Fiscal Year 2017 Substance Use Disorder - Treatment
Contractual Agreement

Between

Mid-State Health Network
530 W. Ionia, Ste. F
Lansing, MI 48933
517-253-7525

And

For the purpose of:

Treatment

Payment by:

TABLE OF CONTENTS

ACRONYM AND GLOSSARY DEFINITIONS

"Admission" is that point in an individual's relationship with an organized treatment service when the intake process has been completed and the individual is entitled to receive services of the treatment program.

"AMS" stands for Access Management System which is required by the Michigan Department of Community Health to screen, authorize, refer and provide follow-up services.

"ASAM" stands for the American Society for Addiction Medicine. It is the medical association for Addictionologists. The members developed the patient placement criteria. The most recent is The ASAM Criteria, 3rd Edition.

"ASI" stands for Addiction Severity Index and is a semi structured interview designed to address seven potential problem areas in clients with substance use disorders for determining level of care.

"Assessment" is those procedures by which a program evaluates an individual's strengths, weaknesses, problems and needs, and determines priorities so that a treatment plan can be developed.

"Care Coordination" and/or "Case Management" means facilitating access to services, community and natural supports to ensure consumer needs are met.

"CareNet" is the web-based data system used by MSHN for collection of state and federal data elements, PIHP performance indicators, utilization management (authorization of services), and reimbursement.

"Clean Claim" means a claim that can be processed without obtaining additional information from the PROVIDER, which is properly completed and contains all data elements necessary for processing in accordance with MSHN policies with all required data fields completed. It does not include a claim from a PROVIDER who is under investigation for fraud or abuse, or a claim under review for medical necessity.

"CMHSP" means Community Mental Health Service Program.

"Co-Occurring Disorders" are concurrent substance-related and mental disorders. Use of the term carries no implication as to which disorder is primary and which secondary, which disorder occurred first, or whether one disorder caused the other.

"Continued Service Criteria" is in the process of client assessment, certain problems and priorities are identified as justifying admission to a particular level of care. Continued Service Criteria describe the degree of resolution of those problems and priorities and indicate the intensity of services needed. The level of function and clinical severity of a client's status in each of the six assessment dimensions is considered in determining the need for continued service.

"Continuum of Care" is an integrated network of treatment services and modalities, designed so that an individual's changing needs will be met as that individual moves through the treatment and recovery process.

"Consumer" means any individual who is determined by MSHN to be eligible for publicly funded substance use disorder treatment benefits.

"Consumer Handbook" means a written and comprehensive document provided to all consumers indicating the services covered under this plan, access to those services, and any limitations to services that may apply.

"Cost-Reimbursement" means Contract pricing method under which allowable and reasonable costs incurred by a contractor in the performance of a contract are reimbursed in accordance with the terms of the contract.

"Covered PROVIDER or PROVIDER" means a licensed substance use disorder facility or other health professional, a licensed hospital, or any other health care entity having an Agreement with MSHN to provide Covered Services to consumers enrolled in MSHN.

"Covered Services" means the medically necessary behavioral health service as amended from time to time in

accordance with this Agreement, and which PROVIDER is qualified and responsible for providing to covered consumer, in accordance with MSHN policies and procedures in return for payments by the MSHN under this Agreement and listed on Attachment B.

"Cultural Competency" is defined as a set of values, behaviors, attitudes, and practices within a system, organization, and program or among individuals and which enables them to work effectively cross culturally. Further, it refers to the ability to honor and respect the beliefs (including religious), language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long term commitment and is achieved over time.

"Discharge Summary" is the written summary of the client's treatment episode. The elements of a discharge summary include description of the treatment received, its duration, a rating scale of the clinician's perception of investment by the client, a client self-rating score, description of the treatment and non-treatment goals attained while the client was in treatment, and detail those goals not accomplished with a brief statement as to why. "Discharge/Transfer Criteria" is in the process of client assessment, certain problems and priorities are identified as justifying treatment in a particular level of care. Discharge/Transfer Criteria describe the degree of resolution of those problems and priorities and thus are used to determine when a client can be treated at a different level of care or discharged from treatment. Also, the appearance of new problems may require services that can be provided effectively only at a more or less intensive level of care. The level of function and clinical severity of a client's status in each of the six assessment dimensions is considered in determining the need for discharge or transfer.

"DSM-V" is the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, by the American Psychiatric Association. It is a practical and useful tool for clinicians with brevity of criteria sets, clarity of language, and explicit statements of the constructs embodied in diagnostic criteria.

"Early Intervention" is a specifically focused treatment program including stage-based intervention for individuals with substance use disorders as identified through a screening or assessment process including individuals who may not meet the threshold of abuse or dependence. (The ASAM Criteria, 3rd Edition Level .05 Early Intervention)

"**Encounter**" is used for billing purposes related to treatment services, recovery support, and early intervention services to indicate a measure of time spent providing a service with a consumer. A minimum of fifteen (15) minutes must be spent with a consumer in order to use this code for either recovery support or early intervention services. No more than one encounter may be billed per consumer within any twenty-four (24) hour time period.

"Episode of Care" is the period of service between the beginning of a treatment service for a drug or alcohol problem and the termination of services for the prescribed treatment plan. The first event in this episode is an admission and the last event is a discharge. Any change in service and/or provider during a treatment episode should be reported as a discharge, with transfer given as the reason for termination. For reporting purposes, "completion of treatment" is defined as completion of all planned treatment for the current treatment episode.

"Fee-for-Service" means payment for each service provided.

"FSR" means Financial Status Report

"HHS" means the United States Department of Health and Human Services.

"HMP" stands for Healthy Michigan Plan which became effective on April 1, 2014 in Michigan as a Medicaid expansion program to serve newly enrolled persons, and has also expanded the array of services available under this new benefit for persons with substance use disorders in need of treatment.
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"LOS" means Length of Stay.

"MDHHS" means the Michigan Department of Health and Humans Services.

"Medicaid Program" or **"Medicaid"** means the MDHHS program for medical assistance established under Section 105 of Act No. 280 of the Public Acts of 1939, as amended, MCLA 400.105, and Title XIX of the Federal Social Security Act, 42. U.S.C. 1396, et. seq.

"Medical Necessity" means determination that a specific service is medically (clinically) appropriate and necessary to meet a client's treatment needs, consistent with the client's diagnosis, symptoms and functional impairments and consistent with clinical Standards of Care.
In considering the appropriateness of any level of care, the four basic elements of Medical Necessity should be met:

1. Client is experiencing a Substance Use Disorder reflected in a primary, validated, DSM5 or ICD-10 Diagnosis (not including V Codes) that is identified as eligible for services in the MSHN Provider Contract.
2. A reasonable expectation that the client's presenting symptoms, condition, or level of functioning will improve through treatment.
3. The treatment is safe and effective according to nationally accepted standard clinical evidence generally recognized by substance use disorder or mental health professionals.
4. It is the most appropriate and cost-effective level of care that can safely be provided for the client's immediate condition based on The ASAM Criteria, 3rd Edition.

"Medically Necessary Services" means substance use disorder treatment services that are necessary for screening and assessing the presence of a substance use disorder, and/or are:

- Required to identify and evaluate a substance use disorder that is inferred or suspected and/or are;
- Intended to treat, ameliorate, diminish or stabilize the symptoms of substance abuse including impairment on functioning and/or are;
- Expected to arrest or delay the progression of a substance use disorder and to forestall or delay relapse and/or are;
- Designed to provide rehabilitation for the clients to attain or maintain an adequate level of functioning.
- Symptom alleviation alone is not sufficient for purposes of admission.

"MSHN" – Mid State Health Network – Prepaid Inpatient Health Plan (PIHP) responsible for twenty-one counties in the MSHN region as of January 1, 2014. www.midstatehealthnetwork.org

"Non-Covered Services" means any and all services, including medically necessary services, not defined as Covered Services by this Agreement.

"Non-Urgent" means a situation not determined to be emergent or urgent in nature.

"OROSC" means Office of Recovery Oriented Systems of Care; State office formerly known as Bureau of Substance Abuse and Addiction Services (BSAAS).

"Peer Support/Recovery Supports" are programs designed to support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary for an individual's recovery. Peer Recovery programs are designed and delivered primarily by individuals in recovery and offer social, emotional, and/or educational supportive services to help prevent relapse and promote recovery.

"MSHN-SUDSP MANUAL**"** means policies and procedures established by MSHN and titled "Mid-State Health Network Substance Use Disorder Services Provider Manual (MSHN-SUDSP Manual), which governs the provision of services covered by this plan by the PROVIDER to the covered consumer. Also referred to as SUD Manual, Provider Manual. See MSHN website at Substance Use Disorder link

"Rate Schedule" means the schedule of charges for Covered Services attached hereto as Attachment D and including any amendments thereto.

"Recovery" means a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. SAMHSA states Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations.

“RISC” means Recovery and Integrated Services Collaborative; regional effort to embed recovery-oriented systems of care (principles and practices) throughout the service PROVIDERS network. Collaborative effort of substance use and mental health PROVIDERS. Comprised of prevention PROVIDERS, treatment PROVIDERS, community members, and individuals in recovery.

“ROSC” means Recovery Oriented System of Care.

"SPF" means Strategic Prevention Framework.

"Stage of Change" means assessing an individual's readiness to act on new healthier behavior while providing strategies or processes of change to guide the individual to action and maintenance. Stages of Change include:

- Pre-contemplation: "People are not intending to take action to change behaviors in the foreseeable future, are most likely unaware that their behavior is problematic, and are not considering change at this stage."

- Contemplation: "People have become aware that a problem exists, may be beginning to recognize that their behavior is problematic and that they should be concerned, start to look at the pros and cons of their continued actions, but are typically ambivalent about their use and changing their behavior."

- Preparation: "People understand the negative consequences of continued behavior outweigh any perceived benefits, are intending to take action in the immediate future, may begin specific planning for change, setting goals, and making a commitment to take small steps towards change."

- Action: "People have chosen a strategy for change and are actively pursuing it by making specific, overt, and drastic modifications in their life style (significant challenges for the person), and positive change has occurred."

- Maintenance: "People are working to sustain positive change, prevent relapse, become aware of situations that will trigger negative behavior, and actively avoid those when possible" a stage which can last indefinitely."

“SUDPDS” means Substance Use Disorder Prevention Data System (also referred to as MPDS) .

“Support Services” are those readily available to the program through affiliation, contract or because of their availability to the community at large (for example, 911 emergency response services). They are used to provide services beyond the capacity of the staff of the program on a routine basis or to augment the services provided by the staff.

“Transfer” is the movement of the client from one level of service to another, within the continuum of care.

“Treatment” is the application of planned procedures to identify and change patterns of behavior that are maladaptive, destructive and/or injurious to health; or to restore appropriate levels of physical, psychological and/or social functioning.

“Urgent” means that the risk of harm to self or others and/or decompensation requires immediate attention. “Urgent situation” means a situation in which an individual is determined to be at-risk of experiencing a substance use disorder or mental health crisis in the near future, without the intervention of care, treatment, or support services. Note: Priority population clients seeking substance use disorder services that meet the level of care criteria for admission to detoxification or residential services are an urgent situation. “Urgent population” means ‘pregnant’ for the purposes of this Agreement as defined by MDHHS.

FY 2017 CONTRACTUAL AGREEMENT

This Agreement is entered into by Mid-State Health Network (hereinafter referred to as "MSHN") and referred to as "PROVIDER") and is effective from October 1, 2016, through September 30, 2017.

I. GENERAL CONTRACT SUMMARY

MSHN and PROVIDER wish to enter into an Agreement whereby the PROVIDER will render treatment and/or prevention services to consumers for whom MSHN arranges such services. The relationship between MSHN and PROVIDER is that of independent contractor and not of employer and employee or principal and agent. Neither party shall give any contrary indication or representation to any covered consumer, to any other consumer or entity, or to the public at large.

Therefore, in consideration of the Agreements set forth below, and intending to be legally bound, MSHN and PROVIDER hereby agree as follows:

A. **Statement of Work:** PROVIDER agrees to undertake, perform and complete the services described in Attachment A that is hereby made a part of this Agreement. Additionally, PROVIDER agrees to follow all MDHHS and OROSC technical advisories and policies that are relevant to identified services for which they are contracted**.**

B. **Method of Payments and Performance Indicators:** The payment procedures and performance indicators shall be followed as described in Attachment B that is hereby made a part of this Agreement by reference.

C. MSHN-SUDSP Manual**.** that is hereby made a part of this Agreement by reference. Contractual and data reporting requirements, located in the MSHN-SUDSP Manual, are also made part of this Agreement through reference. PROVIDER will submit required information using MSHN forms and formats effective on date of this Agreement. MSHN will not change reporting forms or formats unless reasonable circumstances exist or the State or Federal government require a change, in which case MSHN will notify PROVIDER, allowing as much notice as is possible. MSHN reserves the right to modify, add to or delete from the SUDSP Provider Manual at any time for any reasons, and that reasonable notice, as circumstances permit, will be provided with as much advance notice as possible to the effective dates of changes.

D. **Additional Attachments:** PROVIDER is required to comply with language in all attachments to this contract as they apply.
Attachment A Statement of Work
Attachment B Cost Reimbursement
Attachment C HCPCS/CPT Code Narrative Description
Attachment D Service Rate Fees
Attachment E Performance Indicators
Attachment F Business Associate Agreement
Attachment G Provider Reporting Due Date Requirements

II. TREATMENT SERVICE OBLIGATIONS OF THE PROVIDER

A. General Provisions

1. **Authorization:** MSHN shall not make any payment for PROVIDER services rendered to persons who are not eligible for services; for services to eligible consumers which are, in the opinion of MSHN, determined not to be Medically Necessary; services that constitute optional care; or services that have not been properly authorized by MSHN through its Access Center. With the

exception of situations as defined in the **MSHN-SUDSP Manual**., PROVIDER shall obtain specific authorization from the Access Center prior to providing Covered Services to an eligible consumer. Each Access Center authorization for Covered Services shall expire upon the earlier of (i) expiration date specified in the authorization and/or **MSHN-SUDSP Manual**. and (ii) termination of this Agreement. Authorization requests shall be based on clinical eligibility and medical necessity as defined in the **MSHN-SUDSP Manual**.. MSHN obligation to pay any claim shall be subject to MSHN verification of a consumer's status as a Member or financial eligibility at the time the service was rendered. If the consumer did not meet eligibility criteria and is not a Medicaid or Healthy Michigan Plan covered consumer at the time the service was delivered, the PROVIDER may bill the consumer for the service. In no case shall a Medicaid or Healthy Michigan Plan covered consumer be billed for any service or for any portion of a service. The PROVIDER must use Carenet's assessment tool as part of the initial assessment of eligible consumers entering a treatment episode. Please see the **MSHN-SUDSP Manual**. for applicable policies and/or procedures.

2. **Care Management:** PROVIDER agrees to fully cooperate with MSHN by: (i) accepting all pre-certifications, concurrent reviews and retrospective review findings by MSHN to determine Medical Necessity for payment of benefits subject to the applicable appeal procedures as described in the **MSHN-SUDSP Manual**. and (ii) following the procedures outlined for the filing of an appeal or grievance related to the determination of Medical Necessity for payment of benefits as described in the **MSHN-SUDSP Manual**.. PROVIDER acknowledges that the failure to follow the terms of MSHN policies and procedures may result in a reduction in the amount of payments to PROVIDER. PROVIDER further agrees that MSHN has no programmatic responsibility or liability for such Care Management. Reference the **MSHN-SUDSP Manual**. for applicable policies and/or procedures.

