Fiscal Year 20221 Substance Use Disorder - Treatment
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;
CFDA Assistance Listings #: 93.959)

For the purpose of:

Treatment

Payment by:
«CONTRACT_TYPE»

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ACRONYM AND GLOSSARY DEFINITIONS

Abuse 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.

AMS refers to the Access Management System which is required by the Michigan Department of Health and Human Services (MDHHS) to screen, authorize, refer and provide follow-up services.

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

ASAM refers to the American Society for Addiction Medicine. It is the medical association for Addictionologists. The members developed the patient placement criteria, the most recent of which is *The ASAM Patient Placement Criteria*, *3rd Edition*.

ASI [KJ1]~~refers to the Addiction Severity Index, a semi-structured interview designed to address seven potential problem areas in clients with substance use disorders and to determine level of care.~~

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 and determine priorities so that a treatment plan can be developed.

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.

Case Management refers to a substance use disorder case management program that coordinates, plans, provides, evaluates and monitors services or recovery from a variety of resources on behalf of and in collaboration with a client who has a substance use disorder. A substance use disorder case management program offers these services through designated staff working in collaboration with the substance use disorder treatment team and as guided by medical necessity and the individualized treatment planning process.

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.

Community Mental Health Service Program (CMHSP) is a program operated under Chapter 2 of the Michigan Mental Health Code- Act 258 of 1974 as amended. 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.

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.

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.

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

Encounter is used for billing purposes related to treatment services, recovery support, and early intervention services to indicate a measure of time spent providing a service with a consumer.

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 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 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 an 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.

Healthy Michigan Plan (HMP) is a category of eligibility authorized under the Patient Protection and Affordable Care Act and Michigan Public Act 107 of 2013 that began April 1, 2014. HMP is part of Michigan's Medicaid expansion program that expanded the array of services available for persons with substance use disorders in need of treatment.

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.
- Symptom alleviation alone is not sufficient for purposes of admission.

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

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

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

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

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

MSHN-SUDSP MANUAL 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 "Provider Fee Schedule Report - REMI" 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.

RSA-R means Recovery Self-Assessment Revised. It is a validated scale designed to gauge the degree to which programs implement recovery-oriented practices. It is a self-reflective tool designed to identify strengths and target areas of improvement as agencies and systems strive to offer recovery-oriented care. There are three versions designed for different population groups.

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 is used 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.

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 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 lifestyle (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.

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.

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.

FY 20224 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, 20210, through September 30, 20224.

I. GENERAL CONTRACT SUMMARY

MSHN and PROVIDER wish to enter into an Agreement whereby the PROVIDER will render treatment 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**[KJ2] **of Work:** PROVIDER agrees to undertake, perform and complete the services described in Attachment A that is hereby made a part of this Agreement. Additionally, PROVIDER agrees to follow all MDHHS and OROSC policies and technical advisories that are relevant to identified services for which they are contracted.

b. **Method**[KJ3] **of Payments and Performance Measures:** 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**[KJ4] 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**[KJ5] **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 E - Disclosure of Ownership & Controlling Interest Statement
Attachment F - Reporting Requirements for MSHN SUD Providers FY 20224 (Sent as a separate attachment)
Attachment G - MSHN Training Requirements (Sent as a separate attachment)
Attachment H – Provider Fee Schedule Report - REMI (Sent as a separate attachment)

II. TREATMENT SERVICE OBLIGATIONS OF THE PROVIDER

A. General Provisions

1. **Authorization**[KJ6]**:** 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~~Member~~ 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**[KJ7] **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 (Attachment[KJ8] ~~P4.1.1~~ "Access Standards" of PIHP/MDHHS contract) set forth by the Michigan Department of Health and Humans Services (MDHHS) and the MDHHS Office of Recovery Oriented Systems of Care (OROSC)~~ Treatment Policy #7- Access Management System~~. 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. **Utilization**[KJ9] **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.

4. **Admission**[KJ10] **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.

5. **Interim**[KJ11] **Services:** Interim services must be provided as defined by the MDHHS Office of Recovery Oriented Systems of Care (OROSC) Access Standards~~Management System~~ (~~Attachment P4.1.1 of~~ MDHHS/PIHP Master Agreement) .

