ePHI) through technical and non-technical mitigation techniques required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), Michigan Mental Health Code and 42 CFR Part 2. Access to Electronic Health Systems is permitted only from NorthCare managed equipment, Member CMHSP managed equipment or Business Associate managed equipment. No personal equipment shall be used to gain access to Electronic Health Systems.

Record Keeping Requirements

Network Providers are expected to know and follow the NorthCare Network clinical documentation policies which are located on the NorthCare Network website in the policy section under Record Retention & Disposal Schedule Policy. Any questions regarding record keeping requirements should be directed to the NorthCare Network.

Reporting

NorthCare Network is responsible to provide data reports to several entities to comply with the MDHHS/PIHP contract. The reporting of data by NorthCare Network is used for a variety of reasons at MDHHS including legislative boilerplate, annual reporting, and semi-annual update; managed care contract management; system performance improvement; statewide and regional planning; Centers for Medicare and Medicaid (CMS) reporting; and actuarial activities. Individual consumer level data received at NorthCare and MDHHS is kept confidential and published reports will display only aggregate data. Individual level data will be provided back to the agency that submitted the data for encounter data validation and improvement. This sharing of individual level data is permitted under the HIPAA Privacy Rules, Health Care Operations. NorthCare must submit individual level data immediately within 30 days following adjudication of claims for services provided, or in cases where claims are not part of NorthCare's business practices within 30 days following the end of the month in which services were delivered. Therefore, it is imperative that all data entered and/or submitted to NorthCare is accurate and timely, as required by NorthCare.

Provider Network Management

In order to provide quality services to consumers, it is necessary for NorthCare Network and its Network Providers to establish and maintain a cooperative relationship. Consumers must be excluded from any dispute between the Network Provider and NorthCare Network. Network Providers are prohibited from any discrimination against individuals seeking or receiving services and will comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1973, and the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

In the performance of any contract or purchase order resulting here from, the Network Provider agrees not to discriminate against any employee or applicant for employment or service delivery and access, with respect to their hire, tenure, terms, conditions or privileges of employment, programs and services provided or any matter directly or indirectly related to employment, because of race, color, religion, sex, (including pregnancy, sexual orientation, or gender identity), national origin, disability, age (40 or older), genetic information, height, weight, marital status, veteran status, or any other legally protected characteristic related to the individual's ability to perform the duties of the particular job or position. The PIHP further

agrees that every subcontract entered into for the performance of any contract or purchase order resulting here from will contain a provision requiring non-discrimination in employment, service delivery and access, as herein specified binding upon each subcontractor. This covenant is required pursuant to the Elliot Larsen Civil Rights Act, 1976 PA 453, as amended, MCL37.2201 et seq, and the Persons with Disabilities Civil Rights Act, 1976 PA 220, as amended, MCL 37.1101 et seq, and Section 504 of the Federal Rehabilitation Act 1973, PL93-112, 87 Stat. 394, and any breach thereof may be regarded as a material breach of the contract or purchase order. The Network Provider shall incorporate language in all contracts awarded: (1) prohibiting discrimination against minority- owned, women-owned, and handicapper-owned businesses in subcontracting; and (2) making discrimination a material breach of contract.

General Expectations

Network Providers must:

- respond to the cultural, racial, and linguistic needs (including interpretive services as necessary) of individuals served and provide services with necessary and reasonable
- accommodations in a culturally competent manner;
- ensure services are accessible, taking into account travel time, availability of public transportation, and other factors that may affect accessibility; and, that the location of
- primary service Provider is within 60 minutes/60 miles from beneficiary's residence for
- office or site-based services;
- not segregate NorthCare consumers in any way from other consumers receiving their services, and offer hours of operation to NorthCare consumers that are no less than the
- hours offered other consumers receiving their services;
- not discriminate against particular Providers that serve high-risk populations or who specialize in conditions that require costly treatment;
- regularly monitor sub-contractors to ensure all needed services are available and
- accessible to beneficiaries, and to determine whether provider capacity is sufficient in number, mix, and geographic distribution to assure adequate access to serve the expected beneficiary enrollment;
- must ensure Providers are responsive to individual needs, provide for clean comfortable service facilities, have adequate office hours, and appropriately address other quality of
- care issues; and
- require corrective action be taken if there is a failure to comply with applicable requirements for availability of services (42 CFR Part 438.206) or assurance of adequate
- capacity and services (42 CFR Part 438.207).