3. **Admission Preference: Persons presenting with Medicaid or Healthy Michigan Plan (HMP) are entitled to medically necessary SUD services.** Preference for treatment admission shall be applied in the following order (from highest priority to lowest): (i) pregnant injecting drug users; (ii) pregnant substance abusers; (iii) injecting drug users; (iv) a parent whose child has been removed from the home under the Child Protection Laws of this State or is in danger of being removed from the home under the Child Protection Laws of this State because of the parent's substance use; and (v) all others. Consumers identified in i, ii, iii and iv above are prioritized regardless of county of residence (county of residence must be identified within MSHN region for Medicaid). In the State of Michigan, an injecting drug user is defined as anyone who has injected a drug within the last thirty (30) days.

4. **Interim Services:** Interim services must be provided within forty-eight (48) hours to: (i) injecting drug users who cannot be admitted to treatment within fourteen (14) days and (ii) pregnant women who cannot get into treatment immediately. Interim services are defined in Treatment Policy #7 contained in the SUD Services Policy Manual from the MSHN website.

5. **Waiting List:** Outpatient, Residential and Detox PROVIDER should notify the Access Center Manager immediately when they have to implement a waiting list and when the waiting list has ended. Persons with Medicaid or HMP eligibility may not be put on a waiting list. If necessary residential and detox services are not available to a Medicaid or HMP eligible recipient, other appropriate service options must be made available.

6. **Residency Determination**: In order to determine residency, PROVIDER shall request any one of the following documents for verification (the document must include a current or updated regional address):

   - State Driver's License
   - State ID Card

- Voter Registration Card
- Utility bill in the consumer's name
- Medicaid County of Eligibility

If the consumer cannot produce any of these documents, PROVIDER must have the consumer sign an attestation stating the consumer is either homeless or is living in MSHN region temporarily with a plan to move to the region permanently. The attestation can be an added sentence(s) in the case file on a form where the consumer(s) provide signature(s) or it can be a separate document.

In cases where the consumer has Medicaid, or HMP, the consumer must have their county status update/changed within 30-60 days. In cases where the consumer is eligible for block grant funding, the consumer must provide documentation that action has been taken to establish residency within 30-60 days. Documentation of all relevant paperwork and actions taken by both consumer and/or provider should be maintained in the case file.

Considerations for exceptions to this policy shall be reviewed on a case-by-case basis.

B. Billing Provisions

1. **Invoicing:** PROVIDER will follow procedures outlined in the **MSHN-SUDSP Manual**. for billing and submitting claims to MSHN. PROVIDER shall generate a claim using Carenet requesting reimbursement for authorized services. Additional information is contained within the MSHN-SUDSP MANUAL**.**

2. **Cost Reimbursement for Treatment Providers:** PROVIDER will follow "Billing Provisions 1. Invoicing" above as well as submit a monthly FSR for reimbursement. FSR's are due monthly no later than the 10th of the month following the service date. Additional information is contained within the MSHN SUDSP Manual

3. All claims must be generated twice per month on Carenet, following the established calendar due dates posted on the MSHN website.. If PROVIDER is unable to electronically submit claims, for technological reasons for a specified period of time, a temporary resolution may be negotiated between MSHN and PROVIDER. If MSHN is unable, for technological reasons, to accept Carenet claims, PROVIDER will be notified to submit claims on disk (or on paper, if the PROVIDER's billing system cannot save claims to disk). PROVIDER will adhere to the Unit of Service Duration guidelines, contained in the **MSHN-SUDSP Manual**, for file documentation and claims submission for services provided by community block grant, HMP and Medicaid funding.

4. Claims must be submitted in a timely manner. A claim must be initially received and acknowledged within 12 months from the date of service (DOS) to be considered for reimbursement. Claims over one year old must have continuous active review. A claim replacement can be resubmitted within 12 months of the latest remittance advice date or other activity.

5. **Fees:** PROVIDER is responsible for making reasonable efforts (minimum: 2 billing attempts) to collect first and third party fees, deductibles, co-pays, and co-insurances where applicable, and report these in Carenet as primary, secondary, etc. Any under-recoveries of otherwise available fees, resulting from failure to bill for eligible services, will be excluded from reimbursable expenditures. Fees and collections information on MSHN consumers will be submitted to MSHN in accordance with the MSHN-SUDSP MANUAL that is hereby made a part of this Agreement by reference.

6. **Payments:** Medicaid/HMP funding is to be considered the last source of funding, if the consumer is also covered under Medicare or other third party payers. Refer to the MSHN-

SUDSP MANUAL for billing procedures when Medicare or third party insurance is involved. If claims for a consumer were billed under block grant funding, and it was later determined that the consumer was Medicaid/HMP eligible, any co-pay amounts collected by the PROVIDER must be refunded to the consumer. All payments by MSHN for authorized services are contingent upon the availability of funding. If community block grant resources are not available to cover services, MSHN will notify PROVIDER at the time the service is authorized. PROVIDER agrees that compensation for services will be made by MSHN in accordance with Attachment D. Payment for services rendered less any applicable co-payment, deductibles, co-insurance, or third party reimbursement amounts in accordance with this Agreement shall be made within thirty (30) days following the receipt of a Carenet claim, except when the claim is contested in good faith. PROVIDER shall have no right to reimbursement for services provided to MSHN consumer without prior authorization of MSHN, unless otherwise provided herein. PROVIDER acknowledges that it will not receive compensation from MSHN for any services that are not listed in attached schedule (Attachment D). PROVIDER is solely responsible for the collection of all co-payments, deductibles and co-insurance and shall not bill MSHN for any amount owed. Medicaid and Healthy Michigan Plan covered consumers shall not be billed for services or any portion of the cost of those services.

Except as provided in the fee scale, PROVIDER hereby agrees that in no event, including but not limited to non-payment by insolvency or breach of this Agreement, shall PROVIDER bill, charge, collect from, seek compensation, remuneration or reimbursement from, or have any recourse against MSHN consumers or persons other than MSHN acting on MSHN consumers' behalf for services provided pursuant to this Agreement. PROVIDER further agrees (i) that this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of MSHN consumer and (ii) that this provision supersedes any oral or written contrary Agreement now existing or hereafter entered into between PROVIDER and MSHN consumer or person acting on MSHN consumer's behalf.

NOTE: If a consumer is receiving residential treatment services, PROVIDER shall not bill MSHN for days the consumer was not in residence during the treatment episode, with the exception that any time in which a consumer is not present during the residential treatment episode, the MSHN UM department has approved the billed service if appropriate.

For cost reimbursement contracts, the, PROVIDER may receive 1/12th of the budgeted amount as an advance. Subsequent months will be reimbursed based on actual costs, submitted via a Financial Status Report (FSR). The advance must be paid back to MSHN once the pilot program is terminated or the level of care/service is converted to a fee-for-service method of reimbursement. Reference the MSHN-SUDSP MANUAL for applicable policies and/or procedures.

PROVIDER Appeal Process: If MSHN should deny PROVIDER any additional compensation to which PROVIDER believes it is entitled, PROVIDER shall notify MSHN in writing within thirty (30) days of the date of notification of denial, stating the grounds upon which it bases its claim for such additional compensation. Should MSHN fail to pay or adequately provide for such additional payment to PROVIDER within the thirty (30) days following receipt of notification from PROVIDER, PROVIDER shall have the right and process of appeal as set forth in the Grievance and Appeals Process defined in the **MSHN-SUDSP Manual**. Reference the MSHN-SUDSP MANUAL for applicable policies and/or procedures.

7. **Duplicate Coverage**: PROVIDER will collect information concerning duplicate coverage, workers' compensation and personal injury liability at the time of treatment or admission and will provide such information to MSHN. In the event that benefits available through MSHN are determined to be secondary to those of any other health care coverage with respect to Covered Services, PROVIDER shall seek reimbursement pursuant to such other coverage

prior to submitting a claim to MSHN. Any secondary payment shall be determined in accordance with applicable terms of MSHN policies and procedures and Medicaid Plan in effect for each consumer, taking into account amounts billed to and that portion paid by the primary payor. PROVIDER shall cooperate in administering coordination of benefits and other third party reimbursement provisions. PROVIDER agrees to accept the lesser of the primary allowable or MSHN contracted amount as payment in full for a covered service or activity if MSHN is the secondary coverage for any combination of payors, including other carriers which pay before MSHN in the coordination of benefits order of benefit determination. Reference the MSHN-SUDSP MANUAL for applicable policies and/or procedures.

8. **Warranty:** By submitting a claim, PROVIDER warrants and represents that the services for which the claim is made were properly and completely provided to a Medicaid consumer or MSHN eligible consumer, that the services claimed were medically necessary at the time they were delivered, and that the proper documentation of the service exists at the time the claim is submitted. MSHN shall have the right to review PROVIDER records, upon reasonable notice and during business hours, to verify that such services were rendered and shall have the right to reclamation of any amount claimed where these standards have not been met.

9. **Obligations to Continue Care:** In the event of any termination of this Agreement (by reason of insolvency or otherwise), PROVIDER agrees that it shall continue providing services to consumers receiving treatment until implementing and completing an approved transition plan which may include referral to another appropriate service or an orderly discharge. The PROVIDER shall then relinquish all relevant clinical documents, billing information for each recipient, all medications and personal property of recipients and any equipment purchased with the MSHN funds that has not been fully depreciated. This provision shall not prohibit collection from consumers of appropriate amounts with respect to deductible amounts, co-payments, co-insurance and/or non-Covered Services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, in accordance with the terms of the applicable consumer's Subscriber Agreement. The provisions of this Agreement shall remain in effect until the transition plan has been fully executed.

C. Other Provisions

1. **Quality Assurance:** PROVIDER shall cooperate with MSHN and participate in and comply with all peer review program, utilization review, quality assurance and/or total quality management programs, audit systems, site visits, grievance procedures, satisfaction surveys and other procedures as established from time to time by MSHN, or as required by regulatory or accreditation agencies. PROVIDER shall be bound by and comply with all final determinations rendered by each such peer review or grievance process.

2. **Credentialing/Re-Credentialing:** PROVIDER agrees to meet criteria for acceptance in the MSHN PROVIDER network including compliance with all applicable Federal and State laws, rules and regulations, and required criminal background checks, and accepts and shall abide by all credentialing procedures, re-credentialing requirements, quality improvement standards policies, principals and procedures developed from time to time by MSHN including without limitation the provisions of the MSHN-SUDSP MANUAL. MSHN retains the right to approve, suspend or terminate providers from participation in the Medicaid-funded services (e.g., exclusions from Medicare/Medicaid; specific regional performance issues and/or criminal convictions under sections 1128(a) and 1128(b)(1)(2) or (3)-See also MDHHS/PIHP Contract Attachment PII B.A. Substance Abuse Disorder Policy Manual.

   PROVIDER shall not assign a consumer to any practitioner who has not fully complied with credentialing process.

PROVIDER shall participate in MSHN Consumer Satisfaction Surveys. Failure to participate in Consumer Satisfaction Surveys may result in contract sanctions. PROVIDER further agrees to provide data requested by MSHN in order for MSHN to conduct credentialing, quality assurance, and/or utilization management activities concerning consumers.

PROVIDER acknowledges MSHN or any representative agent shall have the right to review and inspect records related to credentialing activities maintained by PROVIDER relative to its staff and contracted personnel/agencies. To the extent permitted by law, PROVIDER shall make such records available to MSHN or any representative agent and any governmental agency without charge to MSHN. Reference the MSHN-SUDSP MANUAL for applicable policies and/or procedures.

3. **Medicaid Fair Hearing**: Medicaid consumers who request or receive alternative services that are paid for with Medicaid funds per Michigan's approved use of Section (a)(1)(A) of the Social Security Act do not have the right to Medicaid Fair Hearing. They have the right to local dispute resolution processes when alternative services are denied, reduced, suspended or terminated.

4. **Covered Services:** PROVIDER represents and warrants to MSHN that Covered Services shall be provided to all consumers in an appropriate, timely, and cost effective manner. Further, PROVIDER represents and warrants to MSHN that PROVIDER shall furnish such services according to applicable medical, mental health and substance use disorder practices, national standards and applicable laws and regulations.

5. **Covered Consumers**: PROVIDER reserves the right to provide professional services to consumers other than covered consumers, however, they will not solicit, request, or require any covered consumer, as a condition of receiving medical services, to dis-enroll from the Plan or MSHN and become a private consumer of PROVIDER or enroll in any fee-for-service health benefit plan or other health benefit plan in which PROVIDER participates.

6. **PROVIDER Training:** PROVIDER agrees to obtain, at its own expense, ongoing training, and supervision according to applicable medical, mental health and substance use disorder practices and the licensing, credentialing or other qualifications policies, procedures or regulations of the State of Michigan and/or MSHN. PROVIDER shall furnish a written summary of such training and supervision efforts to MSHN. Reference the MSHN-SUDSP MANUAL for applicable policies and/or procedure.

7. **Record Transfer:** Upon receipt of written request from MSHN, PROVIDER shall transfer to PROVIDER, designated in the request, copies of all medical records, and other data in the possession or control of the PROVIDER pertaining to the covered consumer within ten (10) working days of such notice.

8. **Health and Safety:** Covered consumers shall be subject to immediate transfer to another participating PROVIDER and this Agreement shall be subject to immediate termination, in the event that MSHN determines that a covered consumer's health or safety is in immediate jeopardy.

9. **Medical Records:** PROVIDER shall keep complete and accurate medical records for all covered consumers. The medical records shall contain such information as may be required by MSHN, Medicaid, MDHHS, HHS, and any other State or Federal regulatory bodies having jurisdiction over the delivery of medical services to covered consumers under this Agreement. PROVIDER shall retain all medical records of covered consumers for at least seven (7) years after services are rendered and, in the case of minor consumers, until seven (7) years after a minor consumer attains the age of majority.

PROVIDER shall make such medical records available to MSHN for the purpose of assessing quality of care, conducting medical care evaluations and audits, determining the medical necessity and appropriateness of services provided to covered consumers, and investigating grievances or complaints made by covered consumers. PROVIDER shall, upon request, supply MSHN a copy of PROVIDER clinical protocols and must use the protocols in planning and providing treatment to covered consumers. The provisions of this section shall survive the expiration or termination of this Agreement regardless of cause, including non-payment by MSHN, insolvency or breach of this Agreement by either party.

10. **Record Availability:** PROVIDER shall make available, to a covered consumer at his/her request, access to his/her medical records and shall comply with all State and Federal laws and regulations regarding the privacy and confidentiality of medical records and release of a covered consumer's' medical records to third parties. The provisions of this section shall survive the expiration or termination of this Agreement regardless of cause, including non-payment by MSHN, insolvency or breach of this Agreement by either party.

11. **Consumer Tracking Capacity:** Treatment PROVIDER is responsible for developing an internal system for tracking consumers who do not show for appointments.

12. **Financial Review:** The PROVIDER shall submit, on request of MSHN, financial statements and related reports and schedules that accurately reflect the financial position of PROVIDER. PROVIDER must submit, no later than nine (9) months following the close of the providers fiscal year, its financial statements and supporting reports and schedules as presented to its governance authority. MSHN reserves the right to require the PROVIDER to secure an independent financial audit. Reference the **MSHN-SUDSP Manual**. for applicable policies and/or procedures.

13. **IRS Form 990:** PROVIDER that is non-profit tax-exempt organizations and required to file IRS form 990 shall submit a copy of the most recent informational return to the MSHN immediately following filing of same. For-profit organizations are required to submit a copy of their most recent corporate tax return to MSHN following filing of same.

14. **Accounting and Internal Controls:** PROVIDER shall ensure its accounting procedures and internal financial controls conform to generally accepted accounting principles in order that the costs allowed by this Agreement can be readily ascertained and expenditures verified there from. The parties understand and acknowledge that their accounting and financial reporting under this Agreement must be in compliance with MDHHS accounting and reporting requirements. PROVIDER shall submit, upon request from PAYOR, complete and accurate equipment inventory listing itemizing any equipment purchases made through federal or state funds. Reference the **MSHN-SUDSP Manual**. for applicable policies and/or procedures.

