



PROVIDER MANUAL

MENTAL HEALTH SERVICE AND SUPPORT PROVIDERS

JUNE 2014

Table of Contents

Welcome	3
About Pathways	3
Mission, Vision and Values	6
Mission	6
Vision	6
Values	6
Questions, Concerns, Contact Information	7
Pathways Responsibilities	8
Network Provider Responsibilities	8
Provider Coverage during Absences	9
Obligation to Report/Duty to Warn	9
Access Center	9
Customer Services	10
Education and Marketing	10
Rights and Protections of Individuals Served	10
Grievances and Appeals	11
Education	11
Advance Directives	12
Satisfaction	12
Financial Management	12
Participating Provider Payment Methodology and Fees	12
Claims Processing and Encounter Reporting	12
Coordination of Benefits	13
Restrictions on billing of consumers	13
Appeal Procedures	13
Information Management	14

Electronic Health Record.....	14
Record Keeping Requirements.....	14
Reporting.....	14
Provider Network Management.....	14
General Expectations	15
Debarment and Suspension.....	15
Network Provider Selection.....	16
Credentialing.....	17
Network Provider Monitoring.....	17
Contract Termination.....	17
Provider Disputes & Appeals Process.....	18
Quality Assessment and Performance Improvement	18
Performance Measures	18
Incident Reporting	18
Quality of Care.....	18
Quality of Service.....	19
Compliance and Ethics	19
Code of Conduct.....	19
Conflict of Interest.....	20
Privacy and Confidentiality.....	20
Service and Utilization Management.....	20
Utilization Management.....	20
Medical Necessity.....	21
Person Centered Planning and Self Determination	21
Clinical Practice Guidelines	22

Welcome

Welcome to Pathways Community Mental Health. Pathways is part of the NorthCare Network, which is the Prepaid Inpatient Health Plan for Medicaid Specialty Services and Supports for Michigan's Upper Peninsula. Pathways is committed to quality services for all individuals served by providing a well-established network of competent providers. Pathways developed this manual to provide fundamental information necessary to fulfill obligations as a provider of services and supports to individuals with a mental illness and/or who have intellectual/developmental disabilities. All policies, procedures and plans are available at: www.pathwaysup.org. All Network Providers are required to review these at our website. Each Network Provider will receive a notice of any new or updated policy, procedure or plan and are responsible for informing appropriate staff within your organization. We ask that you update your contact information as needed to ensure proper and timely notice is received by your organization.

Pathways operates as a Community Mental Health Service Provider (CMHSP) for persons living in Alger, Delta, Luce, and Marquette Counties. We provide services to persons with developmental disabilities, serious mental illnesses, serious emotional disorders (children and adolescents) and/or substance abuse disorders as requested by NorthCare and the Michigan Department of Community Health.

Pathways has 20,500 Medicaid covered lives in its region, and manages approximately \$46.5 million in Medicaid, Adult Benefit Waiver, General Fund, MI Child, and Children's Waiver revenue annually. We welcome you to the Pathways provider network, and ask you to work with us to continue to assure the most effective and best value services for our consumers.

About Pathways

Pathways to healthy living, is part of a public Community Mental Health System that has been in existence for over 40 years. Officially, Pathways was created in January of 1998 when Alger, Delta, Luce, and Marquette county mental health systems merged to form one mental health authority. Community Mental Health Centers were designed to support and treat people in their home communities versus institutional settings, and this change has not changed. We remain focused on providing services and supports that help people thrive in their own community.

Pathways offers services to adults with serious mental illness or developmental disabilities, and children with serious emotional disturbances regardless of their ability to pay for services. This is made possible through federal, state, county, and private funding. We service approximately 2,500 people annually. To learn more, visit www.pathwaysup.org.

• 1962 to 1963

Under the Kennedy administration, Community Mental Health Centers were created and received federal support. A minimum population base of 100,000 people was required in order to receive funding. Alger County, Marquette County, and Delta County collaborated to meet the minimum population requirement and began providing services.