Debarment and Suspension

Assurance is hereby given to NorthCare Network that the Network Provider will comply with Federal Regulation 45 CFR Part 76 and 42 CFR part 180, and certifies to the best of its knowledge and belief that it, including its employees and subcontractors:

a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or PIHP;
b) Have not within a three-year period been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c) Are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state or local) with commission of any of the offenses enumerated in section B, and;
d) Have not within a three-year period had one or more public transactions (federal, state or local) terminated for cause or default.
e) Provider agrees to immediately notify NorthCare if Provider or its employees are under investigation or if Provider receives notice of actions, claims or events regarding potential debarment or suspension.

Network Provider Selection

It is the policy of NorthCare Network to develop and maintain a Provider Network that meets the needs of consumers for Mental Health Specialty Supports and Services and Substance Use Services in the Upper Peninsula of Michigan. NorthCare Network will continually assess consumer needs and ensure the full array of services in appropriate settings to meet those care needs while evaluating and planning for the expansion, adjustment, and improvement of the Provider Network. Soliciting providers for the service delivery system must be done with due deliberation and sensitivity to procurement and contracting issues. Reimbursement will be the lowest rate paid by other payers for the same or similar service. This includes advertised discounts, special promotions, and other programs where reduced pricing is in effect. NorthCare Network retains final authority for provider panel membership.

NorthCare will not discriminate for the participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification; and is not required to contract with Providers beyond the number necessary to meet the needs of its beneficiaries and is not precluded from using different practitioners in the same specialty. In addition, selection policies and procedures cannot discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatments. NorthCare Network will

not contract with a Provider who prohibits, or otherwise restricts, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient.

When it has been determined that NorthCare Network is in need of contractual services for either an organizational provider or individual practitioner, the Chief Executive Officer (CEO) or designee, shall either initiate the procurement process for goods and services or make systemic inquiries, within the current network of Providers, on the availability of any contractual service provider(s) whom may have the qualifications and the experience required to meet the specific needs of NorthCare Network. All qualified Providers, meeting specific criteria (e.g. accreditation status, fiscal stability, litigation status properly credentialed and appropriate insurance coverage) expressing an interest in contracting with NorthCare Network will be given the opportunity to compete for contracts. Contracts will be awarded in accordance with NorthCare Network's Procurement of Goods and Services Policy. This policy also lists certain circumstances where NorthCare Network's CEO may grant a waiver from the procurement process and select a service Provider or vendor without a competitive bidding process.

If an organizational Provider, group/individually licensed Provider disagrees with a determination by NorthCare Network in the application process or during review of a provider's status and wishes to have the matter reviewed at a higher level, the provider may do so in accordance with NorthCare Network's Network Provider Grievance Appeal Process-Administrative Policy.

Credentialing

NorthCare Network assures due diligence in credentialing and recredentialing to provide a competent workforce for the individuals we serve. The Balanced Budget Act (BBA) and MDHHS have rules and regulations that require managed care entities to follow clearly defined policies and procedures for credentialing and recredentialing staff. The NorthCare Credentialing Program Policy and associated policies on the website outlines the credentialing process, policies, and forms to assure staff who provide clinical oversight, management, and services to individuals receiving services within the Provider Network are fully qualified and in good standing. Initial credentialing must be completed prior to hire and recredentialing must be completed every two years thereafter.

Network Provider Monitoring

NorthCare Network monitors each Network Provider for the purposes of ensuring compliance with Federal and State standards and regulations, provider contracts, NorthCare policies and procedures, and managed care administrative delegations. Monitoring of performance will occur at least once during each fiscal year via desk audit and/or on-site reviews, more frequently when deemed necessary. NorthCare may delegate provider monitoring and monitoring of direct operated group homes to Member CMHSPs. NorthCare will monitor all

delegated activities. Clinical documentation reviews and verification of services will be part of provider monitoring.

