Fiscal Year 2023~~3~~4 Substance Use Disorder - Recovery
Contractual Agreement

Between

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

And

«PROVIDER»
(as a "Subrecipient" as that term is defined in OMB 2 CFR 200 Subpart A; Assistance Listings #: 93.959)

For the purpose of:

Recovery Residences

Payment by:
«CONTRACT_TYPE»

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ACRONYM AND GLOSSARY DEFINITIONS

Abuse: As defined in 42 CFR 455.2, provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet the professionally recognized standards for health care. ~~refers to practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the payor, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for healthcare.~~

Access System refers to providing individuals who seek assistance with guidance and support while reflecting the philosophies of support and care that the Michigan Department of Health and Human Services (MDHHS) promotes and requires through policy and contract, including person-centered, self-determined, recovery-oriented, trauma-informed, and least restrictive environments. Includes standards such as welcome, screen, determine eligibility, collect information, refer, inform, and conduct outreach.

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 determined eligible to receive services of the treatment program.

~~**Appeal**: A review at the local level by a PIHP of an Adverse Benefit Determination, as defined above. 42 CFR 438.400.~~

Assessment includes those procedures by which a qualified clinician evaluates an individual's strengths, areas identified for growth, problems, and needs to establish a SUD ~~diagnoses~~ diagnosis and determine priorities so that a treatment plan can be developed.

Care Coordination means a set of activities designed to ensure needed, appropriate and cost effective care for beneficiaries. As a component of overall care management, care coordination activities focus on ensuring timely information, communication, and collaboration across a care team and between Responsible Plans. Major priorities for care coordination in the context of a care management plan include:

- Outreach and contacts/communication to support patient engagement,
- Conducting screening, record review and documentation as part of Evaluation and Assessment,
- Tracking and facilitating follow up on lab tests and referrals,
- Care Planning,
- Managing transitions of care activities to support continuity of care,
- Address social supports and making linkages to services addressing housing, food, etc., and
- Monitoring, Reporting and Documentation.

Care Management means the application of systems, science, incentives, and information to improve practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.

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 stands for Community Mental Health Service Program. MSHN has 12 CMHSP partners each of which has a role in being a potential door for clients to access SUD services.

Continued Service Criteria is when, 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 of ASAM is considered in determining the need for continued service.

Continuity of Care – "means the quality of care over time, including both the patient's experience of a 'continuous caring relationship' with an identified health care professional and the delivery of a 'seamless service' through integration, coordination and the sharing of information between different providers".

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Continuum of Care refers to 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.

Co-Occurring Disorders are concurrent substance-related and mental health 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.

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

Customer 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.

Critical Incident is an event, which is reviewed to determine whether it meets the criteria for a sentinel event. Incidents include but are not limited to those identified by MDHHS/MSHN including the death of a recipient, ~~a serious physical illness requiring admission to a hospital~~, an alleged cause of abuse or neglect, an accident resulting in an injury to recipient requiring emergency room visit or hospital admission, a serious challenging behavior, medication error or the administration of Narcan.

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. It refers to the ability to honor and respect the beliefs (religious or otherwise), 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 when, in the process of treatment, certain problems and priorities indicate a different level of care, a different provider, or discharge from treatment may be necessary. The level of functioning and clinical severity of a client's status in each of the six ASAM dimensions is considered in determining the need for discharge or transfer.

DSM-V refers to the *Diagnostic and Statistical Manual of Mental Disorders (5th Edition*), developed by the American Psychiatric Association (APA). It is the standard classification of mental health disorders used by mental health professionals in the United States. It is intended to be used in SUD clinical settings by clinicians for determining behavioral health diagnoses that are part of the assessment and inform development of an individualized treatment plan with the medically necessary level of care.

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.

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.

Excluded individuals or entities are individuals or entities that have been excluded from participating, but not reinstated, in

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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.

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

Fraud: As defined in 42 CFR 455.2, means an intention deception or misrepresentation by a person with the knowledge the deception could result in unauthorized benefit to him/herself or some other person. This includes any act that constitutes fraud under applicable Federal or State laws.

FSR means Financial Status Report

~~**Grievance**: A Consumer's expression of dissatisfaction about service issues, other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a service provider and the consumer, failure to respect the Consumer's rights regardless of whether remedial action is requested, or a Consumer's dispute regarding an extension of time proposed by the PIHP to make a service authorized decision. 42 CFR 438.400.~~

~~**Grievance and Appeal System:** The processes implemented to handle Appeals of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them. 42 CFR 438.400.~~

HMP refers to Healthy Michigan Plan, Michigan's Medicaid expansion program which became effective on April 1, 2014, to serve newly enrolled persons. HMP expanded the array of services available for persons with substance use disorders in need of treatment.

Limited English Proficiency (LEP): Means being limited in the ability or unable to speak, read and/or write the English language well enough to understand and be understood without the aid of an interpreter.

LOS means Length of Stay.

MDHHS refers to the Michigan Department of Health and Human Services (MDHHS).

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, DSM-V 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 mental illness, developmental disability or substance use disorder, and/or are:

- Required to identify and evaluate a mental illness, developmental disability or substance use disorder that is inferred or suspected and/or are;
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability, or 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.

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- 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.

~~**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.

Prepaid Inpatient Health Plan (PIHP): A PIHP is an organization as defined in 42 CFR Part 438 and meets the requirements of MCL 330.1204b.

MSHN-SUDSP MANUAL which is incorporated into this agreement by reference and made a part hereof, means policies, procedures, and standards 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 "HCPCS/CPT Service Code – Substance Use Disorder Services" 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.

Recovery Housing means providing a location where individuals in early recovery from a behavioral health disorder are given time needed to rebuild their lives, while developing the necessary skills to embark on a life of recovery. This temporary arrangement will provide the individual with a safe and secure environment to begin the process of reintegration into society, and to build the necessary recovery capital to return to a more independent and functional life in the community. These residences provide varying degrees of support and structure. Participation is based on individual need and the ability to follow the requirements of the program.

REMI stands for the Regional Electronic Medical Information (REMI) system. REMI is the web-based managed care information system used by MSHN implemented on February 1, 2018. REMI replaced CareNet for collection of state and federal data elements, PIHP performance indicators, utilization management (authorization of services), and reimbursement.

RISC means Recovery and Integrated Services Collaborative, a regional effort to embed recovery-oriented systems of care (principles and practices) throughout the service provider network. Collaborative efforts of substance use and mental health providers and comprised of prevention providers, treatment providers, community members, and individuals in recovery.

Root Cause Analysis (RCA) is an analysis or investigation, which includes "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998)

ROSC refers to Recovery Oriented System of Care which describes a paradigm shift from an acute model of treatment to a care model that views SUD as a chronic illness. A ROSC is a coordinated network of community-based services and supports that is

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person-centered and builds over a period of months and/or years on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

Sentinel Event-An "unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase or 'risk thereof' includes any process variation for which a reoccurrence would carry a significant change of serious adverse outcome." (JCAHO, 1998)

SPF means Strategic Prevention Framework.