• **Mid 60's**

Michigan Public Act 54 was established and this facilitated State funding of local mental health centers which are referred to as Act 54 Boards. At this time, outpatient clinic services were provided by Social Workers, Psychologists, and Psychiatrists.

• **1974**

Michigan Public Act 258 was established and this created Community Mental Health Boards. Delta County became a separate entity from Alger-Marquette County. PA 258 clearly identified the responsibilities of the Department of Social Services, State Hospitals, and Community Mental Health Centers as:

<u>DSS</u>	<u>State Hospitals</u>	<u>CMH</u>
Case Management	Inpatient Care	Outpatient Services
Residential Services		After Care

• **The late 70's...**

A shift in the Department of Social Services responsibilities to provide case management and residential services was transferred to Community Mental Health Centers. Funds could be secured from the Department of Mental Health to the location where the consumer was living; thus promoting local service for each consumer.

• **The early 80's...**

Community Mental Health became a full management agency and accepted responsibility for all public funding for mental health services. This included: outpatient services, in-patient treatment, residential services, and case management.

Newberry State Hospital patients continued to be placed into the community. To facilitate community living, day programs were established to help teach the needs skills to successfully adapt to community life for both people with developmental disabilities and mental illness.

• **The mid 80's...**

Title 19 Clinic Service Provider Status for Medicaid allowed for reimbursement of outpatient and partial day program services.

ACT, Assertive Community Treatment, programs were established to provide case management services to the chronically mentally ill, and focused on community technology as opposed to institutional technology. ACT promoted skill development that would allow consumers to live as independently as possible.

• **The late 80's**

Coordinated Community Planning began to promote collaboration among agencies and more efficient use of resources.

Supported employment programs flourished further advancing opportunities for the developmentally disabled and mentally ill to be productive and gain new skills. Job coaches were also developed to assist those who were not able to become or stay employed without assistance. The main function of the job coach was to help the employee learn the duties of their position and gradually fade out of the employment site.

• The early 90's...

Family Outreach Teams (FOT) were established to provide home based services primarily targeted to children. FOT also works with other family members to identify workable solutions to every day living.

Consumer-run Drop-in centers were created to provide opportunities for people with mental illness to socialize and support each other.

Fifteen final placements from Newberry State Hospital to our community were completed. In 1992, Newberry State Hospital closed.

• Mid 90's

Due to the skyrocketing cost of mental health services, the State of Michigan's Department of Community Mental Health strongly encouraged alliances and mergers to prepare Community Mental Health agencies for a competitive bid out and movement toward capitated funding to control costs. Mergers would allow CMH's to operate efficiently and to effectively manage the risk of operating in a capitated world.

Person-Centered Planning, a philosophy based on each person's unique desires, became a part of our mental health world. PCP was designed to move mental health services away from "canned" programs and services to individualized supports that were uniquely designed.

Self Determination, a unique program promoting consumer and family independence, was fast becoming a part of the mental health world. With Self Determination, consumers and families were able to propose and manage budgets that would support their unique needs.

A merger between Alger, Delta, Luce, and Marquette counties occurred January 1, 1998. Thus Pathways to healthy living was born and we prepared to position ourselves to survive the funding challenges of the future.

• A new century begins – 2000's...

Day programs were replaced by supporting people in their homes and communities in order to promote success in natural settings.

The State of Michigan shifted their approach from pursuing a competitive bid out of mental health funding to conditionally offering Community Mental Health Centers the first right to mental health funds as long as they continue to deliver quality services and offered administrative efficiencies.

The Eastern Upper Peninsula Substance Abuse Coordinating Agency merged with Pathways—thus adding the responsibility of managing the State of Michigan substance abuse funds for eight counties in the Upper Peninsula.