15. **License Requirements; Credentialing and Privileging Requirements:**
The Provider shall obtain and maintain during the term of this Agreement all licenses, certifications, registrations, accreditations, authorizations, and approvals required by Federal, State and local laws, ordinances, rules and regulations for the Provider to operate and/or to provide Medicaid programs and supports/services within the State of Michigan.

    The Provider shall ensure, through credentialing, that the Provider's staff professionals and the Provider's subcontractors and their staff professionals have obtained and maintain all approvals, accreditations, certifications and licenses required by Federal, State and local laws, ordinances, rules and regulations to practice their professions in the State of Michigan and to perform Medicaid supports/services hereunder. PROVIDER shall ensure credentialing and re-credentialing processes do not discriminate against:
        - A health care professional solely on the basis of license, registration or certification;

- A health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.

16 The PIHP retains the right to approve, suspend or terminate providers from participation in the Medicaid funded services, e.g. exclusions from Medicare/Medicaid and/or criminal convictions as described under sections 1128(a) and 1128(b)(1), (2) or (3) of the Social Security Act.

17 PROVIDER shall maintain a complete list of their providers and conduct monthly OIG exclusion database searches of all their providers.

18 PROVIDER shall obtain Disclosure of Ownership, Control and Criminal Convictions for all of their providers at the time of application, upon execution of provider agreements, during re-credentialing, contract renewal or within thirty-five (35) days of any change in ownership of a disclosing agency.

19 The PIHP shall work in coordination with the PROVIDER as the responsible Provider responsible for removing, if necessary, disqualified participants from the network.

In the event that the PROVIDER license, certification, accreditation, or authorization is ever suspended, restricted, revoked, or expires and is not renewed, that affects the ability of the Provider to fulfill the requirements of this contract, the Provider shall immediately notify the Payor, in writing.

20**. Compliance with the MDHHS/PIHP Contract:**
It is expressly understood and agreed by the parties hereto that this Agreement is subject to the terms and conditions of the MDHHS/PIHP Contract. The Provider shall comply with any applicable terms or conditions of such contract. The MDHHS Contract is incorporated by reference to this Contract, and by such incorporation, is made part of this Contract. Amendments to the MDHHS Contract are also terms of this Contract.

The provisions of this Agreement shall be applicable unless a conflict exists between this Agreement and the provisions of the MDHHS/PIHP Contract.

In the event that any provision of this Agreement is in conflict with the terms and conditions of the MDHHS/PIHP Contract, the provisions of said MDHHS/PIHP Contract shall prevail.

However, a conflict shall not be deemed to exist where this Agreement:

(1.) contains non-conflicting additional provisions and additional terms and conditions not set forth in the MDHHS Contracts;
(2.) restates provisions of the MDHHS/PIHP Contract to afford the Payor the same or substantially the same rights and privileges as the MDHHS; or,
(3.) requires the Provider to perform duties and/or services in less time than required of the Payor in the MDHHS/PIHP Contract.

In addition, the terms and provisions of this contract may be amended, by mutual agreement of the Payor and Provider, from time to time to ensure compliance with any Medicaid contract entered into by the Payor with the Michigan Department of Community Health.

21. The Provider's CEO shall inform, in writing, the Payor's CEO of any notice to, inquiry from, or investigation by any Federal, State, or local human services, fiscal, regulatory, investigatory, prosecutory, judicial, or law enforcement agency or protection and/or advocacy organization regarding the rights, safety, or care of a recipient of Medicaid services under this Agreement. The Provider also shall inform, in writing, the Payor's CEO immediately of any subsequent findings, recommendations, and results of such notices, inquiries, or investigations.

22. **Program Compliance:** PROVIDER shall implement and maintain a compliance plan that

is designed to guard against fraud and abuse in accordance with federal and state law.

a. The Compliance Plan must include, at a minimum, all of the following elements:
    1) Written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards, including but not limited to the False Claims Act (31 USC 3729-3733, the elimination of fraud and abuse in Medicaid provisions of the Deficit Reduction Act of 2005; and the Michigan Medicaid False Claims Act (PA 72 of 1977, as amended by PA 337 of 2005) and the Michigan Whistleblowers Protection Act (PA 469 of 1980).
    2) Clearly defined practices that provide for prevention, detection, investigation and remediation of any compliance related matters.
    3) The designation of a compliance officer and a compliance committee that are accountable to senior management;
    4) Effective training and education for the compliance officer and the organization's employees;
    5) Effective lines of communication between the compliance officer and the organization's employees;
    6) Enforcement of standards through well publicized disciplinary guidelines;
    7) Provision for internal monitoring and reporting;
    8) Provision for prompt response to detected offenses, and for development of corrective action initiatives.

b. Upon request, PROVIDER will furnish a copy of the compliance plan to MSHN or the responsible MSHN.

c. PROVIDER agree to report immediately to the MSHN Compliance Officer any suspicion or knowledge of fraud or abuse, including if possible, the nature of the complaint, the name of the individuals or entity involved in the suspected fraud and abuse, including name, address, phone number, Medicaid identification number and/or any other identifying information. The PROVIDER agrees not to investigate or resolve the alleged fraud and/or abuse and to fully cooperate with any investigation by MSHN, its payers and/or the MDHHS or Office of the Attorney General and with any subsequent legal action that may arise from such investigation.

d. PROVIDER who is contracting with MSHN as licensed independent practitioner or individual ancillary service PROVIDER agree to comply with all applicable federal and state standards, including but not limited to the False Claims Act (31 USC 3729-3733, the elimination of fraud and abuse in Medicaid provisions of the Deficit Reduction Act of 2005; and the Michigan Medicaid False Claims Act (PA 72 of 1977, as amended by PA 337 of 2005). The PROVIDER agrees to utilize internal monitoring mechanisms to ensure only valid service claims, free of fraud and abuse, are submitted to MSHN for payment. PROVIDER agrees to immediately report to MSHN any invalid claims for correction and to cooperate with MSHN regarding reclamation of any payments made based upon invalid claims. PROVIDER agrees to implement internal process changes to mitigate the risk of future claims payment issues.

e. PROVIDER agrees to immediately notify MSHN with respect to any inquiry, investigation, sanction or otherwise from the Office of Inspector General (OIG).

III. General Provisions for MSHN

A. Payment Timelines:

1. Fee-For-Service**:** MSHN shall, through application of Medical Necessity determination criteria, authorize Fee-for-Service payment pursuant to the Rate Schedule included in Attachment B. All payments will be made in accordance with applicable Federal and State rules and regulations, and especially pursuant to the payment timeliness standards set forth in the Balanced Budget Act of 1997. These standards require that ninety percent (90%) of payments for services shall be made within thirty (30) days following the receipt of a completed clean claim and ninety-nine percent (99%) of payments shall be made with ninety (90) days, except when the claim is contested in good faith.

2. Cost Reimbursement: MSHN shall make payment to provider within thirty (30) days of MSHN's receipt of the PROVIDER's FSR.

B. Care and Treatment: PROVIDER is solely responsible for all decisions regarding the medical care and treatment of MSHN consumers that are referred for treatment and that the traditional relationship between PROVIDER and consumer, shall in no way be affected by the terms of this Agreement, notwithstanding the fact that MSHN is responsible for determinations concerning claims, utilization review, coverage and benefit issues.

Any determination by MSHN denying approval for a particular service shall not relieve PROVIDER from providing or recommending such service they deem as appropriate. PROVIDER shall not render any service that is not a Covered Service unless PROVIDER first informs MSHN consumer that the service is not a Covered Service and that MSHN consumer will be solely responsible for the cost thereof.

C. Advertising: MSHN will include PROVIDER name, address, phone number and areas of specialization in any directories that it may produce and publish for use by consumers who may directly avail themselves of substance use disorder services that are Covered Services. PROVIDER may include, in its advertising, that it is an authorized PROVIDER of Covered Services for MSHN subject to the provisions of section IX.A.1 of this agreement. PROVIDER may not finance any advertising using MSHN funding.

IV. Medicaid/Healthy Michigan Plan (HMP) Behavioral Healthcare Requirements

Please refer to the Acronym, Glossary Definitions for interpretations of acronyms and terms used in this section.

A. Scope and Terms of the Agreement: MSHN hereby retains PROVIDER to provide Covered Services for consumers under the terms and conditions set forth in this Agreement. PROVIDER will make substance use disorder treatment decisions and provide advice for purposes of diagnosis and treatment of covered consumers. MSHN will make benefit determinations with respect to covered consumers. MSHN will perform quality assurance and utilization review functions with respect to Covered Services provided or arranged by PROVIDER. PROVIDER understands that MSHN is dependent upon MDHHS for accuracy and timeliness of Medicaid eligibility data.

The right to provide or arrange for medically necessary services for covered consumers is, and shall remain, the exclusive property and business of MSHN, subject only to the limited delegation specified in this Agreement. Except as otherwise required by applicable statutes and regulations, MSHN's list of Medicaid/HMP consumers enrolled in the Plan and its list of covered consumers are and shall remain the exclusive property of MSHN, and the use thereof for any purpose shall be subject to MSHN's exclusive control.

B. Acceptance of Consumers: PROVIDER shall accept consumers referred by MSHN and shall render Medically Necessary Covered Services, which PROVIDER is qualified by law to render, customarily provides, and has the capacity to provide. PROVIDER shall not distinguish between a Medicaid/HMP consumer and other consumers in the quality of the behavioral health care services rendered. Reference the **MSHN-SUDSP Manual** for applicable policies and/or procedures.

C. Accessibility: PROVIDER shall ensure that all consumers are able to receive services in accordance to the access standards (Attachment P4.1.1 "Access Standards" of PIHP/MDHHS contract) set forth by the Michigan Department of Health and Humans Services (MDHHS). PROVIDER also ensures services are delivered in a manner that takes into consideration the consumer's ethnicity, cultural differences, language proficiency, communication abilities, and physical limitations. PROVIDER shall maintain adequate facilities and sufficient personnel to provide consumers with timely access to Covered Services. PROVIDER agrees to notify MSHN of any material additions, reductions or elimination of services as soon as possible. Reference the

MSHN-SUDSP Manual for applicable policies and/or procedures.

D. **Referral of Consumers:** When a consumer requires services that the PROVIDER does not customarily render, or where otherwise required by law or ethical professional practice, PROVIDER shall abide by the procedures set forth in the **MSHN-SUDSP Manual** in transferring the consumer to an appropriate source of care. When a consumer requires services, in addition to services that the PROVIDER does customarily render, PROVIDER shall abide by the procedures set forth in the MSHN-SUDSP Manual in Dually Enrolled Consumers and/or Care Coordination (See MSHN-SUDSP Manual).

E. **Clinical Protocols:** Clinical protocols are guidelines for the care of consumers, providing clinicians with the objective criteria for making treatment decisions. Clinical protocols are distinct from level of care guidelines. PROVIDER shall submit to MSHN a copy of its clinical protocols and assure that the protocols submitted are used in the planning and provision of treatment (MSHN-SUDSP MANUAL).

F. **Hearing/Grievance and Appeals:** PROVIDER will assure that consumer rights to a Fair Hearing and/or Grievance and Appeals is provided as defined in the **MSHN-SUDSP Manual.**

PROVIDER agrees to comply with applicable sections of Federal law 42CFR 431.200-250 regarding Administrative Hearings. Substance Use disorder rights are defined in Section 3 of the Licensing Administrative Rules (R 325.14101 – R 325.14125). Reference the **MSHN-SUDSP Manual** for applicable policies and/or procedures.

G. **Consumer Choice:** PROVIDER must assure that consumers are given a choice in the selection of a treatment program within MSHN PROVIDER network. This choice must be documented in the consumer's file. Consumers are to be given a choice of PROVIDER (clinician) to the extent feasible.

H. **Consumer Eligibility:** PROVIDER is responsible for identifying a consumer's active eligibility for Medicaid/HMP reimbursement and retains a copy of eligibility documentation in the consumer's file. As Medicaid/HMP eligibility is determined on a month-to-month basis, on-going monthly verification of coverage must be documented in the consumer's file. Reference the **MSHN-SUDSP Manual** for applicable policies and/or procedures.

I. **Compensation:** PROVIDER hereby agrees that in no event, including but not limited, to non-payment by insolvency or breach of this Agreement, shall PROVIDER bill, charge, collect from, seek compensation, remuneration or reimbursement from, or have any recourse against consumers or persons other than MSHN acting on the consumers' behalf for services provided pursuant to this Agreement. PROVIDER shall look solely to MSHN and not to any Covered consumer for payment for all Covered Services provided (excluding patient pay amount) to covered consumers under this Agreement. PROVIDER shall be responsible for paying for all costs that it incurs in providing Covered Services under this Agreement. PROVIDER shall defend, indemnify, and hold harmless covered consumers, Medicaid/HMP, MDHHS, and MSHN against any and all such claims.

In addition, MSHN shall have the right to deduct and retain, from any and all sums, at any time owing by it to PROVIDER, the full amount of any such claim. PROVIDER further agrees:

1. That this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the consumer and

2. That this provision supersedes any oral or written contrary Agreement now existing or hereafter entered into between PROVIDER and consumer or person acting on the consumer's behalf.

3. This provision shall not apply to charges for services that are not Covered Services which are requested by a consumer, or a consumer's parent or legal guardian, after the

consumer or consumer's parent or legal guardian have been informed, orally and in writing, at least twenty-four (24) hours in advance of such services, that the services are not Covered Services.

J. **Warranty:** PROVIDER warrants and represents that the Medical Services Administration has not previously sanctioned PROVIDER.

V. Medicaid Responsibilities of MSHN

A. MSHN shall furnish all of the following to PROVIDER:

1. **Access Center Phone Number:** An access center telephone number will be available twenty-fours (24) hour per day, seven (7) days per week for network referrals.

2. **Eligibility Data Systems:** MSHN shall maintain a current eligibility data system with mechanisms for PROVIDER access and a process for reconciliation of errors. PROVIDER understands that MSHN is dependent upon MDHHS representatives for the accuracy and timeliness of Medicaid eligibility data.

3. **30-day Notice:** Thirty-day notice of change in benefits, Covered Services, and all operational policies and procedures with which PROVIDER shall comply as a condition of participation under this Agreement, unless circumstances warrant otherwise. Reference the **MSHN-SUDSP Manual** for applicable policies and/or procedures.

VI. CONTRACTUAL PROVISIONS

A. General Responsibilities of the PROVIDER

1. **Publication Rights:** Where activities supported by this Agreement produce books, films, or other such copyrighted materials issued by the PROVIDER, the PROVIDER may copyright, but shall acknowledge that MSHN reserves a royalty-free, non-exclusive and irrevocable license to reproduce, publish and use such materials and to authorize others to reproduce and use such materials. This cannot include service consumer information or personal identification data. Any copyrighted materials or modifications bearing acknowledgment of or by MSHN must be approved by MSHN prior to reproduction and use of such materials. The PROVIDER shall give recognition to the MSHN in any and all publication papers and presentations arising from the program and service contract herein; MSHN will do likewise.

   In all cases, whether the material is copyrighted or not, the PROVIDER shall acknowledge on all of its publications, reports, brochures, flyers, etc., that public funds, provided by the State of Michigan through MSHN, were used to support the cost of publication and the delivery of the service, program, event, or publication described by it.