Stages 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."

~~**State Fair Hearing**: Impartial state level review of a Medicaid Consumer's appeal of an adverse benefit determination presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.~~

Subrecipient means an entity that expends awards received from a pass-through entity to carry out a project. As defined by Office of Management and Budget (OMB) 2 Code of Federal Regulations (CFR) 200 Subpart A, a subrecipient relationship exists when funding from a pass-through entity is provided to perform a portion of the scope of work or objectives of the pass-through entity's award agreement with the awarding agency. A pass-through entity is an entity that provides an award to a subrecipient to carry out a project. For purposes of this agreement, "subrecipient" refers to the Provider named on this agreement, whereas "pass-through entity" refers to MSHN. See OMB 2 CFR 200 Subpart A for further information.

Substance Use Disorder (SUD): As defined in MCL 330.1100d(11) of the Michigan Mental Health Code.

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SUDPDS means Substance Use Disorder Prevention Data System (also referred to as MPDS), is the State's web-based data system that captures all direct funded prevention services and specific recovery-based services and community out-reach services.

SUGE means Substance Use, Gambling and Epidemiology; State office formerly known as Office of Recovery Oriented Systems of Care OROSC

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 or from one provider 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.

Waste refers to the overutilization of services, or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions, but rather the misuse of resources.

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FY 2024~~3~~ CONTRACTUAL AGREEMENT

This Agreement is entered into by Mid-State Health Network (hereinafter referred to as "MSHN") and «PROVIDER», as the subrecipient as defined in OMB 2 CFR 200 Subpart A (hereinafter referred to as "PROVIDER") and is effective from October 1, 2023~~2~~, through September 30, 2024~~3~~.

I. GENERAL CONTRACT SUMMARY

MSHN and PROVIDER wish to enter into an Agreement whereby the PROVIDER will render recovery residences and support 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 SUGE~~OROSC~~ policies and technical advisories that are relevant to identified services for which they are contracted**.**

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

c. **MSHN-SUDSP MANUAL** is hereby incorporated into this Agreement by reference and made a part hereof. Information on 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. is hereby incorporated into this Agreement by reference and made a part hereof. Information on 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, incorporated by reference and made a part hereof.
Attachment A - Statement of Work
Attachment B - Cost Reimbursement
Attachment C - Performance Measures
Attachment D - Business Associate Agreement
Attachment - MSHN Training Requirements (Sent as a separate attachment)
Attachment - Reporting Requirements for MSHN SUD Providers FY 2024~~3~~ (Sent as a separate attachment)
Attachment - HCPCS/CPT Service Code – Substance Use Disorder Services (Sent as a separate attachment)

II. RECOVERY SERVICE OBLIGATIONS OF THE PROVIDER

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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 Utilization Management (UM) Department. Each UM Department authorization for Covered Services shall expire upon the earlier of (i) expiration date specified in the authorization and/or (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 Medicaid/HMP beneficiary or verification of 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 REMI's brief screening and level of care determination as part of the initial determination of eligibility for services at the time of the initial request for services, prior to an assessment being scheduled.

2. **Access to Service:** MSHN, in partnership with its SUDSP network and Community Mental Health Service Provider (CMHSP) network, maintains a regional multi-portal 24/7/365 access system for SUD services. PROVIDER shall ensure that all consumers are able to receive services in accordance with the access standards ("Access Standards" of PIHP/MDHHS contract) set forth by the Michigan Department of Health and Humans Services (MDHHS) and the MDHHS Substance Use, Gambling and Epidemiology (SUGE)~~Office of Recovery Oriented Systems of Care (OROSC)~~. PROVIDER is also required to utilize the Level of Care Determination in REMI at the time of the initial request for services to document access and referral activities. Requirements of PROVIDER pertaining to after-hours access include:
   a. PROVIDER phone systems link directly to the CMHSP access system during non-business hours or their automated response systems instruct callers to contact the CMHSP access system during non-business hours.
   b. The CMHSP and PROVIDER establish a written after-hours protocol for handling referrals during non-business hours.

3. **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. 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. 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. 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.

4. **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; (v) individual under supervision of MDOC and referred by MDOC or an individual being released directly from an MDOC without supervision and referred by MDOC; and (vi) all others. Consumers identified in i, ii, iii and iv above are prioritized regardless of county of residence within the MSHN region. In the State of Michigan, an injecting drug user is defined as anyone who has injected a drug within the last thirty (30) days.

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5. **Interim Services:** Interim services must be provided as defined by the MDHHS Substance Use, Gambling and Epidemiology (SUGE) ~~Office of Recovery Oriented Systems of Care (OROSC)~~ Access Standards (MDHHS/PIHP Master Agreement).

Residency: The PROVIDER must limit access to the programs and services funded by this portion of the Agreement only to the residents who reside within Region 5 catchment area.

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 REMI requesting reimbursement for authorized services.

2. **Cost Reimbursement for Treatment & Recovery Providers:** PROVIDER shall submit a monthly Financial Status Report (FSR) by the 10th day of each month after the month in which the service was rendered. All reimbursement requests for the fiscal year must be submitted no later than forty-five (45) days following the close of the fiscal year. Any reimbursement requests not submitted by the deadline may not be reimbursed by MSHN.

    a. For cost reimbursement contracts, the, PROVIDER may receive 1/12th of the budgeted amount as an advance pursuant to MSHN's cash advance policy. 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.

    b. PROVIDER will adhere to the capped funding levels described in Attachment B.

    c. By submitting a request for reimbursement, PROVIDER warrants and represents that the services for which the request is made were provided. MSHN shall have the right to review PROVIDER records, upon reasonable notice and during business hours, to verify that such services were provided and retains the right to disqualify any expenditure claimed that is unallowable or is inconsistent with the terms of this section.

3. **Claims Submission:** 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.

4. **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 REMI 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.

5. **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 HCPCS/CPT Service Code – Substance Use Disorder Services (Sent as a separate attachment). 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 REMI claim, except when the claim is contested in good faith. PROVIDER shall have no right to reimbursement for services provided to MSHN consumer without approved authorization of

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MSHN, unless otherwise provided herein. PROVIDER acknowledges that it will not receive compensation from MSHN for any services that are not listed in attached code grid. 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 or recovery housing services, PROVIDER shall not bill MSHN for days the consumer was not in residence during the treatment episode. If circumstances require the individual to leave the residential treatment facility/recovery residence for more than 24 hours (i.e.: brief hospitalization) but the individual is expected to return to the residential facility/recovery residence to resume treatment, the provider should notify the MSHN UM department of the reason for the gap in service.

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 Provider Appeals Process defined in the MSHN-SUDSP MANUAL.

6. **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.

7. **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 or Healthy Michigan 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, and that the rendering provider meets provider qualifications. 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.