Upper Peninsula CMH's pooled together to form a regional alliance and submitted a proposal to the State requesting Pathways would serve as the lead agency for our region with the responsibility of receiving and managing mental health funds for the five Community Mental Health Boards. The State of Michigan accepted our application. This part of Pathways became known as NorthCare. (Oct 2002)

The State chose to limit the number of Prepaid Inpatient Health Plans (PIHP) and required that they separate from the CMH's. Effective January 1, 2014 NorthCare (PIHP) split from Pathways (CMH).

NorthCare is responsible for managing the Medicaid funds throughout the Upper Peninsula. Pathways contracts with NorthCare; Pathways providing the services, NorthCare paying with Medicaid, Healthy Michigan and MiChild. Pathways contracts directly with the State for General Fund services.

Pathways directly employs approximately 250 employees and provides services such as ACT, Behavioral Support Services, Case Management / Supports Coordination, CLS, Crisis Intervention, Health Services, Home-Based Services for Children and Families, Medication Management, Mental Health Therapy and Counseling for Adults, Children, and Families, and Skill-Building Assistance.

Pathways contracts out for many services also, such as Community Inpatient, CLS, Crisis Residential, Peer-Delivered Drop In Centers, Respite, Specialized Residential, Specialty Discipline (OT, PT, SLP, and Psychiatric), Transportation, and Vocational. These contracted services account for approximately \$27.8, which is about 60% of our overall budget.

Mission, Vision and Values

Mission

Pathways Community Mental Health supports individuals with severe mental illnesses, severe emotional disturbances, and developmental disabilities in their personal journey toward a self-directed life.

Vision

Pathways will operate at the forefront of national standards of excellence for providing community mental health services.

Values

- Intrinsic worth of every person
- Recovery and community integration
- Excellent clinical services
 - Incorporate evidence based practices
 - Skilled and diverse workforce
- Welcoming environment
 - Promote an inclusive and respectful community
 - Use a person centered approach
- Community partnerships
 - Education
 - Collaboration
- Effective methods of communication
- Anti-stigma efforts
 - Internally at Pathways
 - Community Memberships
- Fiscally responsible and accountable to the public

Questions, Concerns, Contact Information

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

Pathways Alger County Office
1516 Sand Point Road
Munising, MI 49862
906-387-3611

Pathways Delta County Office
2500 7th Avenue South, Suite 100
Escanaba, MI 49829
906-786-6441

Pathways Luce County Office
14126 County Road 428 West
Newberry, MI 49868
906-293-3284

Pathways Marquette County Office
200 West Spring Street
Marquette, MI 49855
906-225-7210

Toll Free to Any County: 888-728-4929
NorthCare Network Access Unit
1-888-906-9060 or 1-906-225-4433

Chief Executive Officer	Mary Swift mswift@up-pathways.org 906-225-9827
Chief Financial Officer	John Blemberg jblemberg@up-pathways.org 906-225-7214
Chief Information Officer Security Officer	Matt Maskart mmaskart@up-pathways.org 906-225-5138
Compliance Officer Contract Manager	Jeanne Lippens jlippens@up-pathways.org 906-233-1217
Customer Services Privacy Officer	Faye Witte fwitte@up-pathways.org 906-233-1210
Practice Guidelines	Chad Hale chale@up-pathways.org 906-226-0024
Utilization Management	Barbara Laughbaum blaughba@up-pathways.org 906-233-1256

Pathways Responsibilities

Through a contract with NorthCare, Pathways is responsible for the operation of the Concurrent 1915(b)/(c) Program within its designated service area. Operation of the Concurrent 1915(b)/(c) Program must conform to regulations applicable to the concurrent program and to each (i.e., 1915(b) and 1915 (c)) Waiver. Pathways 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 their contact. If Pathways elects to subcontract, Pathways shall comply with applicable provisions of federal procurement requirements, as specified in NorthCare's MDCH Contract - Attachment P 6.4.1.1. Pathways is responsible for complying with all reporting requirements as specified in their contract with the NorthCare Network and the MDCH.