Contract Termination

Either NorthCare Network or a Network Provider may choose to terminate the provider contract as outlined in the contract. This includes action taken as a result of any other breaches highlighted in the contract as a "material breach" and a potential cause for termination such as discrimination, non-compliance with applicable laws, non-compliance with consumers' recipient rights and consumer grievance procedures, etc. A contract shall terminate immediately upon provider loss of required certification/licensure; listing of the provider by a department or agency of the State of Michigan as being suspended from service participation in the Michigan Medicaid and/or Medicare programs; and/or the provider being listed by a department or agency of the State of Michigan in its registry for Unfair Labor practices.

If a Network Provider chooses to resign from the network, NorthCare Network must be notified in writing as indicated in the provider contract. NorthCare Network will acknowledge receipt of the provider's request and confirm the disenrollment date. If NorthCare Network chooses to terminate a contract, written notification of the termination including the effective date will be given as specified in the provider contract.

Provider Grievance and Dispute Resolution Process

All participating Providers in the NorthCare Network have the right to dispute actions taken by NorthCare relating to their status within the Provider Network and actions related to Provider's non-compliance, professional competency or conduct. These actions may include decisions made in the NorthCare provider monitoring process or instances when NorthCare has chosen to discontinue a Provider's participating status within the Network based on issues of quality of care/service, performance or noncompliance. It also includes action taken as a result of any other breaches highlighted in the contract as a "material breach" and a potential cause for termination such as discrimination, non-compliance with applicable laws, non-compliance with consumers' recipient rights and consumer grievance procedures, etc.

The two-level appeals process is outlined in NorthCare Network's Network Provider Grievance Appeal Process-Administrative Policy and does not apply to Provider Appeal Process – Medicaid Adverse Benefit Determination (Medical Necessity) and Payment Policy or conditions dictated in the provider contract that result in immediate termination. See the provider contract for a full listing of conditions for immediate termination.

Quality Assessment and Performance Improvement

Performance Measures

Network Providers shall meet the performance indicators and objectives in accordance with requirements outlined in the MDHHS/PIHP Contract and PIHP/Provider Contract. This includes

participation in regional Quality/Performance Improvement Projects, assessment of members experience with services, studies to regularly review outcomes for individuals served, etc. as required.

Incident Reporting

All incidents are to be reviewed by NorthCare Network or appropriate Member CMHSP to determine if they meet the criteria and definitions to be categorized as a sentinel event, critical event, risk event, or an immediately reportable event. Events may meet criteria for more than one category. Providers must review and notify NorthCare Network and/or the appropriate Member CMHSP according to NorthCare Network's Incident, Event & Death Reporting & Monitoring Policy.

Quality of Care

In order to ensure high quality of care for our members, providers must meet the criteria included in the Provider Panel and Credentialing Application such as being officially licensed, properly accredited (if an organizational provider) and insured.

Providers must agree to participate in NorthCare Network Utilization Management and Performance Improvement programs as detailed in the provider contract and adhere to the following access to care standards as stipulated by MDHHS.

Quality of Service

NorthCare Network has identified a minimum set of standards to ensure quality of service for our consumers including:

- Access to emergency services 24 hours a day, seven days a week
- Office hours that reflect consumer need and must provide consumers with a 24hr, 7-day a week confidential telephone line to leave messages.
- Provider offices must be clean and free of clutter with unobstructed passageways.
- Office staff must be responsive to consumers; all consumers must be treated with respect and dignity.
- Phone calls are to be answered within 4 rings and when that cannot happen, return calls are expected to be responded to within the next business day.
- Providers must be able to communicate with individuals speaking languages other than English and those who are hearing or vision impaired or provide interpretive services at no cost to the consumer.
- Providers must be able to accommodate consumers with physical disabilities.

<u>LEP – Limited English Proficiency</u>

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient, or "LEP." These individuals may be entitled to language assistance with respect to a particular type or service,

benefit, or encounter. The following website may be helpful: www.LanguageLine.com.

Using a Sign Language Interpreter

Signing Pros, LLC - Michigan's Premier American Sign Language Interpreting Agency in contracted for our region. To schedule Sign language interpreter services, you will need to go to Signingprosllc.com to request an appointment. Appointments requested within 48 hours will be considered Emergency services.