   Record Retention: PROVIDER shall maintain adequate program, participant, and fiscal records and files including source documentation to support program activities and all expenditures made under the terms of this Agreement, as required. PROVIDER shall assure that all terms of the Agreement will be appropriately adhered to and that records and detailed documentation for the services identified in this Agreement will be maintained pursuant to MSHN and MDHHS Record Retention guidelines. MSHN adheres to MDHHS' General Schedule #20 – Community Mental Health Services Programs' Record Retention and Disposal Schedule.
   MSHN's policy regarding record retention is located here

2. **Notification of Modification**: The Director of the PROVIDER agency shall ensure at

least 60 days notification to the MSHN, in writing, of any action by its governing board or any other funding source, which would require or result in significant modification in the provision of services or funding or compliance with the terms and conditions of this contract, its attachments and referenced documents, including the **MSHN-SUDSP Manual**.

3. **Notices to MSHN:** PROVIDER shall notify MSHN within ten (10) business days of any of the following events: (i) of any civil, criminal, or other action brought against it for any reason or any finding of any licensing/regulatory body or accrediting body, the results of which suspend, revokes, or in any way limits PROVIDER authority to render Covered Services: (ii) of any actual or threatened loss, suspension, restriction or revocation of PROVIDER license or ability to fulfill its obligations under this agreement; (iii) of any malpractice action filed against PROVIDER; (iv) of any charge or finding or ethical or professional misconduct by PROVIDER; (v) of any loss of PROVIDER professional liability insurance or any material change in PROVIDER liability insurance; (vi) of any material change in information provided to MSHN in the accompanying PROVIDER Network Application or in the Credentialing Information concerning any PROVIDER; (vii) any other event which limits PROVIDER ability to discharge its responsibilities under this Agreement professionally, promptly and with due care and skill or (viii) PROVIDER is excluded from participation with the Federal procurement programs or any healthcare program (including the Medicare and Medicaid Programs).

4. **Research Restrictions on Human Subjects**: PROVIDER shall notify MSHN who will seek approval, from MDHHS, for any research involving human subjects as defined in the MDHHS-PIHP contract.

B. Assurances of PROVIDER

1. **Compliance with Applicable Laws:** PROVIDER will comply with applicable Federal and State laws, guidelines, rules and regulations in carrying out the terms of this Agreement. PROVIDER will also comply with all applicable general administrative requirements such as OMB Circulars covering cost principles, grant/Agreement principles, and audit requirements, in carrying out the terms of this Agreement.

2. **Non-Discrimination:** PROVIDER shall not discriminate against or grant preferential treatment: to any employee or applicant for employment with respect to hire, tenure, terms, conditions, or privileges of employment, programs and service provided, or any matter directly or indirectly related to employment, in contract solicitations, or in the treatment of any consumer, recipient, patient or referral, under this Agreement, on the basis of race, color, national origin, age, disability or sex including discrimination based on pregnancy, gender identity and sex stereotyping or otherwise as required by the Michigan Constitution, Article I, Section 26, the Elliott Larsen Civil Rights Act, 1976 PA 453, as amended, MCL 37.1101 et seq., PWDCRA and ADA and Section 504 of the Federal Rehabilitation Act of 1973, PL 93-112, 87 Stat 394, ACA Section 1557. Any breach of this section may be regarded as a material breach of this contract.

   PROVIDER agrees to assure accommodation of physical and communication limitations for consumers served under this contract. In accordance with 42 CFR 438.6(m), PROVIDER must assure that the recipient is allowed to choose his or her health care professional to the extent possible and appropriate.

   Assurance is given that proactive efforts will be extended in subcontracting to minority-owned, women-owned and handicapped-owned businesses in accordance with ethical affirmative action practices. Discriminating against any of these people groups is prohibited and a material breach of contract.

3. **Debarment and Suspension:** By signing this agreement, assurance is hereby given to

MSHN that PROVIDER will comply with Federal regulation 45 CFR Part 76 and certifies to the best of its knowledge and belief that it and its subcontractors:

a. Are not now, nor ever been suspended, excluded from participating in, or subject to any sanction by a Federal or State health care program, or debarred from (nor affiliated with, as defined under the Federal Acquisition Regulations, anyone who is debarred from) participating in procurement activities governed by applicable Federal Acquisition Regulations, or non-procurement activities under the regulations issued under Executive Order No. 12549;

b. Will immediately disclose any proposed or actual suspension, exclusion or sanction from any health care program funded in whole or in part by the Federal or State government, including Medicare or Medicaid, to MSHN;

c. Will disclose any criminal charge or conviction, in particular those that fall within the ambit of 42 USC 1320a-7(a), against it as an entity, its officers, directors, employees or agents, relating to Medicare, Medicaid or other Federal or State health care program and will disclose charges and/or convictions for any other crime involving the delivery of a health care item or service.

1) Has 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.

2) Is 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 i, and;

3) Has not within a three-year period preceding this agreement had one or more public transactions (federal, state or local) terminated for cause or default.

d. **PROVIDER Prohibited Relationships**: In order to comply with 42 CFR 438.610, PROVIDER may not have any of the following relationships with an individual who is excluded from participating in Federal health care programs:

1) Excluded individuals cannot be a director, officer, or partner of PROVIDER

2) Excluded individuals cannot have a beneficial ownership of five percent or more of PROVIDER's equity; and

3) Excluded individuals cannot have an employment, consulting, or other arrangement with PROVIDER for the provision of items or services that are significant and material to PROVIDER's obligations under its contract with the MSHN.

e. "Excluded" individuals or entities are individuals or entities that have been excluded from participating, but not reinstated, in the Medicare, Medicaid, or any other Federal health care programs. Bases for exclusion include convictions for program-related fraud and patient abuse, licensing board actions and default on Health Education Assistance loans.

f. PROVIDER will comply with Federal regulations by disclosing to the MSHN CEO information about individuals with ownership or control interests in the PROVIDER, if any. These regulations also require PROVIDER to identify and report any additional ownership or control interests for those individuals in other entities, significant and material to PROVIDER obligations under its contract with MSHN, as well as identifying when any of the individuals with ownership or control interests have spousal, parent-child, or sibling relationships with each other. PROVIDER must disclose changes in ownership and control information at the time of enrollment, re-enrollment, or within thirty-five (35) days of whenever a change in entity ownership or control takes place.

g. An individual is considered to have an "ownership" or "control interest" in PROVIDER entity if it has direct or indirect ownership of 5 percent or more, or is a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity as defined in section 1126(b) of the Act and under 42 CFR section 1001.1001(a)(1).

h. PROVIDER shall comply with federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions as specified in 42 C.F.R. §455.104-106. In addition, PROVIDER shall ensure that any and all contracts, agreements, purchase orders, or leases to obtain space, supplies, equipment or services provided under the Medicaid agreement require compliance with 42 C.F.R. §455.104-106.

i. **PROVIDER Responsibilities for Monitoring Office of Inspector General's Exclusions Database**: At the time of employment or establishment of an agreement or contract with a licensed independent health care practitioner (a licensed physician or fully licensed psychologist), director, or manager of PROVIDER, an individual with beneficial ownership of five percent or more, or an individual with a consulting, or other arrangement (e.g., sub-contract) with PROVIDER, for the provision of items or services that are significant and material to PROVIDER obligations under its contract (e.g., as defined in Attachment A) with MSHN, PROVIDER must search, at least on a monthly basis, the Office of Inspector General's (OIG) exclusions database at http://www.oig.hhs.gov to ensure the individual or entity has not been excluded from participating in federal health care programs. PROVIDER will maintain documentation of the completion of such checks and make them available to MSHN for inspection.

j. **Notice requirements:** PROVIDER must notify MSHN CEO immediately if search results indicate that any licensed independent health care practitioner, director, or manager of the PROVIDER, an individual with beneficial ownership of five percent or more, or an individual with, a consulting or other arrangement with PROVIDER, for the provision of items or services that are significant and material to PROVIDER obligations under its contract with MSHN are on the OIG exclusions database.

k. **PROVIDER Responsibility for Disclosing Criminal Convictions**: PROVIDER is required to promptly notify MSHN CEO if any staff member, director, or manager of PROVIDER, individual with beneficial ownership of five percent or more, or an individual with an employment, consulting, or other arrangement with PROVIDER, for the provision of items or services that are significant and material to PROVIDER obligations under its contract with MSHN, has been convicted of a criminal offense described under sections 1128(a) and 1128(b)(1), (2), or (3) of the Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act. (See 42 CFR 1001.1001(a)(1).

l. **Disclosure of Convictions:** PROVIDER must require staff members, directors, managers, or owners or contractors, for the provision of items or services that are significant and material to PROVIDER obligations under its contract with MSHN, to disclose all felony convictions and any misdemeanors for violent crimes to PROVIDER. PROVIDER employment, consulting or other agreements must contain language that requires disclosure of any such convictions to PROVIDER.

m. **PROVIDER Responsibility for Notifying the PIHP CEO of Administrative Actions that Could Lead to Formal Exclusion**: PROVIDER must promptly notify MSHN CEO if they have taken any administrative action that limits employee, director, manager, owner, consultant or other contractor participation in the Medicaid program, including any conduct that results in suspension or termination of such individuals or entities.

n. **Review of Exclusion List:** The United States General Services Administration (GSA) maintains a list of parties excluded from federal programs http://www.sam.gov. Any rules and/or restrictions pertaining to the use of EPLS data can be found on GSA's web page. The State sanctioned list is at the Michigan Department of Health and Humans Services (MDHHS) www.michigan.gov/MDHHS (click on PROVIDERs, click on Information for Medicaid PROVIDER, click on List of Sanctioned PROVIDERs). The State of Michigan Department of Labor register is at MCLA 423.322. PROVIDER must make a monthly search for all excluded parties using all lists provided here and in Section 3.i. in addition to any/all other state and federal lists that may become available.

o. **Acceptance of Claims:**

1) MSHN will not accept claims from PROVIDER for any items or services furnished, ordered or prescribed by excluded individuals or entities.
2) In the event PROVIDER has not made required disclosures, MSHN will not be held financially liable to accept PROVIDER claims from excluded individuals or entities.
3) If payment had been disbursed to PROVIDER prior to MSHN receiving required disclosures of excluded individuals or entities, PROVIDER shall reimburse MSHN total actual cost(s) of identified claims.

4. **Subcontracts:** PROVIDER shall not subcontract any portion of this agreement without the written authorization of MSHN. Reference the MSHN-SUDSP Manual for relative policies and/or procedures. However, any such subcontract shall not terminate the legal responsibility of the Provider to assure that all services required of it hereunder are fulfilled. The Provider agrees that any such subcontract shall:

(1.) Be in writing, and include a full specification of the subcontracted services;
(2.) Contain a provision stating that this Agreement is incorporated by reference into the subcontract and made a part thereof;
(3.) Contain a provision stating that the subcontract is subject to the terms and conditions of this Agreement, and expressly incorporating this Agreement into the subcontract, and,
(4.) Contain all subcontracting requirements of the MDHHS/PIHP Contract, under applicable sections, "SUBCONTRACTING" Part I, Section 38.0 and Part II, Section 11.0.

The Provider, as a prime subcontractor of the Payor, is responsible under this Agreement for primary verification that the Provider's contracting procedures meet the MDHHS's requirements of the Payor as set forth in the MDHHS/PIHP Contract and that each of the

Provider's subcontractors and each of its subcontracts therefore meet the requirements under this Agreement.

5. **Health Insurance Portability and Accountability Act:** To the extent that this act is pertinent to the services that the PROVIDER provides under this contract, the PROVIDER assures that it is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (The HITECH Act) of Title XIII, Division A of the American Recovery and Reinvestment Act of 2009, and related regulations found at 45 CFR Parts 160 and 164, including the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule), the Security Standards for the Protection of Electronic PHI (Security Rule), and the rules pertaining to Compliance and Investigations, Imposition of Civil Money Penalties, and Procedures for Hearings (Enforcement Rule), as amended from time to time, (hereafter collectively referred to as "HIPAA Regulations"); the Federal Confidentiality Law, 42 USC §§ 290dd-2 and underlying Regulations, 42 CFR Part 2 ("Part 2"). This includes the distribution of consumer handbooks and PROVIDER directories to consumers, and/or the MSHN HIPAA Privacy Notice. Reference the **MSHN-SUDSP Manual** for applicable policies and/or procedures.

6. **Tobacco-free Environment Federal Requirement/Pro-Children Act:** The PROVIDER also assures, in addition to compliance with P.L. 103-227, any services or activity funded in whole or in part through this Contract will be in a smoke-free facility or environment. Smoking shall not be permitted anywhere in the facility, or those parts of the facility under the control of the Contractor. If activities or services are delivered in facilities or areas that are not under the control of the Contractor (e.g., a mall, restaurant or private work site), the activities or services shall be smoke-free.

C. Block Grant Requirements

PROVIDER shall accept consumers referred and shall render Medically Necessary Services, which PROVIDER is qualified by law to render, customarily provides, and has the capacity to provide. PROVIDER shall not distinguish between an MSHN consumer and other consumers in the quality of, or access to, the health care services rendered. Additionally, as a requirement of the Block Grant, PROVIDER must ensure that Block Grant Funds shall not be used to:

1. Pay for inpatient hospital services except under conditions specified in federal law
2. Make cash payments to intended recipients of services
3. Purchase or improve land, purchase, construct, or permanently improve and building or any other facility, or purchase major medical equipment
4. Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of funds
5. Provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs
6. Enforce state laws regarding the sale of tobacco products to individuals under the age of 18
7. Pay the salary of an individual as a rate in excess of Level I of the Federal Executive Schedule, or approximately $199,700

D. Termination

5. **By Either Party Without Cause**: This Agreement may be terminated by either party without regard to breach or other cause, and without liability by reason of such termination, upon sixty (60) days prior written notice to the other party.

6. **By Either Party for Breach:** This Agreement may be terminated on thirty (30) days prior written notice upon the failure of either party to carry out the terms and conditions of this

Agreement, provided the alleged defaulting party is given notice of the alleged breach and fails to cure the default within the thirty (30) day period.

7. **By MSHN**: This Agreement may be terminated immediately without further liability on the part of MSHN, if PROVIDER or an official of PROVIDER or an owner is convicted of any activity in the above-referenced sections of this Agreement during the term of this Agreement or any extension thereof. This agreement may be terminated immediately by MSHN without further liability in the event of unavailability, reduction or loss of funding whatever the cause.

   a. **Final Reporting Upon Termination:** Should this Agreement be terminated by either party, within sixty (60) days after the termination, PROVIDER shall provide MSHN with all financial, performance, and other reports required as a condition of this Agreement. MSHN will make payments to PROVIDER for allowable reimbursable costs not covered by previous payments or other State or Federal programs. PROVIDER shall immediately refund to MSHN any funds not authorized for use and any payments or funds advanced to PROVIDER in excess of allowable reimbursable expenditures. Any dispute arising as a result of this Agreement shall be resolved in the State of Michigan.

   b. **Severability:** If any provision of this Agreement or any provision of any document attached to or incorporated by reference is waived or held to be invalid, such waiver or invalidity shall not affect other remaining provisions of this Agreement.

   c. **Amendments:** Any changes to this Agreement will be valid only if made in writing and executed by all parties to this Agreement.

   d. **Liability**: All liability to third parties, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities, such as direct service delivery, to be carried out by PROVIDER in the performance of this Agreement shall be the responsibility of the PROVIDER, and not the responsibility of MSHN, if the liability, loss, or damage is caused by, or arises out of, the actions or failure to act on the part of PROVIDER, any subcontractor, anyone directly or indirectly employed by PROVIDER, provided that nothing herein shall be construed as a waiver of any governmental immunity that has been provided to PROVIDER or its employees by statute or court decisions.

      All liability to third parties, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities such as the provision of policy and procedural direction, to be carried out by MSHN in the performance of this Agreement, shall be the responsibility of MSHN and not the responsibility of PROVIDER if the liability, loss, or damage is caused by, or arises out of, the action or failure to act on the part of any MSHN employee or agent, provided that nothing herein shall be construed as a waiver of any governmental immunity by the State, its agencies or employees as provided by statute or court decisions.