8. **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

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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 including fiscal monitoring, 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. PROVIDER acknowledges and agrees that MSHN may also obtain site review findings and reports regarding the Provider from other PIHPs or CMHSPs, and MSHN may utilize such information in the exercise of its rights under this Agreement. MSHN retains the right to seek additional information or take further actions following the Provider site review, including, without limitation, conducting follow up site reviews. 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.

2. **Rendering Provider Credentialing and Recredentialing:** PROVIDER agrees to meet MSHN and MDHHS credentialing and recredentialing requirements, required criminal background checks, and accepts and shall abide by all credentialing policies and procedures.

   The PROVIDER shall ensure, through credentialing, that the PROVIDERS's staff professionals and the PROVIDER's subcontractors and their staff professionals have obtained and maintain all approvals, 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. A health care professional solely on the basis of license, registration or certification;
   b. A health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.

   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)).

   PROVIDER acknowledges and agrees 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.

3. **Consumer Satisfaction Surveys:** PROVIDER shall participate in MSHN Consumer Satisfaction Surveys. Provider shall identify sources of dissatisfaction, and identify systematic action, when needed, as a result of the findings. Failure to participate in Consumer Satisfaction Surveys may result in contract sanctions.

4. **Sentinel Events:** Provider agrees to review ~~all incidents~~incidents as identified by MSHN and MDHHS. W~~w~~ithin 3 business days of the critical incident the Proivder will~~to~~ determine if the event is sentinel. If the critical incident is determined to be sentinel, a root cause analysis (RCA) is required to commence within 2 business days of the determination of the sentinel event~~.~~. Sentinel events and critical incidents are to be reported as indicated in the reporting requirements.

~~5. **State Fair Hearing**: Medicaid consumers who request or receive services that are paid for with Medicaid funds per Michigan's approved use of Section (a)(1)(A) of the Social Security Act will be~~

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~~provided an Adverse Benefit Determination when services are denied, reduced, suspended or terminated. Consumers must exercise their right to a local appeal process before requesting their right to a State Fair Hearing.~~

~~6.~~5. **Covered Services:** PROVIDER represents and warrants to MSHN that Covered Services shall be provided to all eligible 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.

~~7.~~6. **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.

~~8.~~7. **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 as outlined in Attachment F - MSHN Training Requirements. PROVIDER shall furnish a written summary of such training and supervision efforts to MSHN upon request.

~~9.~~8. **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. PROVIDER will utilize, accept and honor the approved MDHHS 5515 standard consent form to release SUD records.

~~10.~~9. **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.

~~11.~~10. **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 make such medical records available to MSHN upon request for the purposes 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.

~~12.~~11. **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.

~~13.~~12. **Financial Review:** MSHN conducts annual reviews of all Subrecipients based on its Fiscal Monitoring and Oversight Procedure. In addition, the PROVIDER must submit, no later than six (6) months following the close of the provider's fiscal year, an independent financial audit, and Single Audit if applicable, conducted by a Certified Public Accounting (CPA) firm. MSHN may waive the CPA firm audit if providers are not currently operating under a Corrective Action Plan (CAP) and their total MSHN payments for the fiscal year in question are less than $100,000.

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~~14.~~13. **IRS Form 990:** PROVIDER that is non-profit tax-exempt organizations and required to file IRS form 990 shall submit, upon request of MSHN, a copy of the most recent informational return to the MSHN immediately following filing of same. For-profit organizations shall submit, upon request of MSHN, a copy of their most recent corporate tax return following filing of same.

~~15.~~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 and OMB 2 CFR 200. PROVIDER shall submit, upon request from MSHN, complete and accurate equipment inventory listing itemizing any equipment purchases made through federal or state funds.

~~16.~~15. **Agency Credentialing Requirements:** PROVIDER agrees to meet criteria for acceptance in the MSHN PROVIDER network including compliance with all applicable Federal and State laws, rules and regulations. 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. PROVIDER must notify MSHN in the event any license, certification, registration, accreditation, authorization, or approval expires, lapses, or is not renewed. MSHN must recredential PROVIDER biennially. PROVIDER shall provide MSHN with relevant documentation, upon request by MSHN, to support recredentialing reviews.

i. **Licensure:** PROVIDER shall maintain all necessary licenses, registrations or certifications as required by the Administrative Rules for Substance Abuse Service Programs in Michigan.
ii. **Certification:** PROVIDER shall maintain a Level III or higher certification as a Recovery Residence from NARR/MARR which shall be submitted to MSHN prior to providing services.
iii. PROVIDER hereby acknowledges and agrees that MSHN or its designee may share its credentialing information, site review findings and written report with other PIHPs or CMHSPs, upon request and as determined by MSHN, and any written response from the Provider. Notwithstanding anything to the contrary contained in this Agreement, PROVIDER agrees that MSHN may also obtain credentialing information, site review findings and reports regarding the Provider from other PIHPs or CMHSPs, and MSHN may utilize such information in the exercise of its rights under this Agreement.

~~17.~~16. **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:

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

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

~~18.~~17. The PROVIDER's CEO shall inform, in writing, MSHN's CEO of any notice to, inquiry from, or investigation by any Federal, State, or local human services, fiscal, regulatory, investigatory,

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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, MSHN's CEO immediately of any subsequent findings, recommendations, and results of such notices, inquiries, or investigations.

~~19.~~18. **Program Compliance:** PROVIDER shall implement and maintain a compliance and program integrity plan that is designed to guard against fraud and abuse in accordance with federal and state law, including but not limited to 42 CFR 438.608 and as included in the MDHHS/PIHP Master Agreement.

a. The Compliance Plan must include, at a minimum, all of the following elements:
   i. 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).
   ii. Clearly defined practices that provide for prevention, detection, investigation and remediation of any compliance related matters.
   iii. The designation of a compliance officer and a compliance committee that are accountable to senior management;
   iv. Effective training and education for the compliance officer and the organization's employees;
   v. Effective lines of communication between the compliance officer and the organization's employees;
   vi. Enforcement of standards through well publicized disciplinary guidelines;
   vii. Provision for internal monitoring and reporting;
   viii. 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.

c. PROVIDER agrees 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, until guidance has been given by the PIHP, and agrees 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 agrees 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's Compliance Officer with respect to any inquiry, investigation, sanction or otherwise from the Office of Inspector General (OIG).

f. PROVIDER will submit information on program integrity activities, when requested, to comply with requirements of the Office of Inspector General (Program Integrity Section of the MDHHS/PIHP Master Contract). This may include, but not limited to:
   i. Identification and investigation of fraud, waste and abuse
   ii. Audits performed
   iii. Overpayments collected
   iv. Corrective Action Plans Implemented
   v. Provider Dis-Enrollments
   vi. Contract Terminations

g. **MDHHS-OIG Sanctions**: When MDHHS-OIG sanctions a PROVIDER, including for a credible allegation of fraud under 42 CFR 455.23, MSHN must, at a minimum, apply the same

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sanctions upon written notification of the sanction from MDHHS-OIG to MSHN. MSHN may pursue additional measures/remedies independent of the State.