Compliance and Ethics

NorthCare Network's Compliance Program is designed to further NorthCare's commitment to comply with applicable laws, promote quality performance throughout the NorthCare Network, and maintain a working environment that promotes honesty, integrity and high ethical standards. NorthCare's Compliance Program is an integral part of NorthCare's mission, and all NorthCare Personnel, Member CMHSPs, contracted Providers and subcontracted Providers are expected to comply with all regulations related to health care. These include but are not limited to; the Michigan Mental Health Code, Michigan Medicaid Provider Manual, BBA, the ADA, and civil rights laws and regulations, including limited English proficiency regulations, and applicable accreditation standards. It is up to the Provider to be aware of the laws and regulations governing health care services but may at any time contact the NorthCare Network Compliance Officer with any questions. Network Providers are expected to have policies and practices in place that will assist in the education and prevention of fraud, waste, and abuse of public resources. Policies and practices shall also promote an open-door policy for reporting suspected or known fraud, waste, or abuse as well as whistleblower provisions and non- retaliation protections when reporting in good faith.

Code of Conduct

Network Providers are expected to conduct themselves in accordance with standards set forth in the NorthCare Network Code of Conduct Plan, applicable federal and state laws, rules and regulations, NorthCare Network Compliance Plan and policies and procedures, standards of conduct incumbent upon an individual by virtue of holding state licensure or registration, and ethical standards binding on an individual as a practitioner of a particular profession. Network Providers have a responsibility to treat consumers and family members with dignity and respect and to provide services and supports that are developed to meet the medical necessity of each individual or family.

Conflict of Interest

Network Providers may not engage in any transaction, arrangement, proceeding or other matter or undertake positions with other organizations that involve a Conflict of Interest. Network Providers should avoid not only actual conflicts of interest, but the appearance of Conflicts of Interest as well. Network Providers shall disclose all potential or known Conflicts of

Interest to NorthCare Network.

Privacy and Confidentiality

Network Providers shall preserve the confidentiality of Protected Health Information (PHI). All information (oral, written, or electronic) in and regarding the clinical record or obtained in the course of providing services is confidential. In the use and disclosure of PHI, Network Providers are to comply with all legal, ethical, and applicable accreditation standards. PHI may be used or disclosed for treatment, payment and coordination of care activities per the Michigan Mental Health Code and NorthCare policy, unless it is protected under 42 CFR. Part 2.

Except as otherwise required by law (e.g. Mental Health Code, 42 CFR, Part 2 relative to substance abuse services, HIPAA), consumer identifying, and confidential information shall not be released without an appropriately signed Consent to Share Behavioral Health Information or official judge's court order.

Network Providers shall have written policies and procedures that comply with HIPAA, 42 CFR Part 2, the Michigan Mental Health Code and NorthCare Policies. Individuals needing access to an individual's medical record must do so only in the course of assigned duties and responsibilities. All individuals must follow the standards of "minimum necessary" and "need to know" for any and all access to protected health information.

Consent to Share Information

NorthCare and Network Providers will utilize, accept and honor the MDHHS-5515 Consent to Share Behavioral Health Information for Care Coordination Purposes. The consent form is to be utilized for all electronic Health Information Exchange (HIE) environments. NorthCare Network providers must obtain a consent to share information such as mental health records or information on treatment or referrals for alcohol and substance use services as required by law and NorthCare Policy.

If the following information is requested, a HIPAA compliant consent to share information must be used:

a) Psychotherapy notes except when in the course of treatment, payment, or health care operations (see 45 CFR 164.508 (a)(2) for further details)
b) Marketing with the exceptions noted in 45 CFR 164.508 (a)(3)

It is the responsibility of the primary care clinician and/or care coordinator who has first contact with the individual to secure the proper consent. This consent is then uploaded into the Altruista Integrated Care Bridge for MHL enrollees or faxed to the other parties (UPHP/ICO, NorthCare Network, Providers) as authorized.