6. **Waiting**[KJ12] **List:** Outpatient, Residential and Withdrawal Management PROVIDER should notify the UM Department immediately when they have to implement a waiting list and when the waiting list has ended. Persons with Medicaid or HMP eligibility may not be put on a waiting list. If necessary residential and withdrawal management services are not available to a Medicaid or HMP eligible recipient, other appropriate service options must be made available.

7. **Residency**[KJ13]: The PROVIDER may not limit access to the programs and services funded by this portion of the Agreement only to the residents of the PROVIDERS region, because the funds provided by the Department under this Agreement come from federal and statewide resources. Members of federal and state-identified priority populations must be given access to screening and to assessment and treatment services, consistent with the requirements of this portion of the Agreement, regardless of their residency. However, for non-priority populations, MSHN may give its residents priority in obtaining services funded under this portion of the Agreement when the actual demand for services by residents eligible for services under this portion of the Agreement exceeds the capacity of the agencies funded under this portion of the Agreement.[CM14][SP15]

8. **Biopsychosocial**[KJ16] **Assessment:** To support the use of the ASAM criteria and aid in matching individuals with the appropriate level of care, Michigan is requiring the use of an assessment tool that utilizes the ASAM criteria. Per MDHHS approval, only the ASAM Continuum~~GAIN I-core or other approved Centers for Medicare and Medicaid Services (CMS) ASAM compliant assessments~~ is approved and will be allowed after September 30, 2021 to support assessing adults for SUD services. The GAIN I Core will ~~be the only assessment allowable for use to assess adolescents for SUD services.~~ All providers will be required to use the ASAM Continuum and GAIN I Core from October 1, 2021 forward. ASAM Continuum requires clinicians utilizing the system complete an 8-hour training, and also recommends staff have attended the ASAM "Basic" 2-day training. Refer to the MSHN SUD Provider Manual for further details. The GAIN I Core requires training and certification prior to implementation through either Chestnut Health Systems or a MSHN regional local trainer. Further, the provider is required to use the electronic GAIN Assessment Building System (ABS) to collect all GAIN I Core data. To that end, PROVIDER must complete the necessary steps to obtain organization and user permissions to access GAIN ABS. This includes completing Chestnut Health Systems GAIN ABS Request for Agency Set-Up, Data Use Agreement, and New User Agreement. For all approved biopsychosocial assessments, the PROVIDER must comply with MSHN and MDHHS data collection requirements. ~~Regardless of what tool is utilized, it must collect necessary information to provide a Diagnostic and Statistical Manual based diagnosis and recommend ASAM placement needs. If using GAIN I-Core, PROVIDER staff must be trained and certified by either Chestnut Health Systems or a regional local trainer. Further, PROVIDER is required to use the electronic GAIN Assessment Building System (ABS) to collect all GAIN I-Core assessment data. To that end, PROVIDER must complete the necessary steps to obtain organization and user permissions to access GAIN ABS. This includes completing Chestnut Health Systems' GAIN ABS Request for Agency Set-up, Data Use Agreement, and New User Agreement. For all approved biopsychosocial assessments, the PROVIDER must comply with MSHN and MDHHS data collection requirements.~~

~~9. **Gambling**[KJ17] **Disorder Screening, Assessment, and Referral:** Outpatient and Residential providers shall administer the 3-question NODS-CLiP Gambling Disorder screen to consumers. Results of the NODS-CLiP screen must be documented and made~~

~~available to MSHN in a format to be provided by MSHN. PROVIDER shall administer the 9-question NODS-SA assessment upon affirmative response to any one of the three questions on the NODS-CLiP. The assessment outcome must be documented and made available to MSHN in a format to be provided by MSHN with either a "rule out" of gambling disorder or a diagnosis of gambling disorder (hereinafter referred to as "GD").~~

~~If there is a GD diagnosis, PROVIDER shall add a goal to the treatment plan regarding the GD diagnosis and make a referral to the Gambling Disorder Helpline. Progress notes following a referral to the Helpline should document ongoing check-in regarding GD with the consumer to encourage follow-through with the Helpline and to discuss parallels and differences in their addictions to gambling and to substances. Discharge should reflect coordination of care regarding GD with the next level of care.~~