20. **Disclosure of Litigation, or Other Proceeding.** Contractor must notify MSHN within 10 calendar days of receiving notice of any litigation, investigation, arbitration, or other proceeding (collectively, "**Proceeding**") involving Contractor, a subcontractor, or an officer or director of Contractor or subcontractor, that arises during the term of the Contract, including: (a) a criminal Proceeding; (b) a parole or probation Proceeding; (c) a Proceeding under the Sarbanes-Oxley Act; (d) a civil Proceeding involving: (1) a claim that might reasonably be expected to adversely affect Contractor's viability or financial stability; or (2) a governmental or public entity's claim or written allegation of fraud; or (e) a Proceeding involving any license that Contractor is required to possess in order to perform under this Contract.

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: 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.

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 VI.A.1 of this agreement. PROVIDER may not finance any advertising using MSHN funding.

D. 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.

All media promoting programs funded all or in part by MSHN must acknowledge the funding source by using text or a logo provided by MSHN.

If Provider is planning on conducting a local Media Campaign, all materials must be approved by MSHN and/or MDHHS.

Providers shall submit materials for review and approval along with the MSHN "SUD Services Media Campaign Request Form" linked to the MSHN website.

~~D.~~

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

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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. 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 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.

C. Accessibility: PROVIDER shall ensure that all consumers are able to receive services in accordance to the access standards ("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 is responsible for procuring any necessary supports or accommodations that are required by the consumer. 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, reduced capacity or elimination of services as soon as possible. Provider shall not offer hours of operation that are less than the hours of operation offered to commercial members or not comparable to Medicaid fee-for-service (FFS), if the provider serves only Medicaid members.

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 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 relating to Dually Enrolled Consumers and/or Care Coordination. Please refer to the MSHN-SUDSP Manual for additional procedural guidance regarding Integrated Coordination of Care, Transfer, Warm Transfer

~~**E. Grievance, Appeals, and Fair Hearings:** PROVIDER will assure that consumer rights to a Grievance, Appeals, and/or Fair Hearing are provided. PROVIDER agrees to comply with applicable sections of Federal law 42 CFR 431.200-250 and 42 CFR 438.400-438.424 regarding Grievance, Appeals, and Fair Hearings. Substance Use disorder rights are defined in Part 5 of the Michigan Administrative Code, Licensing and Regulatory Affairs, Bureau of Community and Health Systems: (R 325.1391).~~

~~F.~~E. **Consumer Choice:** PROVIDER must assure that consumers are given a choice in the selection of a qualified treatment program. This choice must be documented in the consumer's file. Consumers are to be given a choice of rendering provider to the extent feasible.

~~G.~~F. **Consumer Eligibility:** PROVIDER is responsible for identifying a consumer's Block Grant eligibility at the time of admission to services. Financial information needed to determine ongoing ability to pay (financial responsibility) must be reviewed every 90 days or at a change in an individual's financial status, whichever occurs sooner. Please see MSHN website Finance Policies and Procedures for the most current version of the SUD Income Eligibility & Fees Policy and Procedure.

~~H.~~G. **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

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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;

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; and

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.

I. **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. **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.

2. **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.

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.

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2. **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. Refer to MSHN's Record Retention policy.

3. **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.

4. **Notices to MSHN:** PROVIDER shall notify MSHN within seven (7) 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 of 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). PROVIDER agrees to furnish MSHN's CEO with immediate notice of any severe incident involving any recipient of SUD services performed under the terms of this agreement.

5. **Notification of Recipient Sentinel Event**: Provider shall notify MSHN of all events that are sentinel including but not limited to all death ~~within 48 hours of a death~~ that are~~is~~ the subject of a recipient rights, licensing, or police investigation are to be reported to MDHHS within 48 hours of the death or notification of the death.. The following information is to be included in the notification: Name of beneficiary; Beneficiary ID number (Medicaid/MI Child); Consumer ID if no beneficiary ID; Date, time, and place of death; Preliminary cause of death; Contact persons' name and Email address.

6. **Notification of Staffing Changes:** The PROVIDER shall notify MSHN within three (3) days of any changes to the composition of its employed staff, contracted staff, or subcontractors that negatively affect consumer access to care. PROVIDER shall have procedures to address changes that negatively affect access to care. Changes in staff composition that MSHN determines to negatively affect recipient access to covered services may be grounds for sanctions such as a hold on new admissions.

7. **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 and within the MSHN Research Policy.

8. **Trauma Informed Care Organizational Survey:** PROVIDER under contract with MSHN shall complete the Trauma Informed Care (TIC) Organizational Survey. This document shall be uploaded to Box, with supporting documentation if necessary. PROVIDER shall set goals annually and report progress. The Trauma Informed Organizational Survey will be utilized as a self-assessment and completed every three years.

~~3.~~ B. Assurances of PROVIDER

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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. In addition, all expenses must meet OMB 2 CFR 200 Subpart E Cost Principles. PROVIDER will also comply with all applicable

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general administrative requirements such as 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, religion, national origin, age, disability or sex including discrimination based on pregnancy, gender identity or expression, sexual orientation ~~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 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.

~~1.~~**3.** **Ownership and Control Interests:** By signing this agreement, assurance is hereby given to MSHN that PROVIDER will comply with Federal regulation 42 CFR 438.610 and certifies that it

a. Has not been convicted of certain crimes as described in section 1128(b)(8)(B) of the Act
b. Is not debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulations or from participating in non-procurement activities under the regulations issued under Executive Order No. 12549 or guidelines implementing Executive Order No. 12549;
c. Is not excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act.
d. 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.

~~2.~~**4.** **Prohibited Relationships:** PROVIDER will not have a "relationship" with any individual or entity that is excluded from participating in any federal health care program under section 1128 or 1128A of the Social Security Act. A "relationship" means someone who the PROVIDER interacts with in any of the following capacities:

a. A director, officer, or partner of the PROVIDER;
b. A subcontractor of the PROVIDER;
c. A person with beneficial ownership of five (5) percent or more of the PROVIDERs equity; or
d. A provider or person with an employment consulting or other arrangement for the provision of items and services which are significant and material to obligations under the PROVIDER contract.

If MSHN finds the PROVIDER has a prohibited relationship as defined above, MSHN:

a. May continue an existing agreement with the PROVIDER unless the State directors otherwise; and
b. May not renew or otherwise extend the duration of an existing agreement with the PROIVDER unless the State provides to MSHN a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.

~~3.~~**5.** ~~5.~~ **Debarment and Suspension:** PROVIDER will comply with 45 CFR Part 76 and certifies to the best of its knowledge and belief that it, including its employees and subcontractors:

a. Have not within a three-year period preceding this agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction, violation of federal or state antitrust statutes or

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commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property.

b. Are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state or local) with commission of any of the offenses enumerated in Section i, and;

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

4.6. MSHN requires the PROVIDER to provide written disclosure in the case that any of the following is or becomes affiliated with any individual or entity that is debarred, suspended, or otherwise excluded from participating is procurement activities under Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or guidelines implementing Executive Order No. 12549:

a. Any director, officer, or partner;
b. Any subcontractor;
c. Any person with ownership of 5% or more of the PROVIDER equity;
d. Any party to an employment, consulting, or other agreement with the PROIVDER for the provision of contract items or services.