To ensure appropriate and timely integration/coordination of care for each person, it is strongly encouraged that the following Providers and health plans, as applicable and chosen by the consumer, be included on the MDHHS-5515:

- UPHP
- NorthCare Network
- Primary Care Physician by name or by name of practice
- Mental Health Provider by name or by name of practice
- Substance Use Disorder Provider by specific name
- Specialty Physician(s), as appropriate

Each disclosure for individuals receiving SUD services and made with the individual's consent must be accompanied by a re-disclosure statement that reads:

"This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65."

Service and Utilization Management

Utilization Management

NorthCare is accountable for managing the specialty services and support benefits for eligible persons in its service area. As a result, NorthCare has oversight authority to ensure these funds are used for authorized purposes and from that perspective, indirectly manages consumer care from the point of entry, through treatment and delivered services, to discharge. This includes ensuring that value purchasing guides the service selection and service delivery process. As applied to services and supports, value purchasing assures appropriate access, quality, and the efficient and economic provision of supports and services.

Utilization Management (UM) is intended to complement quality improvement activities of Provider organizations such as clinical practice improvement initiatives, service/billing integrity verification, and compliance risk monitoring. The UM Plan is designed specifically to identify roles and responsibilities for service and authorization functions and how those activities are implemented, monitored, and managed. The UM Plan establishes a framework for oversight and guidance of Medicaid Programs by assuring consistent application of program/service eligibility criteria, and in decisions involving the processing of requests for initial and continued authorization of services.

Medical Necessity

The UM program must operate within a common definition of medical necessity which must be consistently applied region-wide to ensure eligible persons have equitable access to services. NorthCare is committed to assuring that services and supports identified in the individual plan

of service meet medical necessity criteria, and are sufficient in amount, duration, and scope to reasonably achieve the purpose of the service.

Person-Centered Planning and Self Determination

As a Network Provider, you may be required to participate in an individual's Person Center Planning (PCP) process and/or may be part of a self-determination arrangement. MDHHS defines Person-Centered Planning as a process for planning and supporting the "Individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities". MCL 330.1700(g) The purpose of the community mental health system is to support adults and children with developmental disabilities, adults with serious mental illness, and co-occurring disorders (including co-occurring substance use disorders), and children with serious emotional disturbance to live successfully in their communities-achieving community inclusion and participation, independence, and productivity. PCP enables individuals to achieve their personally defined outcomes. As described below, PCP for minors (family-driven and youth-guided practice) accommodates the entire family.

PCP is a way for individuals to plan their lives with the support and input from those who care about them. The process is used for planning the life that the individual aspires to have-taking the individuals' goals, hopes, strengths, and preferences and weaving them in plans for a life with meaning. PCP is used anytime an individual's goals, desires, circumstances, preferences, or needs change.

The Mental Health Code also requires use of PCP for development of an Individual Plan of Service: "(1) The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the individual, the individual's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan." MCL 330.1712.

Self-determination is the value that people served by the public mental health system must be supported to have a meaningful life in the community. The components of a meaningful life include; work or volunteer activities that are chosen by and meaningful to person, reciprocal relationships with other people in the community, and daily activities that are chosen by the individual and support the individual to connect with others and contribute to his or her community. With arrangements that support self-determination, individuals have control over an individual budget for their mental health services and supports to live the lives they want in the

community. The public mental health system must offer arrangements that support self-determination, assuring methods for the person to exert direct control over how, by whom, and to what ends they are served and supported.

PCP is a central element of self-determination. PCP is the crucial medium for expressing and transmitting personal needs, wishes, goals, and aspirations. As the PCP process unfolds, the appropriate mix of paid/non-paid services and supports to assist the individual in realizing/achieving these personally defined goals and aspirations are identified. The principles of self-determination recognize the rights of people supported by the mental health system to have a life with freedom and to access and direct-needed supports that assist in the pursuit of their life, with responsible citizenship. These supports function best when they build upon natural community experiences and opportunities. The person determines and manages needed supports in close association with chosen friends, family, neighbors, and co- workers as a part of an ordinary community life.

Clinical Practices Guidelines

The NorthCare Practice Guideline Manual is available at www.northcarenetwork.org with a complete table of contents with direct links to the material of interest to the provider.