      In the event that liability to third parties, loss, or damage arises as a result of activities conducted jointly by MSHN and PROVIDER in fulfillment of their responsibilities under this Agreement, such liability, loss, or damage shall be borne by MSHN and PROVIDER in relation to each party's responsibilities under these joint activities, provided that nothing herein shall be construed as a waiver of any governmental immunity by the MSHN, PROVIDER, the State, its agencies or their employees, respectively, as provided by statute or court decisions.

   e. **Conflict of Interest:** Both parties of this Agreement are subject to the provisions of P.A. 317 of 1968, as amended, MCL 15.321 et seq, MSA 4.1700(51) et seq, and 1973 PA 196, as amended, MCL 15.341 et seq, MSA 4.1700(71) et seq.

f. **State of Michigan Agreement:** This is a State of Michigan Agreement and is governed by the laws of Michigan. Any dispute arising as a result of this Agreement shall be resolved in the State of Michigan.

g. **Confidentiality:** PROVIDER shall assure that medical services to and information contained in medical records of consumers served under this Agreement, or other such recorded information required to be held confidential by Federal or State law, rule or regulation, in connection with the provision of services or other activity under this Agreement shall be privileged communication, shall be held confidential, and shall not be divulged without the written consent of the consumer except as may be otherwise required by applicable law or regulation. Such information may be disclosed in summary, statistical, or other form, which does not directly or indirectly identify particular consumers. PROVIDER must assure compliance with Federal requirements contained in 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, Final Rule, June 9, 1987 and HIPAA Privacy and Security Regulations.

h. **Assignability**: PROVIDER cannot assign this contract to another party.

E. Continuation of Contractual Agreement

In the event that it is the intent of MSHN to initiate a new Agreement, and a new Agreement is not executed by the expiration date of this Agreement, the terms, conditions and funding levels for program(s) contained herein, may be extended as determined necessary by written authorization from MSHN, subject to the availability of funds. This continuation period is not to exceed two consecutive ninety (90) day periods, unless otherwise specifically provided for.

F. Liability Insurance

PROVIDER shall maintain professional liability coverage which provides a minimum coverage of $1,000,000 per claim and $3,000,000 in the aggregate, requiring a $1,000,000 umbrella limit, with respect to any claim or claims that may arise out of any malpractice, professional liability, negligence, act or omission caused or alleged to have been caused by the insured PROVIDER or by their employees or agents in the performance of or omission of any duty assumed by PROVIDER, its employees, or agents or in connection herewith. Insurance policy shall be endorsed to include coverage for sexual abuse and molestation that applies to any PROVIDER with responsibility for consumer interaction in person.

PROVIDER shall maintain unemployment compensation insurance, workers' compensation insurance and auto insurance (when applicable) for all of PROVIDER 's employees in accordance with the requirements of all applicable Federal and State laws and regulations, including without limitation the Michigan Workers' Disability Compensation Law.

PROVIDER agrees that insurance companies authorized to do business in the State of Michigan shall issue all insurance policies required hereunder. PROVIDER shall give MSHN written notice of any changes in or cancellation of the insurance policies, required to be maintained by PROVIDER, at least thirty (30) days before the effective date of such changes or cancellations.

Notwithstanding the foregoing, if PROVIDER elects not to procure and maintain such insurance, PROVIDER may satisfy the insurance requirement by either (i) purchasing self-insured retention ("SIR") policy on such terms and conditions as MSHN determines to be sufficient to satisfy the foregoing insurance requirements; or (ii) placing in escrow an amount equal to the insurance limits in escrow with an independent third party pursuant to the terms of an escrow agreement, as agreed upon by MSHN and PROVIDER.

Fidelity Bonding Documentation: PROVIDER shall maintain fidelity bonding documentation and shall furnish certificate to PAYOR upon request.

G. Resolution of Disputes

1. Every attempt shall be made to jointly resolve contract and service issues/disputes between MSHN and PROVIDER.

2. Unresolved contract issues, as to specific provisions of this Agreement and implementation thereof, and/or service disputes hereunder shall be referred to MSHN's CEO for a final determination in accordance with the MSHN PROVIDER Appeal Policy and Procedure. MSHN's CEO shall furnish PROVIDER's CEO/Director with written notice of any such final determination hereunder.

3. Each party hereto maintains the right to seek recourse, at its options, through legal remedies in a court of competent jurisdiction.

4. Notwithstanding any other provision in this Agreement, the parties hereto agree that the payments from MSHN to the PROVIDER under this Agreement shall not be stopped, interrupted, reduced, or otherwise delayed as a consequence of the pendency of any dispute arising under this Agreement.

H. Special Conditions

1. **Block Grant:** This Agreement is conditionally approved subject to and contingent upon the availability of block grant funds. In the event that claims for services exceed block grant funding available to MSHN, MSHN shall not be liable for the payment of claims made in excess of available funds. It is understood that authorization of services is not a guarantee of payment.

   Medicaid/HMP: Sub-acute detoxification and residential treatment services may be provided to eligible consumers who reside in the PIHP region and request the services. Sub-acute detoxification may be authorized for up to three (3) days or more, if clinically appropriate. Residential services may be authorized for up to twenty-two (22) days or more if clinically appropriate.

2. **Accepted Proposal Applicability:** The proposal submitted by PROVIDER and accepted by MSHN describing the services and programs to be delivered under this agreement are contractual obligations of the PROVIDER. The accepted proposal is incorporated into this agreement by reference and is a part hereof.

I. Contract Remedies and Sanctions

Contract Non-Compliance: The MSHN may use a variety of means to assure implementation of and compliance with contract requirements, policies, procedures, performance standards and indicators and other mandates of the MSHN. The MSHN shall pursue remedial action and possible sanctions as needed, on a progression basis, to resolve outstanding issues, contract, policy procedure violations or performance concerns. In the event of non-compliance by the PROVIDER and/or its subcontractors, the MSHN may take any of the following actions:

a. Discussion with the PROVIDER to identify potential barriers to effective performance and to identify and implement mutually agreeable solutions to performance problems.
b. Require a plan of correction and specified status reports that become a contract performance expectation;
c. Pattern of non-compliance or lack of implementation of the correction action plan.
d. Prior to withholding payment as noted below, the MSHN will give sixty (60) day notice to allow for a period of correction
e. The withholding of payment, in the event the above noted items have not been successful. Measures may include:
    i. For sanctions related to reporting compliance issues and non-compliance issues, MSHN

may delay up to 25% of the scheduled payment to the PROVIDER until after compliance is achieved. MSHN may add time to the delay on subsequent uses of this provision. (NOTE: MSHN may apply this sanction in a subsequent payment cycle and will give prior written notice to the PROVIDER);

f. Reduction in the PROVIDER authorization/budget in the amount directly related to the MSHN loss of funds due to non-compliance.
g. Recoupment of monies from disbursement;
h. Revocation of identified applicable delegated functions;
i. Contract termination in instances of material breach, or where the identified steps above have not resolved the deficiency.

J. Special Certification

The individual or officer signing this Agreement certifies by his or her signature that he or she is authorized to sign this Agreement on behalf of the responsible governing board, official, or contractor. PROVIDER further acknowledges that they have reviewed MSHN's **MSHN-SUDSP Manual**.

	MSHN
By: _____	By: _____
Its:	Its: Chief Executive Officer
Printed Name: _____	Printed Name: Joseph Sedlock
Date: _____	Date: _____
Witness	Witness
By: _____	By: _____
Its: _____	Its: MSHN Contract Manager
Printed Name: _____	Printed Name: Kyle Jaskulka
Date: _____	Date: _____

ATTACHMENT A: STATEMENT OF WORK

1. **Action Plan Guidelines and Action Plan:** PROVIDER will comply with the requirements of the Action Plan Guidelines communicated to it by MSHN, and shall comply with the Action Plan submitted by MSHN to the State of Michigan to the extent that these apply to PROVIDER. Action Plan can be found on MSHN website.

2. **MSHN-SUDSP Manual:** PROVIDER will comply with all requirements and procedures contained within the **MSHN-SUDSP Manual**. **MSHN-SUDSP Manual** can be found on MSHN website.

3. **Screening and Priority Admission Requirements:** PROVIDER must screen all eligible consumers requesting services for history of injecting drug use, regardless of county of residence, within the past thirty (30) days, and if identified as so, must admit them within fourteen (14) days or if not possible, provide interim services. Interim services minimally include a referral for counseling and education about HIV/AIDS, tuberculosis and hepatitis, the risk of needle sharing, transmission to sexual partners and children, steps that can be taken to ensure that HIV/AIDS transmission does not occur, and referral to HIV/AIDS and tuberculosis services if necessary. The interim service efforts must be documented in the consumer case record. Screening to determine if a consumer has a history of injecting drug use is the responsibility of Access, Assessment and Referral Services or approved PROVIDER. PROVIDER must screen all eligible women requesting services, regardless of county of residence, to determine if she is pregnant. If identified as so, the consumer must be given priority for admission to treatment. If admission does not occur within twenty-four (24) hours, interim services must be made available.

   PROVIDER must screen all eligible consumers requesting treatment services to determine if he/she is a parent whose child has been removed from the home under the Child Protection Laws or is in danger of being removed from the home under the Child Protection Laws because of the parent's substance use, and if identified as so, provide priority for treatment admission.

   PROVIDER must provide all consumers with an HIV risk assessment and referrals to HIV appropriate services as indicated.

   PROVIDER must refer all consumers for Hepatitis B surface antigen and core or surface antibody testing, and PROVIDER must refer all consumers who are injecting drug users for Hepatitis C antibody testing.

4. **Staff Qualifications, Professional Development and Privileging:** Assure that all staff hired in MSHN funded programs meet the requirements as identified in the **MDHHS-BHDDA Substance Abuse Disorder Policy Manual, Credentialing and Staff Qualification Requirements (Attachment P.II.B.A. of the MDHHS/PIHP Contract)**.

   PROVIDER agrees to conduct primary source verification, which at a minimum shall include all of the following: Licensure/Certification; Education level (Board Certification, if applicable); Verification of non-debarrment or suspension as well as criminal background checks, on newly hired direct service staff and retain this information at PROVIDER site and produce to MSHN upon request.

   PROVIDER staff cannot provide services if they are not certified or do not have a registered a development plan with MCBAP. Staff in this situation must complete a *Temporary Privileging Form* (See **MSHN-SUDSP Manual**). The privileging form must be completed and submitted to MSHN along with a completed development plan before staff can render services. This form must be signed by the requesting staff person and program director. If a request is received by a PROVIDER outside the MSHN twenty-one county region, we will accept the PROVIDER's Home PIHP's privileging form. If the PROVIDRER's Home PIHP does not require one, then MSHN's must be submitted. PROVIDER must notify MSHN once the staff member has achieved

certification and/or had their plan registered with MCBAP. Privileging requests should be mailed to the MSHN Director of Provider Network Management Systems.

5. **Fee Policies and Procedures:** PROVIDER must comply with the Fee Policies and Procedures that are included in the **MSHN-SUDSP Manual**.

6. **Communicable Diseases:** PROVIDER is required to ensure the confidentiality of identified HIV-positive consumers, and must have procedures and/or policies to ensure protection of the consumer's HIV status. PROVIDER must assure that all prevention and treatment staff attend communicable diseases trainings as specified in the **MSHN-SUDSP Manual**. The Level One training can be found online. PROVIDER must assure all consumers entering residential treatment will be tested for TB upon admission and the test result is known within five (5) days of admission. High-risk TB consumers should be treated using Universal Precaution Practices until test results are known. Consumers who exhibit symptoms of active TB need to be given a surgical mask to wear and placed in respiratory isolation immediately. If respiratory isolation is not available, consumer should be moved to another location until test results are known.

7. **Twelve (12) Month Availability of Services:** PROVIDER shall assure that for any treatment or prevention service, availability will be maintained throughout the fiscal year to consumers who do not have the ability to pay.

8. **Licensure:** PROVIDER shall maintain all necessary licenses, registrations or certifications as required (please refer to the "Administrative Rules for Substance Abuse Service Programs in Michigan"). PROVIDER will provide MSHN with notice of any change to PROVIDER licensing status and/or related licensing information.

9. **Accreditation:** Treatment PROVIDER shall maintain accreditation as an alcohol and/or drug use disorder program by one (1) of the six (6) national accrediting bodies; 1) Joint Commission on Accreditation of Health Care Organizations (TJC), 2) Commission on Accreditation of Rehabilitation Facilities (CARF), 3) Council on Accreditation of Services for Families and Children (COA), American Osteopathic Association (AOA), 5) Accreditation Association for Ambulatory Health Care (AAAHC).or National Committee on Quality Assurance (NCQA). PROVIDER will provide MSHN with proof of current accreditation at the time of credentialing/re-credentialing or upon request by MSHN.

10. **Consumer Satisfaction Surveys:** Treatment PROVIDER is required to participate in a Consumer Satisfaction Survey process, as outlined in the **MSHN-SUDSP Manual**, for all consumers funded by MSHN. MSHN will compile and publish survey results.

11. **Data Reporting Requirements:** PROVIDER must comply with data reporting requirements contained in the **MSHN-SUDSP Manual** and in this contract. The PROVIDER is responsible for submitting timely reports to the PAYOR, as may from time to time be required by the PAYOR, complying with all reporting requirements as specified in Part II, Section 7.7.1 of the contract and the finance reporting requirements specified in Part II, Section 8.7. Additional requirements are identified in Attachment P 8.9.1 (Performance Objectives). (Reference Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver ProgramFY16 – Part II(B) Section 25.4; Attachment(s) P.7.7.1.1.; PII B.A. Substance Abuse Disorder Policy Manual; See SUD Services Policy Manual/Section I Data Requirements: Substance Abuse Encounter Reporting HCPCS and Revenue Codes Chart; Part II(B) Section).

Cooperation with External Medicaid Evaluation: PROVIDER is expected to cooperate with

MSHN efforts in external evaluation of Medicaid services. PROVIDER will assure compliance with submission of necessary data and facilitate access to consumer's files and other records as required.

12. **Primary Care Coordination:** PROVIDER must assure that substance use disorder treatment services are coordinated with primary health care. Treatment files must include the physician's name and address, a signed waiver release or a statement that the consumer refused to sign.

13. **Media Campaign:** PROVIDER shall not finance any media campaign using block grant funding without prior approval. Advertising about the availability of services within MSHN region is not considered a media campaign.

15. **Notice of Funding Excess or Insufficiency:** PROVIDER must advise MSHN in writing by March 30th and immediately any time thereafter if the amount of MSHN funding may not be used in its entirety or appears to be insufficient.

16. MDOC/MPRI Consumers: MSHN will not subsidize the cost of treatment for consumers who are placed in treatment programs under contract with the Michigan Department of Corrections (MDOC) or Michigan Prisoner Re-entry Initiative (MPRI). In no case will MSHN funds constitute duplication of payment for any consumer receiving funds under the MDOC/MPRI contracts. This includes State Disability Assistance.

When consumers who are on parole or probation seek treatment on a voluntary basis, these self-referrals must be handled like any other self-referral to the MSHN-funded network. PROVIDER may seek to obtain consent Agreement releases to communicate with a consumer's probation or parole agent but in no instance may this be demanded as a condition for admission or continued stay.

17. **Case Management Services:** Services that assist PROVIDER in designing and implementing strategies for obtaining services and support that are goal oriented and individualized and that assist consumers with access to needed health services, financial assistance, housing, employment, education, social services and other services. PROVIDER must comply with MSHN Case Management Policy in the **MSHN-SUDSP Manual**.

18 **Hypodermic Needles**: PROVIDER assures that no Federal, State or Local public funds will be used to provide consumers with hypodermic needles or syringes enabling such consumers to use illegal drugs.