MSHN requires PROVIDERS to disclose information on individuals or corporations with an ownership and control interest in the PROVIDER to MSHN at the following times:

a. When the PROVIDER submits a proposal in accordance with MSHN's procurement process;
b. When the PROVIDER executes a contract with MSHN;
c. When the MSHN extends or renews and contract; and
d. Within 35 days after any change in ownership of the PROVIDER.

Exclusions Monitoring: 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 following exclusion databases:

a. 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;
b. The United States General Services Administration (GSA) http://www.sam.gov to ensure the individual or entity has not been excluded from federal programs;
c. The State sanctioned list is at the Michigan Department of Health and Humans Services (MDHHS) List of Sanctioned Providers.

PROVIDER must make a monthly search for all excluded parties using all lists provided herein addition to any/all other state and federal lists that may become available PROVIDER will maintain documentation of the completion of such checks and make them available to MSHN for inspection.

Disclosure Requirements: 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. 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.

5.2. **Notice Requirements:** PROVIDER must notify MSHN CEO immediately if:

a. 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

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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 any of the aforementioned exclusions databases;

b. PROVIDER has 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.

c. Any disclosures are made with regard to the ownership or control by a person that 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): or

d. Any staff member, director or manager, individual with beneficial ownership of five percent or more, or an individual with an employment, consulting, or other arrangement with the PROVIDER 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)).

~~6.~~**7. Acceptance of Claims:** MSHN will not accept claims from PROVIDER for any items or services furnished, ordered or prescribed by excluded individuals or entities. 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. 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.

~~7.~~**8. Subcontracts:** PROVIDER shall not subcontract any portion of this agreement without the written authorization of MSHN. 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:

a. Be in writing, and include a full specification of the subcontracted services;

b. Contain a provision stating that this Agreement is incorporated by reference into the subcontract and made a part thereof;

c. 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

d. Contain all subcontracting requirements of the MDHHS/PIHP Contract, under applicable sections, “SUBCONTRACT”

The Provider, as a prime subcontractor of the MSHN, is responsible under this Agreement for primary verification that the Provider’s contracting procedures meet the MDHHS’s requirements of the MSHN 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.

~~8.~~**9. 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.

~~9.~~**10. 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

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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:

1. 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:
   a. Pay for inpatient hospital services except under conditions specified in federal law;
   b. Make cash payments to intended recipients of services;
   c. Purchase or improve land, purchase, construct, or permanently improve and building or any other facility, or purchase major medical equipment;
   d. Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of funds;
   e. Provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs;
   f. Enforce state laws regarding the sale of tobacco products to individuals under the age of ~~18~~21;
   g. Pay the salary of an individual at a rate in excess of Level I of the Federal Executive Schedule, or approximately $199,700.

D. Termination

1. **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. The PROVIDER must make a good faith effort to give written notice of termination of a contracted service to each member who received his/her primary care from, or was seen regularly by, the terminating providers program. Notice to the member must be provided by the later of thirty (30) calendar days prior to the effective date of termination, or fifteen (15) calendar days after receipt or issuance of the termination notice.

2. **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.

3. **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

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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

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PROVIDER, at its sole expense, must obtain and/or maintain the insurance coverage identified below. All required insurance must protect the MSHN from claims that arise out of, are alleged to arise out of, or otherwise result from PROVIDER's or subcontractor's performance.

Required Limits	Additional Requirements
Commercial General Liability Insurance	
Minimum Limits: $1,000,000 Each Occurrence $1,000,000 Personal & Advertising Injury $2,000,000 General Aggregate $2,000,000 Products/Completed Operations	
Automobile Liability Insurance	
Minimum Limits: $1,000,000 Per Accident	PROVIDER must have their policy include Hired and Non-Owned Automobile coverage.
Workers' Compensation Insurance	
Minimum Limits: Coverage according to applicable lawsgoverning work activities	Waiver of subrogation, except where waiver is prohibited by law.
Employers Liability Insurance	
Minimum Limits: $500,000 Each Accident $500,000 Each Employee by Disease $500,000 Aggregate Disease	
Privacy and Security Liability (Cyber Liability) Insurance	
Minimum Limits: $1,000,000 Each Occurrence $1,000,000 Annual Aggregate	PROVIDER must have their policy cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability.
Professional Liability (Errors and Omissions) Insurance	
Minimum Limits: $3,000,000 Each Occurrence $3,000,000 Annual Aggregate	

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If any required policies provide claims-made coverage, the PROVIDER must: (i) provide coverage with a retroactive date before the effective date of this contract or the beginning of contracted activities; (ii) maintain coverage and provide evidence of coverage for at least three (3) years after completion of the contracted activities; and (iii) if coverage is cancelled or not renewed, and not replaced with another claims-made policy form with a retroactive date prior to the effective date of this contract, PROVIDER must purchase extended reporting coverage for a minimum of three (3) years after completion of work.

PROVIDER must: (i) provide insurance certificates to MSHN, containing the agreement or delivery order number, at the time of contract execution and within twenty (20) calendar days of the expiration date of the applicable policies; (ii) require that subcontractor's maintain the required insurances contained in this Section; (iii) notify the PAYOR within five (5) business days if any policy is cancelled; and (iv) waive all rights against MSHN for damages covered by insurance. Failure to maintain the required insurance does not limit this waiver.

This Section is not intended to and is not to be construed in any manner as waiving, restricting or limiting the liability of either party for any obligations under this Contract (including any provisions hereof requiring PROVIDER to indemnify,defend and hold harmless MSHN).

~~PROVIDER shall maintain professional liability coverage which provides a minimum coverage of $1,000,000 per claim and $2,000,000 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. Privacy and Security Liability (Cyber Liability) Insurance: Minimum Limits: $1,000,000 Each Occurrence $1,000,000 Annual Aggregate; PROVIDER must have their policy cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability.~~

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.

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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.

2. **Medicaid/HMP:** PROVIDER services will be authorized based on medical necessity as well as considering the individual needs of the person receiving services.

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3. **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. Any expansions to the original proposal shall be submitted to MSHN for review and approval prior to implementation.

4. **Access to Full-Service Array:** MSHN requires of its substance use disorder Provider Network that no MSHN client is denied access to or pressured to reject the full-service array of evidence-based and potentially life-saving treatment options, including Medication Assisted Treatment (MAT), that are determined to be medically necessary for the individualized needs of that client.

5. **MAT Inclusive Policy:** PROVIDER is expected to adopt a MAT-inclusive philosophy in which 1) the provider demonstrates willingness to serve all eligible treatment-seeking individuals, including those who are using MAT as part of their individual recovery plan at any stage of treatment or level of care, and without precondition or pressure to adopt an accelerated tapering schedule and/or a mandated period of abstinence, 2) the provider develops policies that prohibit disparaging, delegitimizing, and/or stigmatizing of MAT either with individual clients or in the public domain.