NorthCare is responsible for adopting, implementing and evaluating regional practice guidelines. (See the BBA, subpart D, section 438.236 and the MDHHS/PIHP Contract – Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans) The BBA allows the adoption of practice guidelines either from a nationally recognized expert body or a consensus of healthcare workers in a particular field. The federal agency charged with providing guidance in our field is the Substance Abuse & Mental Health Services Administration (SAMHSA). They offer the following definitions of Practice Guidelines (PG) and Evidence Based Practices (EBP):

Practice Guidelines (PG)--Systematically developed statements to standardize care and to assist in practitioner and patient decisions about the appropriate health care for specific circumstances. Practice guidelines are usually developed through a process that combines scientific evidence of effectiveness with expert opinion. Practice guidelines are also referred to as clinical criteria, protocols, algorithms, review criteria, and guidelines. (SAMHSA)

Evidence Based Practices (EBP) --In the health care field, evidence-based practices generally refer to approaches to prevention or treatment that are validated by some form of documented scientific evidence. What counts as "evidence" varies. Evidence often is defined as findings established through scientific research, such as controlled clinical studies, but other methods of establishing evidence are considered valid as well. Evidence-based practice stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence. (SAMHSA)

The clinical context for utilization of a specific practice is whether as a treatment it supports a Recovery–Oriented System of Care. MDHHS and NorthCare both have policies mandating all

services and supports be based on recovery principles. Both policies are provided in the Policies section of the NorthCare website. The components of a recovery-oriented environment are those that: Encourage individuality; promote accurate and positive portrayals of psychiatric disability while fighting discrimination; focus on strengths; use a language of hope and possibility; offer a variety of options for treatment, rehabilitation, and support; support risk-taking, even when failure is a possibility; actively involve service users, family members, and other natural supports in the development and implementation of programs and services; encourage user participation in advocacy activities; help develop connections with communities; and help people develop valued social roles, interests and hobbies, and other meaningful activities.

Behavioral Health Home

NorthCare Network PIHP participates in the Michigan Behavioral Health Home Program. Any person with Medicaid and a qualifying mental health diagnosis is eligible for Behavioral Health Home (BHH) services at any NorthCare enrolled BHH provider. BHH enrollees are not required to meet the specialty mental health service level of care. Providers are required to follow all expectations in the MDHHS BHH handbook, located at http://www.michigan.gov/bhh under provider resources.

Home and Community Based Services (HCBS)

HCBS settings where people live or receive HCBS services must have the following characteristics to the same extent as those individuals not receiving Medicaid HCBS: - Be integrated in, and support full access to; the greater community, including opportunities to seek competitive and integrated employment, control of personal resources, and access to community services; - Be selected by the individual from among a variety of setting options and, for residential settings, consistent with the individual's available resources to pay for room and board; - Ensure individuals have the right to privacy, dignity and respect, as well as freedom from coercion and restraint; - Optimize, but not regiment, the individual's autonomy and independence in making life choices regarding what they participate in and with whom; and - Facilitate the individual's choice of services and supports as well as who provides them.

The Michigan Department of Health and Human Services (MDHHS) developed a statewide transition plan to bring its waiver programs into compliance with federal regulations while continuing to provide vital services and support to Michigan residents. This plan involved a statewide comprehensive survey process to survey HCBS providers and the Medicaid beneficiaries receiving HCBS services. The survey process was utilized to determine provider compliance with the HCBS Final Rule. In addition, a provisional approval process for all new HCBS providers was put in place and is currently required.

Veteran Navigator

The PIHP Veteran Navigator works to ensure Veterans, military members, and their families

receive efficient, comprehensive and sustained behavioral health and substance use disorder services in the publicly funded system. The plan is designed around a multi-prong, coordinated approach to meet the comprehensive needs of these individuals and families, to includes access to Veterans Affairs and other community resources to address their specified needs. By maintaining close relationships with Federal, State, and county Veterans organizations, Navigators stay current on resources and updates through the Department of Veterans Affairs. The Veteran Navigator will further act as an advocate on behalf of Veterans and supply information to other agencies or providers as the needs dictate.

MI Health Link

MI Health Link (MHL) Program offers a broad range of medical and behavioral health services, pharmacy, home and community-based services and nursing home care, all in a single program designed to meet individual needs.