19. **Charitable Choice (Faith-based PROVIDER Only):**

Regulations:

a. The faith-based organization is based on the self-identification as a faith-based organization.
b. The faith-based organization is eligible to participate as a network PROVIDER.
c. Consumers receiving services from a faith-based organization who objects to the religious character has a right to notice, referral, and alternative services that meets the standards of timeliness, capacity, accessibility and equivalency.
d. The transferring faith-based organization PROVIDER must notify the alternative PROVIDER, and
e. Notify MSHN UM Department (Access Center) of the transfer. Utilizing the CareNet System can help facilitate this transfer.

Procedures:
Under Charitable Choice, States, local governments and religious organizations, such as SAMHSA grant recipients (including faith-based PROVIDER s) must:

- Provide notice to all potential and actual consumers of their right to alternative services.
- Refer program consumers to alternative services as needed / requested.
- The notice is to read, "**No PROVIDER of substance use disorder services receiving Federal funds from the U.S. Substance Abuse and Mental Health Services Administration, including this organization, may discriminate against you on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice. If you object to the religious character of this organization, Federal law gives you the right to a referral to another PROVIDER of substance use disorder services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after your request them. The alternative PROVIDER must be accessible to you and have the capacity to provide substance use disorder services. The services provided to you by the alternative PROVIDER must be of a value not less than the value of the services you would have received from this organization**."

20. **Discharge dates**: PROVIDER agrees to ensure that the actual last date of documented service in the chart is the date entered into all discharge records in Carenet.

Transportation Guidelines: MSHN women's specialty designated PROVIDER'S, MSHN outpatient PROVIDER'S and other qualified PROVIDER'S, as identified by MSHN, must maintain documentation for transportation provided to the consumer, adhering to the **MSHN-SUDSP Manual**.

21. **Peer Recovery/Recovery Support Services**: The focus of Peer Recovery/Recovery Support services are shifted from professional-assisted to peer-assisted in a less formal community setting. These services are provided primarily by individuals in recovery in order to help prevent relapse and to promote recovery.

    Billable services include, but are not limited to; face-to-face contact with the Consumer, telephone contact with the Consumer, service planning, in-home or community visits, transportation and referrals to other needed services. PROVIDER must comply with MSHN Peer Recovery/Recovery Support Policy within the **MSHN-SUDSP Manual**. Recovery support services may be provided at the beginning, during, or at the end of treatment episodes and can be provided as a stand-alone service.

22. **Integrated Treatment/Co-occurring Capable**: Treatment PROVIDER will document Integrated Services planning efforts for treating consumers with co-occurring substance and mental health disorders. Identified co-occurring disorder treatment issues must be addressed in the assessment and as goals in the individualized treatment plan.

    Co-occurring capable programs are defined as programs that address mental health and substance use disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning. Reference the **MSHN-SUDSP Manual** for additional details.

    Fetal Alcohol Spectrum Disorders (FASD): Treatment PROVIDER that serve women should have policies and procedures in place to (i) prescreen for potential FASD of all dependent children (ii) prescreen for potential FASD for all children with whom PROVIDER has contact, (iii) screen when appropriate and (iv) include FASD prevention into treatment regimen. PROVIDER must make FASD screening evaluations, when appropriate. MDHHS BSAAS Treatment Policy 11 requirements must

be met in full. Charts should document individual FASD-related screens, referrals and services. It is recommended men be considered for these services as well, when appropriate.

23. **ROSC Participation:** MSHN will continue leading the journey of transformational system change to build a better, more Recovery Oriented Systems of Care (ROSC) in the region. This systems change

will be inclusive and a long-term process that will entail changes not only for PROVIDER s of services and supports but for all parts of the system including fiscal, policy, regulatory and administrative strategies. MSHN wants to ensure that this process represents a broad range of stakeholder viewpoints.

- We believe in the value of collaboration and cooperation of efforts in order to effect positive change in communities/counties. We will act consistent with this belief and expect that you join us.
- We believe the process of systems change is really a process of community change. It

requires the united passion, critical thinking and collaboration of a variety partners in all of our communities/counties. We will act consistent with this belief and ask that you join us.

- We believe recovery exists on a continuum of improved health and functioning in which there are a variety of diverse roles for all involved to provide input. These roles include prevention and treatment PROVIDER's, peer support specialists, community based support services, and others. All of these roles are equally appreciated, valued and needed in order to promote sustained health and wellness in our communities/counties. We will act consistent with this belief and ask that you join us.
- We believe that only together can we make sustained recovery a reality for individuals, families and communities in the communities/counties we serve. We ask that you join us and accept our commitment to act consistent with this belief.

Therefore, all PROVIDER partners shall engage in this process; shall participate and provide input in the development of Recovery Oriented Systems of Care (ROSC) for the region and at local/county levels.

MSHN asks that PROVIDER partner identify a minimum of one representative to participate in MSHN-convened ROSC meetings. Participation can be defined as in person, by phone, videoconference, or connection through email list-serve.

24. **PROVIDER Participation:** With the implementation of each Fiscal Year Action Plan, PROVIDER will be asked to participate. Action Plan can be found at MSHN website.

25. **Customer Service Requirements/Recipient Rights**: PROVIDER is required to:

- Distribute the Consumer Handbook to individuals at intake, annually, and as requested.
- Display Regional Consumer Service poster in a common area within the location/building that consumers can view.

ATTACHMENT B: COST REIMBURSEMENT

FY 2017 FUNDING ALLOCATION SUMMARY

Cost-Reimbursement

A total cost estimate is determined before contract work commences. The contractor cannot exceed the maximum without the contracting officer's permission. The final pricing will be determined when the contract is completed, or at some other previously established date in the contracting period.

PROGRAM(S)	$$ AMOUNT
	$

TOTAL COST REIMBURSEMENT ALLOCATION **$**

ATTACHMENT B.1: FEE FOR SERVICE
FY2017 Fee-For-Service Programs

Fee-For-Service

If applicable, programs identified under this section will be reimbursed based on the rate fee schedule listed in Attachment D.

ATTACHMENT C: SERVICE DESCRIPTION

I. The following services will be provided by the PROVIDER as determined and authorized by MSHN through the Carenet System.

PSYCHOTHERAPY

Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other QHCP, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. (Resource: AMA, Current Procedural Terminology, Edition2016)

Psychotherapy Individual (Encounter) (30, 45, 60 minutes)

Psychotherapy, face-to-face, with individual and/or family member, insight oriented, behavior modifying and/or supportive.

Code(s) Assigned: 90832:HF;90834:HF; 90837:HF

Family Psychotherapy (60 minutes)

Family Psychotherapy with or without client present (Substance Abuse Treatment Specialist only can use these codes)

Family psychotherapy, without client (90846), with client (90847)

Code(s) Assigned: 90846:HF; 90847:HF;

Psychotherapy Group (60, 90 or 120 minutes)

Group Psychotherapy, adult or child (other than of a multiple-family group) A process in which a number of people (Best Clinical Practices: 3 minimum, 12 maximum) are involved in a therapeutic setting at the same time under the guidance of a clinician. Groups range from focusing on an individual within the context of a group, on interactions that occur among individuals in the group, or on the group as a whole.

i. Code(s) Assigned: 90853:HF

Psychiatric Diagnostic Evaluation – No Medical Services (Encounter)

Diagnostic interview examination completed by a licensed, credentialed Psychiatrist, with **no medical** services. Integrated biopsychosocial assessment, including history, mental status and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.

Code(s) Assigned: 90791:HF

Acupuncture (15 minute increment; Maximum four (4) per day)

An individual who holds a Certificate of Training in Detoxification Acupuncture as an Acupuncture Detoxification Specialist (ADS) issued by NADA and is under the supervision of a person licensed to practice medicine in the state may use the NADA protocol for substance use disorder treatment. Administered and approved via LARA certified diplomate of the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in Acupuncture or Oriental Medicine. (Source MDHHS-licensing), One or more needles, Initial (97810) without electrical stimulation-initial fifteen (15) minutes of personal one-on-one contact with the consumer, Subsequent (97811) without electrical stimulation-each additional fifteen (15) minutes of personal one-on-one contact with the consumer, with re-insertion of needle(s) (list separately in addition to code for primary (initial) procedure. (Not billable to Medicaid/HMP; billable to Block Grant only).

Code(s) Assigned: 97810; 97811

Medication Reviews – New & Established Patients (Encounter)

Brief assessment, 15-20 Minutes; may also be Tele-Med dosage adjustment, TD testing

completed by a licensed, credentialed Professional. New (99202), Established (99213)

i. Code(s) Assigned: 99202:HF:GT; 99202:HF; 99213:HF; 99213:HF:GT

Individual Assessment (Encounter)

Individual face-to-face alcohol and/or drug assessment at the licensed provider level for the purpose of identifying functional and treatment needs and to formulate the basis for the individualized treatment plan.

Code(s) Assigned: H0001

Drug Screen (Encounter)

Alcohol and/or drug screening; laboratory analysis (**H0003**) of specimens for presence of alcohol and/or drugs. (Not billable to Medicaid/HMP; billable to Block Grant only).

Codes(s) Assigned: H0003 & **H0048 (Instant drug testing)**

Behavioral Health Counseling (15 minute increment)

Individual Counseling

Code(s) Assigned: H0004:HF

Group Counseling by a Clinician (60, 90 or 120 Minutes)

Alcohol and/or drug services; Group Counseling by a clinician

i. Codes(s) Assigned: H0005

Methadone Administration Daily Dose (Encounter) (Daily Dosing)

Methadone is an opioid medication used in the treatment and recovery of opioid dependence to prevent withdrawal symptoms and opioid cravings, while blocking the euphoric effects of opioid drugs. In doing so, methadone stabilizes the individual so that other components of the treatment and recovery experience, such as counseling and case management, are maximized in order to enable the individual to reacquire life skills and recovery. Methadone is not a medication for the treatment and recovery from non-opioid drugs. (BSAAS, #05-2012)

1. Opioid replacement and maintenance therapy is provided under a defined set of policies and procedures, including admission, discharge, and continued service criteria stipulated by state law and regulation and the federal regulations at FDA 21 CFR Part 291. For the complete policy and procedure regarding Opioid/Methadone treatment refer to the Treatment Policy: Criteria for Using Methadone for Medication-Assisted Treatment and Recovery. A link to the policy is located on the website at www.midstatehealthnetwork.org.
2. Maintain all necessary licenses, registrations or certifications in accordance with the laws of the State of Michigan for SUD treatment and Methadone PROVIDER's.
3. Maintain accreditation for Methadone PROVIDER's by one of the following accrediting bodies: the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or the Joint Commission (TJC) formerly JCAHO.
4. Maintain certification by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an Opioid Treatment Program
5. Maintain registration by the Drug Enforcement Administration (DEA).

Code(s) Assigned: H0020

Alcohol and/or Drug Intervention (Encounter)

Alcohol and/or drug intervention service (planned facilitation); May be individual or group. As previously noted, clients seeking this level of care, must meet, at a minimum, Level 0.5 of the *ASAM PPC-2R*, and be experiencing some problems and/or consequences associated with their substance use. For example, those who are seeking services related to a first time DUI charge would not be eligible without also meeting ASAM criteria. Clients already engaged in more intensive services, or at a level of contemplation that makes them appropriate for treatment, should not receive early intervention services. However, those clients waiting for

treatment services may access early intervention as an interim service. (BSAAS, #09-2011)

i. Codes(s) Assigned: H0022

Case Management (Encounter)

Case Management means a substance use disorder case management program that coordinates, plans, provides, evaluates and monitors services or recovery from a variety of resources on behalf of and in collaboration with a client who has a substance use disorder. Services provided to link, refer and coordinate consumers to other essential medical, educational, social and/or other services (BSAAS, #08) (Not billable to Medicaid/HMP; billable to Block Grant only)

1. Code(s) Assigned: H0006

Brief Intervention (15 minute increment)

Alcohol and/or drug services; brief Intervention.

Code(s) Assigned: H0050 (brief intervention)

Crisis Intervention (15 minute increment)

Crisis Intervention, a service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher level of care (LOC) if intervention is not provided. This code is **NOT** to be used if a client calls in a crisis situation and is talked with on the phone and/or an individual session is then scheduled. (BSAAS #10-2013)

ii. Code(s) Assigned: H2011:HF

PsychoEducation Services Didactic Groups (15 minute increment)

Psychoeducation services-Generally more educational in nature and are used to provide clients with such information as, but not limited to: impact of alcohol and drug misuse, social skill-building information, relapse prevention skill building, etc.

iii. Code(s) Assigned: H2027:HF

Clinically Managed Residential Detoxification (Per Diem)

Alcohol and/or drug services; sub-acute detoxification; clinically monitored residential detox; non-medical or social detox setting (ASAM Level III.2-D. For residential settings (H0012): provider agency licensed and accredited as substance abuse residential detoxification program. Supervision by licensed physician

Codes(s) Assigned: H0012 (Room and Board bundled)

Medically Monitored Residential Detoxification (Per Diem)

Alcohol and/or drug services; sub-acute detoxification; medically monitored residential detox (ASAM Level III.7-D). For residential settings (H0010): provider agency licensed and accredited as substance abuse residential detoxification program. Supervision by licensed physician

Code(s) Assigned: H0010 (Room and Board bundled)

Low-Intensity Residential Treatment Services (Per Diem).

These services are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual in the worlds of work, education, and family life. Treatment services are similar to low-intensity outpatient services focused on improving the individual's functioning and coping skills in Dimension 5 and 6. The functional deficits found in this population may include problems in applying recovery skills to their everyday lives, lack of personal responsibility, or lack of connection to employment, education, or family life. This setting allows clients the opportunity to develop and practice skills while reintegrating into the community.

Five (5) hours min. of weekly core **and** life skills services. Source (BSAAS #10) ASAM 3.1

Code(s) Assigned: H0018:HF (Room and Board must be billed separately)

Medium-Intensity Residential Treatment Services. (Per Diem)

These programs provide a structured recovery environment in combination with medium-intensity clinical services to support recovery. Services may be provided in a deliberately repetitive fashion to address the special needs of individuals who are often elderly, cognitively impaired, or developmentally delayed. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning.
The deficits for clients at this level are primarily cognitive, either temporary or permanent. The clients in this LOC have needs that are more intensive and therefore, to benefit effectively from services, they must be provided at a slower pace and over a longer period of time. The client's level of impairment is more severe at this level, requiring services be provided differently in order for maximum benefit to be received.
Thirteen (13) hours min. of weekly core **and** life skills services. Source (BSAAS #10) ASAM 3.3

Code(s) Assigned: H0019 (Room and Board must be billed separately)

High-Intensity Residential Treatment Services. (Per Diem)

These programs are designed to treat clients who have significant social and psychological problems. Treatment is directed toward diminishing client deficits through targeted interventions. Effective treatment approaches are primarily habilitative in focus; addressing the client's educational and vocational deficits, as well as his or her socially dysfunctional behavior. Clients at this level may have extensive treatment or criminal justice histories, limited work and educational experiences, and antisocial value systems. The length of treatment depends on an individual's progress. However, as impairment is considered to be significant at this level, services should be of a duration that will adequately address the many habilitation needs of this population. Very often, the level of impairment will limit the services that can actually be provided to the client resulting in the primary focus of treatment at this level being focused on habilitation and development, or re-development, of life skills. Due to the increased need for habilitation in this client population, the program will have to provide the right mix of services to promote life skill mastery for each individual. Twenty (20) hours min. of weekly core **and** life skills services. Source (BSAAS #10) ASAM 3.5

ii. Codes(s) Assigned: H0019 (Room and Board must be billed separately)

Recovery Support Services (Encounter)
Non-clinical services that assist individuals and families to recover from alcohol or drug problems. They include social support, linkage to, and coordination among, allied service providers, and a full-range of human services that facilitate recovery and wellness contributing to an improved quality of life. These services can be flexibly staged and may be provided prior to, during, and after treatment. RSS may be provided in conjunction with treatment, or as separate and distinct services, to individuals and families who desire and need them. Services can be provided by appropriately trained staff when working under the supervision of a SATS or SATP. (BSAAS, #07-2012)

Codes(s) Assigned: T1012 (individual)

Recovery Support – Group (15 Minute Increment)
Services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery. Self-help/peer services. Services can be provided by appropriately trained staff when working under the supervision of a SATS or SATP.
Code(s) Assigned: H0038:HF

Recovery Housing (Per Diem) **Housing environment that is abstinence-focused and**

uses a peer-driven model to support recovery

Code(s) Assigned: S9976

Residential Room & Board (Block Grant/State Disability Assistance) (Per Diem)

Lodging, per diem, not otherwise specified. (Not billable to Medicaid/HMP; billable to Block Grant only)

iii. Code(s) Assigned: S9976:HF; S9976:SD (cannot be bundled with H0018:HF and H0019)

Non-Emergency Transportation (Per Mile; IRS Rate Maximum)

Non-emergency transportation services.