6. **Access to Multiple Pathways of Recovery:** In the interest of consumer choice, MSHN will contract with Abstinence-Based providers who offer written policies and procedures stating the following:
   a. If a prospective client, at the point of access, expresses his/her preference for an abstinence-based treatment approach, the access worker will obtain a signed "MSHN Informed Consent" form that attests that the client was informed in an objective way about other treatment options including MAT, and the client is choosing an abstinence-based provider from an informed perspective. The informed consent must be initialed by the client to signify receipt and review of MSHN's Informational Grid on Recovery Pathways for Opioid Use Disorder (OUD) and may be found in the MSHN SUD Provider Manual.
   b. When a client already on MAT (or considering MAT) is seeking treatment services (counseling, case management, recovery supports, and/or transitional housing) at the point of access to an AB facility, access staff a) will be accepting of MAT as a choice, b) will not pressure the client to make a different choice, and

c) will work with that client to do a "warm handoff" to another provider who can provide those ancillary services while the client pursues his or her chosen recovery pathway that includes MAT.

c. Providers' policies will include language that prohibits delegitimizing, and/or stigmatizing of MAT (e.g. using either oral or written language that frames MAT as "substituting one addiction for another") either verbally with individual clients, in written materials for clients or for public consumption, or in the public domain.

I . Contract Remedies and Sanctions

1. **Contract Non-Compliance:** MSHN may use a variety of means to assure implementation of and compliance with contract and/or reporting 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 corrective action plan and specified status reports that become a contract performance expectation;
   c. Temporary hold on new client admissions in the event of continual contractual non-compliance and/or identified health or safety issues.
   d. The withholding of payment, in the event that the above noted items have not been successful, the withholding of payment shall be in accordance with MSHN Compliance: Provider Contract Non-Compliance Procedure. Prior to withholding payment as noted below, the MSHN will give sixty (60) days' notice to allow for a period of correction, except for occurrences of required reports not being submitted as outlined in Section I.2 – Delinquent Reports.
   e. Voiding of claims and recoupment of monies from disbursement.
   f. Revocation or suspension of identified applicable delegated functions and/or authorizations until such time as the non-compliance issue(s) have been corrected;
   g. Contract termination in instances of material breach, or where the identified steps above have not resolved the deficiency.

2. **Delinquent Reports:** For sanctions related to required reporting compliance issues as indicated in the Delinquency Procedure for SUD Providers and on Attachment "Reporting Requirements for MSHN SUD Providers FY2024~~3~~" and/or other reporting requests with due date(s), and/or requested information with due date(s), MSHN may delay scheduled payment to the PROVIDER if not submitted on time as indicated on Attachment "Reporting Requirements for MSHN SUD Providers FY 2024~~3~~" and/or other reporting requests with due date(s), and/or requested information with due date(s), until such time as compliance is achieved. (NOTE: MSHN may apply this sanction in a subsequent payment cycle should the required reports, as indicated on Attachment "Reporting Requirements for MSHN SUD Providers FY 2024~~3~~" and/or other reporting requests with due date(s), and/or requested information with due date(s), not be submitted as required).

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: _____

Its: Chief Executive Officer

Printed Name: Joseph Sedlock

Date:

«PROVIDER»

By: _____

Its:

Printed Name: _____

Date: _____

ATTACHMENT A: STATEMENT OF WORK

1) **Annual Plan Guidelines:** PROVIDER will comply with the requirements of the Annual Plan Guidelines communicated to PROVIDER by MSHN. Annual 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, which is incorporated into this agreement by reference and made a part hereof.

3) **Screening and Admission Requirements:** PROVIDER must screen all eligible consumers requesting services to determine if the individual is appropriate for recovery housing services within their organization. Each organization must have a written policy addressing admission criteria which must include, at a minimum, the length of abstinence prior to admission and the expectation of participation with an outpatient provider.

4) **Staff Qualifications**: PROVIDER shall ensure that all staff meet the provider qualification requirements as required by MDHHS, including training requirements. Provider is responsible for maintaining evidence in staff personnel file that staff meets requirements. Failure to meet provider qualifications, including training requirements, will result in recoupment of funds.

5) **Fee Policies and Procedures:** PROVIDER must comply with the Income Eligibility & Fee Policies and Procedures. Please see MSHN website Finance Policies and Procedures for the most current version of the SUD Income Eligibility & Fees Policy and Procedure.

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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. 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) **Care Coordination:** Required expectations for care coordination in the context of a care management plan shall include, but not be limited to:

a. Outreach and contacts/communication to support participant engagement,
b. Conducting screening, record review and documentation as part of Evaluation and Assessment,
c. Tracking and facilitating follow up on referrals,
d. Post discharge follow up,
e. Care Planning,
f. Managing transitions of care activities to support continuity of care, to include arranging for timely referral appointments and coordinating and transferring necessary information with appropriate consent(s) between internal and external providers.
g. Address social supports and making linkages to services addressing housing, food, etc., and
h. Monitoring, Reporting and Documentation.

8) **Primary Care Coordination:** PROVIDER must assure that substance use disorder recovery services are coordinated with primary health care. Recovery files must include the physician's name and address, a signed waiver release or a statement that the consumer refused to sign. To demonstrate primary care coordination, the provider should minimally send a communication to the physician notifying them of the person receiving SUD services and have documented attempts to coordinate physical/medical care needs with the physician, as appropriate in the persons agency record.

9) **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 and/or other reporting requests with due date(s), and/or requested information with due date(s) to MSHN, and as may from time to time be required, to comply with all reporting requirements as specified in the MDHHS/MSHN Master Agreement.

10)

11) **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) 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.

13) 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.

14) Hypodermic Needles: PROVIDER assures that no Federal or State funds will be used to provide consumers with hypodermic needles or syringes enabling such consumers to use illegal drugs.

15) Charitable Choice (Faith-based PROVIDER Only):

i. Regulations:
   i. The faith-based organization is based on the self-identification as a faith-based organization.
   ii. The faith-based organization is eligible to participate as a network PROVIDER.
   iii. 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.
   iv. The transferring faith-based organization PROVIDER must notify the alternative PROVIDER and Notify MSHN UM Department (Access Center) of the transfer. Utilizing the REMI System can help facilitate this transfer.

j. Procedures: Under Charitable Choice, States, local governments and religious organizations, such as SAMHSA grant recipients (including faith-based PROVIDER s) must:
   i. Provide notice to all potential and actual consumers of their right to alternative services.
   ii. Refer program consumers to alternative services as needed / requested.
   iii. 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 you 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."

16) 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 REMI.

17) Transportation Guidelines: PROVIDER must maintain documentation for transportation provided to the consumer. In accordance with the Medicaid Provider Manual - Non-Emergency Medical Transportation, individuals transporting consumers must hold a valid driver's license appropriate to the class of vehicle being operated as defined by the Michigan Vehicle Code Act 300 of 1949.