Network Provider Responsibilities

In addition to specific responsibilities outlined in other sections of this manual and Pathways Policy, 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 Pathways' CEO and/or Contract Manager.* Changes 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 Pathways 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 Pathways to discuss alternative provider coverage arrangements in any situation when he or she is unable to directly provide the contracted service for an individual 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

Pathways 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 professional and legal requirements in Michigan. 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 Pathways 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 Center

Access to Pathways' services is obtained by calling the Pathways' centralized Access Center at 1-888-906-9060. The Access system functions as the front door for obtaining behavioral health services and they provide an opportunity for callers with perceived problems resulting from trauma, crisis, or problems with functioning to be heard, understood and provided with options including treatment and provider options. The Access system is available, accessible and welcoming to all Michigan residents on a telephone and a walk-in basis. Individuals calling for mental health or substance use disorder (SUD) services or supports are provided timely and welcoming access to eligibility screening.

Access system staff shall first determine whether the presenting mental health 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 presenting as relatively stable and able to function in their current environment are screened for eligibility and if appropriate are scheduled for a face-to-face assessment.

Individuals who are denied services are given an appropriate referral and verbally informed about the right to request a second opinion. A notice of denial for an initial assessment must also be given which includes specific contact information and instructions on appeal rights.

Customer Services

Pathways 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 are mandated functions by the Michigan Department of Community Health and Standards in the Balanced Budget Act.

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

Education and Marketing

All educational materials (both written and on the Pathways website) and other general written communication must be accurate and clearly represent the activities/services provided by Pathways and Network Providers. Documents, as appropriate will indicate that they were paid for with funds from the Michigan Department of Community Health.

All providers shall abide by:

- The Balanced Budget Act
- MDCH Contract Attachment P.6.3.1.1 (Information Requirements 6.3.3)
- URAC Standard Core 10a: PMR 1, b,c,d: PMR 5a.b.; P-MR 10.

Rights and Protections of Individuals Served

Recipient Rights and Protections are delineated in the legal authority 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:

- Recipient 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,
- Pathways 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

All consumers have the right to a fair and efficient process for resolving complaints regarding their services and supports managed and/or delivered by Community Mental Health Services Programs (CMHSPs) and their provider networks. A recipient of or applicant for public mental health services may access several options to pursue the resolution of complaints. These options are defined through the Recipient Rights requirements referenced in the Michigan Mental Health Code (hereafter referred to as the Code) for all recipients of public mental health services, and the MDCH/CMHSP contract. Additional options for Medicaid beneficiaries are explained in the Appeal and Grievance Technical Requirement located in Attachment P.6.3.2.1 of the MDCH contracts with the Pre-paid Inpatient Health Plans (PIHPs). It is important to note that an individual receiving mental health services and supports may pursue their complaint within multiple options simultaneously.

All consumers must receive "due process" whenever benefits are denied, 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 consumers 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 well 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

Individuals will be informed of their rights as outlined by the Michigan Administrative Rules 325.14301-14306 and as indicated in the Pathways policy. Individuals 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 change in policy or in forms requires staff training before implementation.

Advance Directives

Pathways must provide adult consumers with written educational information on advance directives policies and include a description of applicable state law. 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 Pathways Advance Directive 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 website (www.northcare-up.org) and the Michigan Department of Community Health website (www.michigan.gov/mdch) have detailed information about Advance Directives and several forms that may be accessed by individuals or the staff working with them.

Satisfaction

The Provider shall cooperate fully in Pathways implementation of: (1) quantitative and qualitative member assessments periodically, 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

The Michigan Department of Community Health (MDCH) provides NorthCare 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 Pathways using an actuarially sound methodology. Pathways receives directly from MDHHS General Fund dollars.