Codes(s) Assigned: S0215:HF

Non-Emergency Transportation Gas Card (Per Day)

Non-emergency transportation.

Code(s) Assigned: T2003:HF

Non-Emergency Transportation & Bus (Bus Token) (Per Day)

Non-emergency transportation. Payable under HMP and Block Grant only.

Code(s) Assigned: A0110

Women's Specific Treatment Services

To be able to be considered a Women's Specialty program, the PROVIDER needs to either provide the five federal requirements or make arrangements for referral in partnership with community agencies.

1. Primary medical care for women, including referral for prenatal care if pregnant, and while the women are receiving such treatment, child care.
2. Primary pediatric care for their children, including immunizations.
3. Gender specific substance use disorder treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse and parenting.
4. Therapeutic interventions for children in custody of women in treatment, which may, among other things, address their developmental needs, issues of sexual and physical abuse and neglect.
5. Sufficient case management and transportation services to ensure that women and children have access to the services provided in the first four requirements.

Additionally MSHN requires that all treatment services will be coded according to the appropriate code for the level of care with the HD modifier, which indicates a women's specific service and Women's Specialty Funding Source.

Consumer WSS Eligibility is based on the following criteria:

1. Pregnant Women
2. Women with dependent child(ren)
3. Men who are deemed, by the PROVIDER, to be the sole party responsible for the care and well-being of dependent child(ren).

ATTACHMENT D: SUD SERVICE RATES
(Provider specific services and codes will be authorized by MSHN and uploaded to the Carenet System)

FY2017 SUD CPT & HCPC Code Rates

CODE	DESCRIPTION OF CODE	MSHN RATE
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION (No Medical Services)	$110.00
90832	PSYCHOTHERAPY INDIVIDUAL (30 Minutes; Women's Specialty)	$60.00
90832	PSYCHOTHERAPY INDIVIDUAL (30 Minutes)	$55.00
90832	PSYCHOTHERAPY INDIVIDUAL (30 Minutes; Adolescents)	$60.00
90834	PSYCHOTHERAPY INDIVIDUAL (45 Minutes; Women's Specialty)	$90.00
90834	PSYCHOTHERAPY INDIVIDUAL (45 Minutes)	$85.00
90834	PSYCHOTHERAPY INDIVIDUAL (45 Minutes; Adolescents)	$90.00
90837	PSYCHOTHERAPY INDIVIDUAL (60 Minutes)	$110.00
90837	PSYCHOTHERAPY INDIVIDUAL (60 Minutes; Women's Specialty)	$120.00
90837	PSYCHOTHERAPY INDIVIDUAL (60 Minutes; Adolescents)	$120.00
90846	FAMILY PSYCHOTHERAPY WITHOUT PATIENT PRESENT (60 Minutes)	$110.00
90847	FAMILY PSYCHOTHERAPY WITH PATIENT PRESENT (60 Minutes)	$110.00
90853	PSYCHOTHERAPY GROUP (60 Minutes)	$50.00
90853	PSYCHOTHERAPY GROUP (60 Minutes; Women's Specialty)	$55.00
90853	PSYCHOTHERAPY GROUP (60 Minutes; Adolescents)	$55.00
90853	PSYCHOTHERAPY GROUP (90 Minutes)	$75.00
90853	PSYCHOTHERAPY GROUP (120 Minutes)	$100.00
97810	ACUPUNCTURE 1 OR MORE NEEDLES - INITIAL 15 MINUTES	$5.00
97811	ACUPUNCTURE 1 OR MORE NEEDLES – EACH ADDITIONAL 15 MINUTES	$5.00
99202	NEW PATIENT: MEDICATION REVIEW TELE-MED (20 Minutes)	$90.00
99202	NEW PATIENT: MEDICATION REVIEW (20 Minutes)	$90.00
99213	ESTABLISHED PATIENT: MEDICATION REVIEW TELE-MED (15 Minutes)	$85.00
99213	ESTABLISHED PATIENT: MEDICATION REVIEW (15 Minutes)	$85.00
A0110	NON-EMERGENCY TRANSPORTATION & BUS (BUS TOKEN) (10 Units Maximum per day)	$1.50
H0001	INDIVIDUAL ASSESSMENT (Encounter)	$125.00
H0003	LABORATORY ANALYSIS OF DRUG SCREEN	$25.00
H0004	BEHAVIORAL HEALTH COUNSELING (15 Minutes) SUD/MH	$22.50
H0004	BEHAVIORAL HEALTH COUNSELING (15 Minutes; Community Based)	$25.00
H0004	BEHAVIORAL HEALTH COUNSELING (15 Minutes; Women's Specialty)	$25.00
H0004	BEHAVIORAL HEALTH COUNSELING (15 Minutes; Women's Specialty-Community	$27.50
H0004	Based)	$25.00
H0004	BEHAVIORAL HEALTH COUNSELING (15 Minutes; Adolescents)	$27.50
	BEHAVIORAL HEALTH COUNSELING (15 Minutes; Adolescents-Community Based)	
H0005	GROUP COUNSELING BY A CLINICIAN	$45.00
H0005	GROUP COUNSELING BY A CLINICIAN (Women's Specialty)	$50.00
H0005	GROUP COUNSELING BY A CLINICIAN (Adolescent's)	$50.00
H0006	CASE MANAGEMENT (15 Minutes)	$15.00
H0006	CASE MANAGEMENT (15 Minutes; Women's Specialty)	$16.50
H0006	CASE MANAGEMENT (15 Minutes; Adolescent's)	$16.50

H0010	MEDICALLY MONITORED RESIDENTIAL DETOX (PER DAY) (Inc.'s R&B)	$348.00
H0012	CLINICALLY MANAGED RESIDENTIAL DETOX (PER DAY) (Inc.'s R&B)	$316.00
H0018	LOW-INTENSITY RESIDENTIAL TREATMENT (ASAM 3.1)	$70.00
H0018	LOW-INTENSITY RESIDENTIAL TREATMENT (ASAM 3.1; WOMEN'S)	$90.00
H0018	LOW-INTENSITY RESIDENTIAL TREATMENT (ASAM 3.1; ADOLESCENTS)	$255.00
H0019	MEDIUM-INTENSITY RESIDENTIAL TREATMENT (ASAM 3.3)	$110.00
H0019	MEDIUM-INTENSITY RESIDENTIAL TREATMENT (ASAM 3.3; WOMEN'S)	$130.00
H0019	MEDIUM-INTENSITY RESIDENTIAL TREATMENT (ASAM 3.3; ADOLESCENTS)	$270.00
H0019	HIGH-INTENSITY RESIDENTIAL TREATMENT (ASAM 3.5)	$150.00
H0019	HIGH-INTENSITY RESIDENTIAL TREATMENT (ASAM 3.5; WOMEN'S)	$170.00
H0019	HIGH-INTENSITY RESIDENTIAL TREATMENT (ASAM 3.5; ADOLESCENTS)	$286.00
H0020	METHADONE ADMINISTRATION DAILY DOSE (PER DAY)	$7.50
H0022	ALCOHOL AND/OR DRUG INTERVENTION INDIVIDUAL SERVICE	$45.00
H0022	ALCOHOL AND/OR DRUG INTERVENTION – GROUP	$22.00
H0022	ALCOHOL AND/OR DRUG INTERVENTION INDIVIDUAL SERVICE (Community Based)	$49.50
H0038	RECOVERY SUPPORT – GROUP (15 Minutes)	$3.00
H0048	INSTANT DRUG TESTING COLLECTION AND HANDLING ONLY (Instant drug testing; no laboratory)	$12.00
H0050	BRIEF INTERVENTION (Per 15 Minute unit)	$15.00
H0050	BRIEF INTERVENTION (Per 15 Minute Unit-Community Based)	$16.50
H2011	CRISIS INTERVENTION CODE (SEE ATTACHED NOTE BELOW)	$30.00
H2027	PSYCHOEDUCATION SERVICES (15 Minutes) DIDACTIC	$5.00
H2027	PSYCHOEDUCATION SERVICES (15 Minutes) DIDACTIC (Co-Occurring)	$6.00
S0215	NON-EMERGENCY TRANSPORTATION PER MILE (Maximum allowable = IRS Rate)	IRS Rate Max
S9976	RESIDENTIAL ROOM & BOARD – BLOCK GRANT ONLY (only with H0018/19)	$27.00
S9976	RESIDENTIAL ROOM & BOARD – STATE DISABILITY ASST. (only w/H0018/19)	$27.00
S9976	RECOVERY HOUSING	$17.00
T1009	CARE OF CHILD(REN) OF THE INDIVIDUAL RECEIVING OUTPATIENT SUD SERVICES; PER HOUR	$10.00
T1009	CARE OF CHILD(REN) OF THE INDIVIDUAL RECEIVING RESIDENTIAL SUD SERVICES; PER DIEM	$50.00
T1012	RECOVERY SUPPORT SERVICES (Encounter)	$40.00
T1012	RECOVERY SUPPORT SERVICES (Encounter-Community Based)	$44.00
T2003	NON-EMERGENCY GAS CARD	$5.00

NOTE: H2011HF is a Crisis Intervention code only used in situations where a client arrives for group but is in a crisis best handled in a one-on-one, face-to-face setting. The PROVIDER may use up to four 15-minute units (equaling 60 minutes). The group code can then be exchanged for the crisis intervention code. Do NOT request this code in an authorization for services request, as this is an exchange allowed only code. This code is NOT to be used if a client calls in a crisis situation and talks with a PROVIDER on the phone and/or an individual session is then scheduled.

MODIFIERS FOR SUBSTANCE ABUSE HCPCS & CPT CODES	
MODIFIER	**DESCRIPTION**
GT	Telemedicine: the use of an electronic media to link beneficiaries with health professionals in different locations. The examination of the beneficiary is performed via a real-time interactive audio and video telecommunications system. The beneficiary must be able to see and interact with the off-site practitioner at the time services are provided via telemedicine.
HA	Child-Adolescent Program: services designed for persons under the age of 18.
HD	Women's Specialty Services: Pregnant/Parenting Women Program: services provided in a program that treats pregnant or women with dependent children. Men are eligible for WSS if they are determined, by PROVIDER, to be the parent solely responsible for the health and well-being of a dependent child(ren). HD is required for all qualified Women's Specialty Services.
HF	Substance Abuse Program: to be used with those codes shared between Mental Health and SUD. The modifier is to differentiate between SUD and Mental Health for billing purposes.
HH	Integrated Substance Abuse/Mental Health Program: program specifically designed to provide integrated services to persons who need both substance abuse and mental health services; as planned in an integrated, individualized treatment plan. HH modifier is required for qualifying Integrated Substance Abuse/Mental Health services. PROVIDER's will be assigned the use of HH modifiers with submission of documentation of licensure for Integrated Substance Abuse & Mental Health Services. All subsequent services delivered to meet the goals of the integrated plan are to be reported with an "HH". The use of this modifier is only applicable to Treatment based services; Not to be used with Support services.
HH TG	SAMHSA-approved Evidence Based Practice for Co-Occurring Disorders: Integrated Dual Disorder Treatment is provided.
SD	State Disability assistance

ATTACHMENT E: PERFORMANCE INDICATORS

The activities/indicators listed below must be met in the timeframes indicated. Failure to comply may result in a 5% administrative fee until compliance is achieved.

MEASURE

1) Consumers must be discharged from the Carenet system within 60 days of actual discharge (Outpatient PROVIDER's only) or 5 days of actual discharge (Residential/Detoxification PROVIDER's only)
REVIEWED: Quarterly

2) Consumers continuing in treatment in MSHN network must be discharged as a "transfer" in the Carenet system (Residential and detox PROVIDER's only)
REVIEWED: Monthly

3) PROVIDER must comply with Medicaid Indicators (All PROVIDER's)
REVIEWED: Quarterly

4) PROVIDER must submit all reports listed in the MSHN-SUDSP Manual (and others as requested) in the timeframes identified The PROVIDER is responsible for submitting timely reports to the PAYOR, as may from time to time be required by the PAYOR, complying with all reporting requirements as specified in Part II, Section 7.7.1 of the contract and the finance reporting requirements specified in Part II, Section 8.7. Additional requirements are identified in Attachment P 8.9.1 (Performance Objectives). (Reference Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver ProgramFY16 – Part II(B) Section 25.4; Attachment(s) P.7.7.1.1.; PII B.A. Substance Abuse Disorder Policy Manual; See SUD Services Policy Manual/Section I Data Requirements: Substance Abuse Encounter Reporting HCPCS and Revenue Codes Chart; Part II(B) Section). (All PROVIDER's)
REVIEWED: Quarterly

5) PROVIDER must maintain a consumer satisfaction process that demonstrates progress towards continual improvement and must adhere to MSHN's consumer satisfaction policy (All PROVIDER's)
REVIEWED: Annually

6) Discharges coded as "left against staff advice" (ASA) should not be greater than 15% of all discharges recorded in Carenet (All PROVIDER's)
REVIEWED: Quarterly

ATTACHMENT F:

HIPAA/HITECH BUSINESS ASSOCIATE AGREEMENT

This HIPAA Business Associate Agreement ("Addendum") supplements and is incorporated into the agreement between the CMHSP (COVERED ENTITY) and the Provider (BUSINESS ASSOCIATE OR "BA"), and is effective as of the date of the use or disclosure of Protected Health Information ("PHI") as defined below (the "Addendum Effective Date").

WHEREAS, the Parties wish to enter into or have entered into the Agreement whereby Business Associate will provide certain services to, for, or on behalf of Covered Entity which may involve the use or disclosure of PHI, and, in such event, pursuant to such Agreement, Business Associate may be considered a "Business Associate" of Covered Entity as defined below;

WHEREAS, Covered Entity and Business Associate intend to protect the privacy and provide for the security of PHI disclosed to Business Associate pursuant to the Agreement in compliance with, to the extent applicable, the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Standards for Privacy of Individually Identifiable Health Information promulgated thereunder by the U.S. Department of Health and Human Services at 45 CFR Part 160 and Part 164 (the "Privacy Rule"), the Standards for the Security of Electronic Protected Health Information promulgated thereunder by the U.S. Department of Health and Human Services at 45 CFR Part 160, Part 162, and Part 164 (the "Security Rule"), and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act");

WHEREAS, the purpose of this Addendum is to satisfy, to the extent applicable, certain standards and requirements of HIPAA, the Privacy Rule, the Security Rule and the HITECH Act, including applicable provisions of the Code of Federal Regulations ("CFR");

NOW, THEREFORE, in consideration of the mutual promises below and the exchange of information pursuant to this Addendum, the Parties agree as follows:

1. Definitions.

a. "Business Associate" in addition to identifying one of the Parties to this Addendum as set forth above, shall have the meaning given to such term under 45 CFR § 160.103.

b. "Breach" means the acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of 45 CFR Part 164 which compromises the security or privacy of PHI:

(i) For purposes of this definition, compromises the security or privacy of the protected health information means poses a significant risk of financial, reputational, or other harm to the individual.
(ii) A use or disclosure of protected health information that does not include the identifiers listed at 45 CFR 164.514(e)(2), date of birth, and zip code does not compromise the security or privacy of the protected health information.