The MHL program requires effective integration of services and coordination between Providers of primary and behavioral health services, pharmacy, and long term supports and services. This requires coordination between the Upper Peninsula Health Plan, NorthCare Network, and service Providers.

Basic enrollment requirements are that individuals are at least 21 years of age and are covered by both Medicare and Medicaid. Individuals interested in enrolling or learning more about this program should contact Michigan Enrolls at 800-975-7630. Enrollment is identified in CHAMPS with an insurance code of ICO-MC and an MDHHS county code within the UP.

Credentialing

To become an enrolled MHL provider, you must be Medicare and Medicaid enrolled, credentialed by and enrolled as a participating provider with the Upper Peninsula Health Plan (UPHP), complete and submit the required NorthCare paperwork, and be accepted into the NorthCare Panel for MHL. For more information, contact Karena Grasso at kgrasso@northcarenetwork.org.

Access to Services

Direct Request:

An individual may access services by calling NorthCare Access at 888-906-9060. An Access Screening will be completed by telephone to identify the most appropriate level of care, based on information provided. Individuals meeting access criteria will be offered a choice of paneled Providers. Once the individual has selected a provider, NorthCare Access staff will schedule a face-to-face assessment appointment or initiate a three-way call with the individual and selected Provider to schedule. NorthCare Access staff will register the individual in the electronic health record (ELMER) and process the initial authorization for service once the provider is selected.

UPHP Referral:

Individuals enrolled in the MHL program receive initial and annual screenings with their UPHP Care Coordinator. When a need for behavioral health services is identified, the person is referred to NorthCare Access for behavioral health screening. Individuals meeting access criteria will be offered a choice of paneled providers. Once the individual has selected a provider, NorthCare Access staff will schedule a face-to-face assessment appointment or initiate a three-way call with the individual and selected provider to schedule. NorthCare Access staff will register the individual in the electronic health record (ELMER) and process the initial authorization for service once the provider is selected.

Individuals Who Are Receiving Services at Time of MHL Enrollment:

Individuals receiving services through their local CMHSP will continue to receive services outlined in their current Plan of Service.

Individuals receiving services through a community Provider must call NorthCare Access to ensure their current Provider is participating on NorthCare's MHL Provider Panel;

The Provider is to submit the NorthCare Service Notification Form for MI Health Link Beneficiaries to NorthCare Access. This form will ensure that services being provided are added to the claim authorization in the client chart, which helps to facilitate accurate and timely processing of claims submitted for payment.

Authorization/Reauthorization

The individual cannot be billed for services. NorthCare Network requires a secure fax number for the provider to receive communication from NorthCare regarding ongoing service notifications. NorthCare Utilization Management (UM) reserves the right to deny or reduce ongoing authorization(s) due to treatment that is not deemed effective, documentation not supporting the need for treatment or ongoing treatment, or if the service is a non-covered benefit.

When authorization and/or documentation is completed in NorthCare's Electronic Health Record (ELMER) Providers have the benefit of:

- having the ability to request and receive service authorizations without faxing information back and forth
- easily look up available authorizations at any time; and
- view clinical documentation as authorized.

NorthCare's authorization processes are outlined in NorthCare Network's MI Health Link Program and Service Authorization Policy. All policies can be accessed at www.northcarenetwork.org.

Claims Processing

Clean claims must be sent within 30 days after the date of service to:

NorthCare Network
ATTN: Claims
1230 Wilson Street
Marquette, MI 49855

NorthCare will reimburse providers within 30 days of receipt of a clean claim. Providers are required to use the HCFA-1500.

Continuity of Care

The MHL program allows for a continuity of care period for up to 90 days from the date an individual enrolls in the MHL program. NorthCare will pay claims during this 90-day continuity of care period when the:

- individual has received a service from the provider within the previous 12 months
- provider is enrolled in Medicare and Medicaid

This continuity of care period allows for the Provider to be enrolled as a participating Provider on NorthCare's Provider panel or for the individual to be transitioned to a qualified participating Provider.

Claims received after the 90-day continuity of care period may be denied if the provider has not enrolled in NorthCare's provider panel and/or if service authorizations have not been secured.