Claims Processing and Encounter Reporting

Pathways reports encounter data to NorthCare, who in turn reports to the Michigan Department of Health and Human Services (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. Pathways is responsible for complying with all reporting requirements as specified in their contract with NorthCare and the Michigan Department of Health and Human Services; therefore, Contract Providers are responsible for ensuring that documentation is completed and signed within one business day of service delivery. Pathways is responsible for ensuring receipt of sub-contract invoices and that claims data is entered into ELMER within 15 days of the month following the services. Network Providers

are to submit claims by the 15th of each month for the prior month's services. Pathways is responsible for monitoring the completion of all QI fields for every individual served.

Coordination of Benefits

Pathways 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 Liabilities (TPL) before Medicaid. 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 an individual's covered benefit. It is expected that complete and accurate Coordination of Benefits are obtained for all individuals served. Pathways is responsible for verification of, and the accurate and timely recording of, Medicaid Benefits, and all TLPs in the ELMER Insurance and Demographic section of each individual's electronic health record. Pathways and Network Providers 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, Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 14 *Page 50 MA* and the Michigan Mental Health Code and Public Health Code section 226a as applicable. Pathways 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 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, Pathways 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. Full consumer billing criteria is outlined in the attached MMHC Chapter 8.

Appeal Procedures

As part of the Ability To Pay (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, 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 department or community mental health services program to make a new determination of ability to pay, and the department or community mental health services program 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 Pathways managed equipment or Business Associate managed equipment. No personal equipment shall be used to gain access to Electronic Health Systems.

Record Keeping Requirements

Any questions regarding record keeping requirements should be directed to Pathways Contract Manager.

Reporting

Pathways is responsible to provide data reports to several entities; most of which is to comply with our contract with NorthCare and the Michigan Department of Health and Human Services (MDHHS). The reporting of data by Pathways is used to meet several purposes at MDHHS including: legislative boilerplate and 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 Pathways, NorthCare and MDCH 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. Pathways 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 Pathways 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 Pathways is accurate and timely, as required by Pathways.

Provider Network Management

In order to provide quality services to consumers, it is necessary for Pathways and the network providers to establish and maintain a cooperative relationship. Individuals must be excluded from any dispute between the network provider and Pathways. 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, Pathways and 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, national origin, ancestry, age, sex, height, weight, marital status, physical or mental disability unrelated 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. Pathways and 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 in to account travel time, availability of public transportation, and other factors that may affect accessibility; and, that the location of primary service providers is within 60 minutes/60 miles from beneficiary's residence for office or site-based services;
- ✓ not segregate Pathways individuals in any way from other individuals receiving their services, and offer hours of operation to Pathways individuals that are no less than the hours offered other individuals 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 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 Pathways that the Network Provider will comply with Federal Regulation 45 CFR Part 76 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 preceding this agreement 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 preceding this agreement had one or more public transactions (federal, state or local) terminated for cause or default.

Network Provider Selection

It is the policy of Pathways to develop and maintain a Provider Network that meets the needs of individuals for Mental Health Specialty Supports and Services and Substance Use Services in the Upper Peninsula of Michigan. Pathways will continually assess individual needs and provide 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.

Pathways 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. Pathways 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 Pathways 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 Pathways. 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 Pathways will be given the opportunity to compete for contracts. Contracts will be awarded in accordance with Pathways *Procurement Policy*. This policy also lists certain circumstances where Pathways' 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 Pathways 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 *Pathways Network Provider Grievance and Appeals Policy*.

Credentialing

Pathways assures due diligence in credentialing and re-credentialing to provide a competent workforce for the individuals we serve. The Balanced Budget Act (BBA) and the Michigan Department of Health and Human Services (MDHHS) and URAC have regulations and policies and standards that require managed care entities to follow clearly defined policies and procedures for credentialing and re-credentialing staff. The Pathways Credentialing Policy(ies) 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 re-credentialing must be completed every two years thereafter.