The term "Breach" excludes:
(i) Any unintentional acquisition, access, or use of protected health information by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of 45 CFR Part 164.

(ii) Any inadvertent disclosure by a person who is authorized to access protected health

information at a covered entity or business associate to another person authorized to access protected health information at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under subpart E of 45 CFR Part 164.

(iii) A disclosure of protected health information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

c. "Covered Entity" in addition to identifying one of the Parties to this Addendum as set forth above, shall have the meaning given to such term under 45 CFR § 160.103.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR §164.501.

e. "Protected Health Information" or "PHI" means any information, whether oral or recorded in any form or medium, including paper record, audio recording, or electronic format:

(i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care (which includes care, services, or supplies related to the health of an individual) to an individual; or the past, present or future payment for the provision of health care to an individual; and

(ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and

(iii) that shall have the meaning given to such term under 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

f. "Electronic Protected Health Information" or "ePHI" means PHI transmitted by, or maintained in, electronic media, as defined in 45 CFR § 160.103.

g. "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502.

h. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103.

i. "Secretary" shall mean Secretary of the Department of Health and Human Services or designee.

j. "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system, as defined in 45 CFR § 164.304.

k. "Unsecured Protected Health Information" or "UPHI" shall mean unsecured PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5 on the HHS Web site.

l. "Catch-All Definition" Terms used, but not otherwise defined in this Addendum shall have the same meanings as those terms in the Agreement, the Privacy Rule, the Security Rule, or the HITECH Act, as the case may be.

2. Rights and Obligations of Business Associate.

a. Permitted Uses and Disclosures. Except as otherwise Required by Law or limited in this Addendum or the Agreement, Business Associate may use or disclose PHI as permitted by the Privacy Rule and to perform functions, activities, or services to, for, or on behalf of, Covered Entity as specified in the Agreement, provided that such use or disclosure would not violate the Privacy Rule or the Security Rule if made by Covered Entity or the minimum necessary policies and procedures of the Covered Entity. Business Associate may use or disclose PHI for the proper management and administration of the Business Associate as permitted by the Privacy Rule.

b. Nondisclosure. Business Associate shall not use or further disclose PHI other than as permitted or required by this Addendum or the Agreement or as Required by Law.

c. Safeguards. Business Associate shall use appropriate and reasonable safeguards to prevent use or disclosure of PHI other than as provided for by this Addendum. To the extent applicable, Business Associate shall comply with the Security Rule's administrative, technical and safeguard requirements. In addition, to the extent applicable, Business Associate shall implement Administrative Safeguards, Physical Safeguards, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of Covered Entity and shall maintain and implement reasonable policies and procedures that prevent, detect, contain and correct security violations of ePHI. Business Associate shall make its policies, procedures and documentation required by the Security Rule relating to the Safeguards available to the Secretary for the purpose of determining Covered Entity's compliance with the Security Rule.

d. Reporting of Disclosures. Business Associate shall report to Covered Entity any use or disclosure of PHI not provided for by this Addendum of which Business Associate becomes aware. In addition, from and after execution of this Addendum, Business Associate shall report to Covered Entity any Security Incident of which it becomes aware.

e. Notification in Case Breach. If Business Associate and/or Covered Entity access, maintain, retain, modify, record, store, destroy, or otherwise hold, use, or disclose UPHI, and Business Associate becomes aware of a Breach of such UPHI, Business Associate shall notify Covered Entity of such Breach in writing within thirty (30) days of discovery of such Breach. Such notice shall include the identification of each individual whose UPHI has been, or is reasonably believed by Business Associate to have been accessed, acquired, or disclosed during such Breach.

f. Business Associate's Agents. Business Associate shall ensure that any agents, including subProviders, to whom Business Associate provides PHI received from (or created or received by Business Associate on behalf of) Covered Entity agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI. In addition, Business Associate shall ensure that any agent, including a subProvider, to whom it provides ePHI received from Covered Entity agrees to implement reasonable and appropriate safeguards to protect it.

g. Access to PHI . To the extent applicable, Business Associate agrees to provide access, at the request of Covered Entity, and in the time and manner designated by Covered Entity, to PHI in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524 (if Business Associate has PHI in a Designated Record Set).

h. Amendment of PHI. To the extent applicable, Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.

i. Documentation and Accounting of Disclosures. To the extent applicable, Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. To the extent applicable, Business Associate agrees to provide to Covered Entity or an Individual, in time and manner reasonably

designated by Covered Entity, information collected in accordance with this Addendum, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

j. Internal Practices. Subject to any applicable legal privilege, and, if required by law, to the extent consistent with ethical obligations, Business Associate shall make its internal practices, books and records relating to the use and disclosure of PHI received from Covered Entity (or created or received by Business Associate on behalf of Covered Entity) available to the Secretary for purposes of the Secretary determining the Covered Entity's compliance with HIPAA and the Privacy Rule.

k. Mitigation. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI in violation of the requirements of this Addendum.

3. Obligations of Covered Entity.

a. Covered Entity shall provide Business Associate with the Notice of Privacy Practices that Covered Entity produces in accordance with 45 CFR § 164.520, as well as any changes to such notice.

b. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.

c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522.

d. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if made by Covered Entity, to the extent that such change may affect Business Associate's use or disclosure of PHI.

e. Covered Entity shall use appropriate and reasonable safeguards to prevent use or disclosure of PHI. Covered Entity shall comply with the Security Rule's administrative, technical and safeguard requirements. In addition, Covered Entity shall implement Administrative Safeguards, Physical Safeguards, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits and shall maintain and implement reasonable policies and procedures that prevent, detect, contain and correct security violations of ePHI. Covered Entity shall make its policies, procedures and documentation required by the Security Rule relating to the Safeguards available to the Secretary for the purpose of determining Covered Entity's compliance with the Security Rule.

f. Covered Entity agrees to mitigate, to the extent practicable, any harmful effect that is known to Covered Entity of a use or disclosure of PHI or a Breach of UPHI by Covered Entity in violation of legal requirements.

g. Covered Entity agrees to ensure that any agent, including a subProvider, to whom it provides PHI agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

h. Covered Entity shall comply with the administrative requirements set forth in the HIPAA Privacy Rule Part 164.

4. Term and Termination.

a. Term. The Term of this Addendum shall become effective as of the Effective Date of the

preceding agreement that this addendum is incorporated into and shall terminate upon the termination date identified in the preceding agreement **AND** when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, the parties agree that the protections, limitations, and restrictions contained in this Addendum shall be extended to such information, in accordance with the termination provisions of this Section. The provisions of this Addendum shall survive termination of the Agreement to the extent necessary for compliance with HIPAA and the Privacy Rule and Security Rule.

b. Material Breach. A material breach by either party of any provision of this Addendum shall constitute a material breach of the Agreement.

c. Reasonable Steps to Cure If Covered Entity learns of a pattern of activity or practice of Business Associate that constitutes a material breach or violation of the Business Associate's obligations under the provisions of this Addendum, then Covered Entity shall provide written notice to Business Associate of the breach and Business Associate shall take reasonable steps to cure such breach or end such violation, as applicable, within a period of time which shall in no event exceed thirty (30) days. If Business Associate's efforts to cure such breach are unsuccessful, Covered Entity may terminate the Agreement immediately upon written notice.

d. Effect of Termination.

1. Except as provided in paragraph 2 of this Section 4(d), upon termination of the Agreement for any reason, Business Associate shall return or destroy all PHI received from Covered Entity (or created or received by Business Associate on behalf of Covered Entity) that Business Associate still maintains in any form, and shall retain no copies of such PHI.

2. In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible, and shall extend the protections of this Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. The obligations of Business Associate under this Section 4(d)(2) shall survive the termination of the Agreement.

5. Amendment to Comply with Law. The Parties acknowledge that amendment of the Agreement may be required to ensure compliance with the applicable standards and requirements of HIPAA, the Privacy Rule, the Security Rule, the HITECH Act and other applicable laws relating to the security or confidentiality of PHI and/or ePHI. Upon Covered Entity's request, Business Associate agrees to promptly enter into negotiations with Covered Entity concerning the terms of an amendment to the Agreement embodying written assurances consistent with the standards and requirements of HIPAA, the Privacy Rule, the Security Rule, the HITECH Act or other applicable laws relating to security and privacy of PHI and/or ePHI. Covered Entity may terminate the Agreement upon thirty (30) days' written notice in the event Business Associate does not promptly enter into negotiations to amend the Agreement when requested by Covered Entity pursuant to this Section, or Business Associate does not enter into an amendment to the Agreement in order to bring it into compliance with, to the extent applicable, HIPAA, the Privacy Rule, the Security Rule, the HITECH Act or other applicable laws relating to security and privacy of PHI and provide assurances regarding the safeguarding of PHI and/or ePHI that Covered Entity, in its reasonable discretion, deems sufficient to satisfy the standards and requirements of HIPAA, the Privacy Rule, the Security Rule, or any other applicable laws relating to security and privacy of PHI and/or ePHI.

6. Effect on Agreement. Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with a material term of this Addendum, all other terms of the Agreement shall remain in full force and effect.

7. Regulatory References. A reference in this Addendum to a section in the Privacy Rule or Security Rule means the section as in effect or as amended, and for which compliance is required.

ATTACHMENT G: PROVIDER REPORTING REQUIREMENTS

FINANCIAL AND NON-FINANCIAL		
DUE DATES FOR FY 16-17 SUD PROVIDERS		
REPORT NAME	**DUE TO MSHN**	**SUBMIT TO**
CONSISTENT WITH GUIDELINES ESTABLISHED BY THE DEPARTMENT		
SUBMIT ANNUAL BUDGET REQUEST PREVENTION AND TREATMENT AS ESTABLISHED BY MSHN	7/31/2017	amy.keinath@midstatehealthnetwork.org
INDIRECT COST DOCUMENTATION (COST REIMBURSEMENT OR COST SETTLEMENT CONTRACTS ONLY)	WITH BUDGET PRIOR TO OCTOBER 1ST	amy.keinath@midstatehealthnetwork.org
EQUIPMENT INVENTORIES ($5000 OR MORE PER UNIT) (COST REIMBURSEMENT OR COST SETTLEMENT CONTRACTS ONLY)	WITH BUDGET PRIOR TO OCTOBER 1ST	amy.keinath@midstatehealthnetwork.org
CARENET CLAIMS SUBMISSION	TWICE PER MONTH BASED ON THE REPOIRTING DUE DATES IDENTIFIED IN THE PUBLISHED CALENDAR	CARENET WEB BASED DATA SYSTEM
SUD - 1ST QUARTER FSR COST REIMBURSEMENT AND COST SETTLEMENT CONTRACTS ONLY)	1/10/2017	amy.keinath@midstatehealthnetwork.org
SUD - 2ND QUARTER FSR	4/10/2017	amy.keinath@midstatehealthnetwork.org
COST REIMBURSEMENT AND COST SETTLEMENT CONTRACTS ONLY)		
SUD - 3RD QUARTER FSR	7/10/2017	amy.keinath@midstatehealthnetwork.org

COST REIMBURSEMENT AND COST SETTLEMENT CONTRACTS ONLY)		
SUD - 4TH QUARTER FSR COST REIMBURSEMENT AND COST SETTLEMENT CONTRACTS ONLY)	11/10/2017	amy.keinath@midstatehealthnetwork.org
SUD - SPECIAL PROJECTS	1/6/2017	amy.keinath@midstatehealthnetwork.org
SUD AUDIT REPORT	6/30/2017	amy.keinath@midstatehealthnetwork.org
CHARITABLE CHOICE REPORT	August 1, annually	Melissa.Davis@midstatehealthnetwork.org
SATISFACTION SURVEYS	8/1/2017	jeanne.diver@midstatehealthnetwork.org
ACCESS TIMELINESS REPORT		Melissa.Davis@midstatehealthnetwork.org
MONTHLY WAITING LIST REPORT	1st Mon. of month, unless holiday, then Tues.	rebecca.emmenecker@midstatehealthnetwork.org
EARMARK-FUNDED SPECIAL PROJECTS	TBD	Melissa.Davis@midstatehealthnetwork.org
PERFORMANCE INDICATORS (Provider to monitor monthly & correct by due date listed)	12/1/2016	jeanne.diver@midstatehealthnetwork.org
SUD - Sentinel Events Data Report (Residential Treatment Only) October 1, 2014 to March 31, 2015	10/15/2016	rebecca.emmenecker@midstatehealthnetwork.org
PERFORMANCE INDICATORS (Provider to monitor monthly & correct by due date)	3/1/2017	jeanne.diver@midstatehealthnetwork.org
PERFORMANCE INDICATORS (Provider to monitor monthly & correct by due date)	6/1/2017	jeanne.diver@midstatehealthnetwork.org
SUD - Sentinel Events Data Report (Residential Treatment Only)	4/15/2017 (1st of the month following end of 2nd and 4th Qtr's	jeanne.diver@midstatehealthnetwork.org

April 1 to September 30 quarters)		
PERFORMANCE INDICATORS (Provider to monitor monthly & correct by due date)	9/1/2017	jeanne.diver@midstatehealthnetwork.org
SUD - Injecting Drug Users 90% Capacity Treatment Report October 1 - September 30	4th quarter - 10/31/2017 due the end of month following the month following the last month of the quarter	rebecca.emmenecker@midstatehealthnetwork.org
SUD - Priority Populations Waiting List Deficiencies Report October 1 - September 30	Monthly Due end of month following the month in which the exception occurred (must submit even if no data to report)	melissa.davis@midstatehealthnetwork.org
SUD - Treatment Episode Data Set (TEDS) October 1 to September 30 SUD - Michigan Prevention Data System (MPDS) October 1 to September 30	Monthly (last day of month) Submit via DEG to MDCH/MIS Operations - see note below Monthly (15th of the month following the month that services were delivered) uploaded Submit to: mpds.sudpds.com	Melissa.Davis@midstatehealthnetwork.org
SUD - Encounter Reporting via HIPPA 837 Standard Transactions October 1 to September 30	Monthly (minimum 12 submissions per year) Submit via DEG to MDCH/MIS Operations See note below.	Melissa.Davis@midstatehealthnetwork.org
APPEALS/GRIEVANCES/SECOND OPINION (October 1 - March 31) (April 1 - September 30)	 6/30/2017 012/31/17	jeanne.diver@midstatehealthnetwork.org
MEDICAID FAIR HEARINGS (July 1 - September 30	 10/31/2016	jeanne.diver@midstatehealthnetwork.org

October 1- December 31 January 1 - March 31) April 1 - June 30)	1/31/2017 4/30/2017 7/31/2017	
Annual Report on Fraud and Abuse Complaints	10/31/16 4/30/17	kim.zimmerman@midstatehealthnetwork.org
Annual Litigation Report	10/31/2016	kim.zimmerman@midstatehealthnetwork.org
Women's Specialty Services Progress Report	10/15/2016	melissa.davis@midstatehealthnetwork.org
SUD- Women's Specialty Services Children's Referral Report	1/5/2017	melissa.davis@midstatehealthnetwork.org
SUD- Women's Specialty Services Children's Referral Report	4/5/2017	melissa.davis@midstatehealthnetwork.org
SUD- Women's Specialty Services Children's Referral Report	7/5/2017	melissa.davis@midstatehealthnetwork.org
SUD- Women's Specialty Services Children's Referral Report	10/5/2017	melissa.davis@midstatehealthnetwork.org