18) 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 by individuals in recovery in order to help prevent relapse and to promote recovery. PROVIDER must comply with

MSHN Peer Recovery/Recovery Support Policy. 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.

PROVIDER will select the appropriate code (T1012 or H0038) depending on the qualifications of the peer delivering the service. PROVIDER will select the TT modifier for group services. Claims submission for consumers receiving an individual session for peer recovery shall not include the TT modifier. Billable services are based on face-to-face encounters.

19) Recovery Residences: It is the expectation of MSHN that recovery housing be provided to aid clients in recovery in accordance with standards identified by the National Alliance of Recovery Residences (NARR). MSHN supports the recommendations of SUGE~~OROSC~~ as stated in Treatment Technical Advisory #11. Recovery housing is expected to be a safe, structured, and substance free environment. Clients residing in recovery housing must be actively engaged in formal outpatient treatment with a credentialed outpatient provider. Case management, although part of the outpatient treatment services, is not sufficient on its own. The Recovery Housing provider is responsible for monitoring client attendance in treatment by coordinating care with the treatment provider. Recovery housing must be identified as medically necessary in the client's recovery plan and the recovery plan must be present in the client's recovery housing file.

MSHN expects recovery housing providers to employ recovery coaches to enhance a client's recovery experience. If the provider cannot offer this service, they must coordinate care with another local provider of recovery coaching services while the recovery residence actively seeks to hire a trained recovery coach. The provider of the recovery residence will maintain a file on each client admitted into recovery housing. All provided services must be formally documented on the consumer's individual recovery plan. This includes, but is not limited to, individual peer support services, and/or peer group services. All services provided must be documented via an individualized progress note. All progress notes should include a summary of what occurred during the service, start and stop time, date of service, and be signed by the facilitator. In addition, facilitators must indicate any relevant certification/credential and list the date the note was signed. The recovery residence file should include but not be limited to:

- Basic demographic information
- Releases of information are required in client file for the following: primary care physician, outpatient provider, MSHN, emergency contact
- Evidence of engagement with an outpatient provider Application
- Brief Screening completed in REMI
- Signed client acknowledgement of discussion and receipt of recovery housing rules and expectations
- Recovery Plan developed with the client and recovery coach, and included in the client's file at the Recovery House. Recovery Plans must include the following components:
    a) Recovery Plans Developed in Partnership with the consumer as evidenced by the consumer's words
    b) Goals & Objectives are Written using Specific, Measurable, Attainable, Realistic & Time Limited elements.
- Evidence of regular care coordination with service providers
- Evidence of regular attendance with a formal outpatient provider~~. in the MSHN network.~~
- Evidence of regular drug screening, if necessary (this service is not billable to MSHN)
- Evidence of weekly house meetings
- Recovery coaching progress notes if recovery coaching is being provided on location
- Block Grant Income Eligibility & Fee Determination form

20) It is the expectation of MSHN that clients who meet medical necessity and clinical criteria will be admitted to services regardless of their participation in a medication assisted treatment program.

21) MSHN will fund up to 90 days of recovery housing based upon determination of medical necessity. Providers will work with each consumer and the consumer's outpatient treatment provider to develop a recovery plan identifying either alternative housing to which consumer will go after discharge or alternative sources of funding to pay for the consumer's continued stay in recovery housing.

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iv. PROVIDER may submit ~~two~~ an authorization request~~s~~ based on medical necessity:
- The ~~initial~~ authorization request will be for a maximum of 90 days.
- ~~The re-authorization request must be individualized and include a discharge plan and/or the rationale for client's continued housing past 90days~~.

v. PROVIDER shall follow all outpatient request guidelines in the MSHN SUD Provider Manual, as outlined in the Recovery Housing Technical Requirement.

22) 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 PROVIDERs 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.

a) 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.

b) 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.

c) 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.

d) 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.

e) 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.

f) 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.

23) Customer Service Requirements~~/Recipient Rights~~: PROVIDER is required to:

a. Distribute the Customer Handbook to individuals at intake, annually, and as requested.
~~b. Display the LARA "Know Your Rights" Recipient Rights poster in a common area within the location/building available to view by consumers. The poster shall indicate the program rights advisor's name and phone number and shall include the name and phone number of the regional rights consultant.~~
~~c. Ensure Recipient Rights protections are provided to consumers, as defined by LARA, in accordance to the PROVIDER's LARA licensing requirements.~~
~~d.~~ Ensure there is a designated function for "Customer Services" ~~as defined by the State of Michigan in MDHHS/PIHP Agreement "Customer Services Standards."~~and
~~c.~~b. ~~Ensure Customer Services has~~ staff to sufficiently meet the needs of the consumers engaged in services.
~~f. Customer Service staff shall be trained and possess a working knowledge of the State mandated Customer Service topics found within the in MDHHS/PIHP Agreement "Customer Services Standards."~~
~~g.~~c. Upon request, Customer Service staff shall assist ~~beneficiaries~~ consumers with ~~filing grievances and appeals,~~ accessing local dispute resolution processes~~, and coordinate, as appropriate, with the local Recipient Rights Advisor~~.
~~h.~~ The PROVIDER shall sufficiently display and provide to consumers how to contact local Customer Service ~~s~~ via phone and/or mail. ~~The hours Customer Services operates and the process for accessing information from Customer Services outside those hours shall be publicized.~~

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~~i. Telephone calls to Customer Service shall be answered by a live voice during business hours. Telephone menus are not acceptable.~~

d.

24) Information Accessibility/Limited English Proficiency: PROVIDER shall comply with the Office of Civil Rights Policy Guidance on Title VI "Language Assistance to Persons with Limited English Proficiency (LEP)" by abiding by the LEP requirements within the MSHN Information Accessibility/Limited English Proficiency (LEP) Policy. PROVIDER will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) due to literary or impairment reasons have meaningful access and an equal opportunity to participate in services. PROVIDER shall ensure beneficiaries are notified of the availability of alternative formats, translated written information, and oral interpretation in their preferred language based on their language skills. LEP resources shall be provided without cost to the person being served.

25) Medicaid Adverse Benefit Determination, Grievances, Appeals, and Fair Hearings: PROVIDER agrees to comply with applicable sections of Federal law 42 CFR 431.200-250 and 42 CFR 438.400-438.424 regarding Adverse Benefit Determination, Grievance, Appeal, and Fair Hearing. Consumers who receive services that are paid for with Medicaid funds per Michigan's approved use of Section (a)(1)(A) of the Social Security Act will be provided an Adverse Benefit Determination when Medicaid services are denied, reduced, suspended, or terminated. Consumers may exercise their right to a local Medicaid appeal process for Medicaid funded services and must request a local appeal before requesting their right to a Medicaid State Fair Hearing. PROVIDERS must have processes in place to handle Medicaid Adverse Benefit Determinations, Grievances, and Appeals to Adverse Benefit Determinations. Processes are required to be completed through MSHN's REMI system. Notices of Adverse Benefit Determinations, Grievances, and Appeals are required to be provided to Medicaid beneficiaries for Medicaid funded services. Completing the process through MSHN's REMI system will allow providers to maintain records which include the required information of the name of the person for whom the Appeal or Grievance was filed, a general description of the reason for the Appeal or Grievance, the date received, date of each review, date of the resolution, and the resolution details of the Appeal or Grievance. The recordkeeping must be accurately maintained in a manner accessible to MSHN and available upon request. Additionally, Medicaid funded consumers may access local dispute resolution processes and their complaint(s) must be processes as a Medicaid Grievance when their complaint involves the Medicaid service(s) or staff providing the Medicaid funded service(s).