Pathways utilizes standard applications for all providers, whether an individual or an organization, that applies for participation in the provider network. The appropriate form will be provided to interested providers and can also be found at www.pathwaysup.org.

Network Provider Monitoring

Pathways monitors each network provider for the purposes of ensuring compliance with Federal and State standards and regulations, provider contracts, Pathways 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. Pathways may delegate provider monitoring and monitoring of direct operated group homes to Member CMHSPs and Substance Use Disorder (SUD) providers. Pathways will monitor all delegated activities. Clinical documentation reviews and verification of services will be part of provider monitoring.

Contract Termination

Either Pathways 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 an individual’s 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, Pathways must be notified in writing as indicated in the provider contract. Pathways will acknowledge receipt of the provider’s request and confirm the disenrollment date. If Pathways chooses to terminate a contract written notification of the termination including the effective date, will be given as specified in the provider contract.

Provider Disputes & Appeals Process

All participating providers in the Pathways network have the right to dispute actions taken by Pathways 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 Pathways provider monitoring process or instances when Pathways 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 Pathways Network's *Network Provider Grievance and Appeals Policy* and does not apply to medical necessity appeals (which are covered under Utilization Management Policy) or conditions dictated in the provider contract that result in immediate termination such as 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. 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 requirement of the 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 Pathways 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 Pathways according to Pathways *Event Reporting & Notification Policy*.

Quality of Care

In order to ensure high quality of care for our members, Network 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 Pathways Utilization Management and Performance Improvement Programs as detailed in the provider contract and adhere to the following access to care standards as stipulated by the Michigan Department of Health and Human Services (MDHHS).

Quality of Service

Pathways has identified a minimum set of standards to ensure quality of service for our individuals, including:

- Access to emergency service 24 hours a day, seven days a week
- Office hours that reflect individual need and must provide individuals with a 24 hour, seven 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 individuals; it is our expectation that consumers are 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.

Compliance and Ethics

Pathways Compliance Program is designed to further Pathways commitment to comply with applicable laws, promote quality performance throughout Pathways, and maintain a working environment that promotes honesty, integrity and high ethical standards. Pathways Compliance Program is an integral part of Pathways mission, and all Pathways Personnel and Network 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, Balanced Budget Act, 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 Pathways Compliance Officer with any questions.

Code of Conduct

Network Providers are expected to conduct themselves in accordance with standards set forth in the Pathways Code of Conduct, applicable federal and state laws, rules and regulations, Pathways 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 individuals 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 but the appearance of Conflicts of Interest as well. Network Providers shall disclose all potential or known Conflicts of Interest to Pathway.

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 healthcare operations unless it is protected under the Michigan Mental Health Code or 42 C.F.R. Part 2.

Except as otherwise required by law (e.g. Mental Health Code, 42 CFR, Part II relative to substance abuse services, HIPAA), consumer identifying and confidential information shall not be released without an appropriately signed "Authorization to Disclose Confidential 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 Pathways policy. 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.

Service and Utilization Management

Utilization Management

Pathways is accountable for managing the specialty services and support benefits for eligible persons in its service area. As a result, Pathways 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.

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 the Medicaid and ABW 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. Pathways 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. Pathways is equally committed to assuring the various programs within our provider network operate effectively and efficiently. 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.

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 PCP as *"Person-centered planning" means 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 abuse disorders), and children with serious emotional disturbance to live successfully in their communities—achieving community inclusion and participation, independence, and productivity. Person-centered planning (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.

Person-centered planning 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 individual's 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 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.

Person-centered planning (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 Practice Guidelines

Pathways is responsible for adopting, implementing and evaluating regional practice guidelines. (See the Balanced Budget Act (BBA), subpart D, section 438.236 and the Michigan Department of Community Health Master Contract Attachment P 6.7.1.1, X.) 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. Pathways Recovery policy mandates that all services and supports be based on recovery principles. 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.

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