~~**24) Appeal and Grievance:** PROVIDERS must complete Appeal and Grievance processes within MSHN's REMI system. Records must be accurately maintained in a manner accessible to MSHN and available upon request. Records must contain (at a minimum) the following information:~~

~~a. A general description of the reason for the appeal or grievance.~~
~~b. The date received.~~
~~c. The date of each review or, if applicable, review meeting.~~
~~d. Resolution at each level of the appeal or grievance if applicable.~~
~~e. Date of resolution at each level, if applicable.~~
~~f. Name of the covered person for whom the appeal or grievance was filed.~~

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ATTACHMENT B: COST REIMBURSEMENT

FY 2024~~3~~ FUNDING ALLOCATION SUMMARY
«PROVIDER»

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.

If Provider is awarded ~~SOR~~ local or federal supplemental block grant funds, Provider shall~~Grant funds, Provider shall~~ fulfill the expectations and standards of the notices of award(s) (NOA), as summarized ~~NOA & FOA as highlighted~~ below:~~:~~

-
- Provider~~SOR sub-grantees~~ must utilize third party and other revenue realized from the provision of services to the extent possible and use SAMHSA/other grant funds only for services to individuals who are not covered by public or commercial health insurance programs, individuals for whom coverage has been formally determined to be unaffordable, or for services that are not sufficiently covered by an individual's health insurance plan. ~~SOR sub-grantees are~~Provider is also expected to facilitate the health insurance application and enrollment process for eligible uninsured clients.
- ~~SOR sub-grantees'~~Provider performance will be monitored by MSHN via monthly progress/outcomes reports.
- Criminal background checks must be part of ~~SOR sub-grantees~~Providers' conditions for employment.
- ~~SOR sub-grantees~~Provider must have business practices and processes in place to ensure client confidentiality per Title 42 of the Code of Federal Regulations, Part II.
- ~~SOR sub-grantees~~Provider must operate within a recovery-oriented system of care that will improve retention in care.
- ~~SOR sub-grantees~~Provider must meet obligations under the Government Performance and Results (GPRA) Modernization Act of 2010~~0~~.
- ~~SOR sub-grantee treatment p~~Provider~~s~~ must employ evidence-based practices (MAT, Project ASSERT, etc.) and use them with fidelity to the model. MSHN will monitor for fidelity.
- Grant funds may be used to supplement or expand existing activities. Grant funds may not be used to supplant current funding of existing activities. "Supplant" is defined as replacing funding of a recipient's existing program with funds from a local or federal grant.
- Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . and public policy requirements."); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.
- Grant funds for treatment and recovery support services shall only be utilized to provide services to individuals that specifically address opioid and stimulant misuse issues. If an opioid misuse problem (history) exists concurrently with other substance use, all substance use issues may be addressed. Individuals who have no history of or no current issues with opioid or stimulant misuse shall not receive treatment or recovery services with grant funds.
- Provider may not use grant funds for DATA waiver training.
- Provider is required to comply with all applicable requirements of Charitable Choice regulations. Provider must ensure that treatment clients and prevention services recipients are notified of their right to request alternative services. Notice may be provided by the AMS or by faith-based providers. The PIHP must assign responsibility for providing the notice to the AMS, to providers, or both.
- Funds may not be expended through the grant by Provider which would deny any eligible client, patient or individual access to their program because of their use of FDA-approved medications for the

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treatment of substance use disorders (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine monoproduct formulations, naltrexone products including extended-release and oral formulations or long acting products such as extended release injectable or implantable buprenorphine.) Specifically, patients must be allowed to participate in methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an Opioid Treatment Program and ordered by a physician who has evaluated the client and determined that methadone is an appropriate medication treatment for the individual's opioid use disorder. Similarly, medications available by prescription or office-based implantation must be permitted if it is appropriately authorized through prescription by a licensed prescriber or provider. In all cases, MAT must be permitted to be continued for as long as the prescriber or treatment provider determines that the medication is clinically beneficial. Recipients must assure that clients will not be compelled to no longer use MAT as part of the conditions of any programming if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.

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ATTACHMENT B.1: FEE FOR SERVICE
FY2024~~3~~ 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 Provider Fee Schedule Report

«FFS_SERVICES»

ATTACHMENT C: PERFORMANCE MEASURES – RECOVERY HOUSING

The activities/indicators listed below are intended as quality improvement measures. On a quarterly basis, provider performance will be reviewed. The expected outcome is for the provider to show improvement from previous quarters. For providers who do not show improvement, quality improvement initiatives will be required to be implemented.

MEASURE

1) Percentage of clients with housing at discharge

Scope: This includes all persons served as indicated by Behavioral Health Treatment Episode Data Set (BH-TEDS) living arrangement status at admission and then at discharge.

REVIEWED: Quarterly

2) Percentage of clients with employment at discharge

Scope: This includes all persons served as indicated by Behavioral Health Treatment Episode Data Set (BH-TEDS) employment status at admission and then at discharge.

REVIEWED: Quarterly

ATTACHMENT D: HIPAA/HITECH BUSINESS ASSOCIATE AGREEMENT

This HIPAA Business Associate Agreement ("Addendum") supplements and is incorporated into the agreement between the MSHN (COVERED ENTITY) and the Provider («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. Risk analysis is a requirement in § 164.308(a)(1)(ii)(A). Conducting a risk analysis is the first step in identifying and implementing safeguards that comply with and carry out the standards and implementation specifications in the Security Rule. Business Associate shall attest to conducting an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the Business Associate. 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, within 15 business days, 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.

The SUD Provider attests that a risk analysis has been completed as part of their security management process and is in accordance with 45 CFR 164.306 and 164.308 (a)(1)(ii)(A). The SUD Provider agrees to provide a copy of the risk analysis to the PIHP, upon request.

ATTACHMENT: REPORTING REQUIREMENTS FOR MSHN SUD PROVIDERS FY 2024~~3~~
(SENT AS SEPARATE PDF ATTACHMENT)

ATTACHMENT: MSHN TRAINING REQUIREMENTS
(SENT AS SEPARATE PDF ATTACHMENT)

ATTACHMENT: PROVIDER FEE SCHEDULE REPORT (SENT AS SEPARATE PDF ATTACHMENT)