B. Billing[KJ18] 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 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 Provider Fee Schedule Report - REMI (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 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,[CM19][SP20] 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[KJ21][CT22] **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 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**[KJ23][SG24][KZ25][CT26] **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**[KJ27] **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

PROVIDER shall not assign a consumer to any practitioner who has not fully complied with credentialing process as outlined in the MDHHS Credentialing and Re-credentialing Process (Provider CredentialingAttachment P7.1.1), the MDHHS-BHDDA Substance Abuse Disorder Policy Manual – Credentialing and Staff Qualification Requirements (Attachment P.II.B.A of the MDHHS/PIHP Contract), and MSHN Credentialing and Recredentialing policies and procedures. Rendering providers must meet qualifications outlined in MDHHS Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes.Behavioral Health Codes Sets, Charts, and Provider Qualifications.

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

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**[KJ28][SG29][KZ30] **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. **Recovery**[KJ31][SG32] **Self-Assessment**: Provider shall participate in an assessment of the recovery environment. This includes the completion of the self-assessment for administrators and providers. The Provider shall implement a self assessmentself-assessment for persons in recovery. Provider further agrees to provide data as requested by MSHN.

5. **Sentinel**[KJ33][SG34][KZ35] **Events**: Provider agrees to review all required incidents as identified by MSHN DHHS to determine if a sentinel event has occurred requiring a root cause analysis. Sentinel events are to be reported as indicated in the reporting requirements., utilizing the template provided by MSHN.

6. **State**[KJ36][KZ37] **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 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.

7. **Covered**[KJ38] **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.

8. **Covered**[KJ39][SP40] **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.

9. **PROVIDER**[KJ41][CT42] **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 G - MSHN Training Requirements. PROVIDER shall furnish a written summary of such training and supervision efforts to MSHN upon request.

10. **Record**[KJ43][KZ44] **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 ~~must use the~~ approved MDHHS 5515 standard consent form to release SUD records.

11. **Health**[KJ45][KZ46] **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.

12. **Medical**[KJ47][KZ48] **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.

13. **Record**[KJ49][KZ50] **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.

14. **Financial**[KJ51] **Review:** **MSHN conducts annual reviews of all Subrecipients based on its Fiscal Monitoring and Oversight Procedure. In addition, t**~~T~~he 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.

15. **IRS**[KJ52] **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.

16. **Accounting**[KJ53] **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.

17. **Agency**[KJ54][CT55] **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.

    a. **Licensure:** PROVIDER shall maintain all necessary licenses, registrations or certifications as required by the Administrative Rules for Substance Abuse Service Programs in Michigan.
    b. **Accreditation:** Treatment PROVIDER shall maintain accreditation as an alcohol and/or drug use disorder program by one (1) of the six (6) national accrediting bodies; 1) Joint Commission on Accreditation of Health Care Organizations (TJC), 2) Commission on Accreditation of Rehabilitation Facilities (CARF), 3) Council on Accreditation of Services for Families and Children (COA), American Osteopathic Association (AOA), 5) Accreditation Association for Ambulatory Health Care (AAAHC).or 6) National Committee on Quality Assurance (NCQA).
    c. 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.

18. **ASAM**[KJ56][CT57] **Level of Care (LOC) Enrollment Requirements:** MSHN shall enter into agreements with PROVIDERS who have completed the MDHHS Level of Care Enrollment process and received a formal designation for the LOC that is being offered. MSHN shall enter into a contract for those services only after the provider has received a state designation. PROVIDERS must reenroll with MDHHS every two years, from the date of the

initial enrollment authorization from MDHHS. Refer to the MSHN SUD Provider Manual for enrollment procedures. The provision of SUD treatment services must be based on the ASAM LOC criteria. To ensure compliance with and fidelity to ASAM, PROVIDER shall ensure that policies and practices are in accordance with the designated LOC. PROVIDER must notify MSHN of changes to the LOC offered.

19. **Compliance**[KJ58][CT59] **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.

    During the current COVID-19 State of Emergency; Federal and/or State policy or Executive Orders issued and in effect beginning on March 10, 2020, including any modifications of such Executive Orders or policies in relation to COVID-19, issued after that date, that provide different guidance or requirements than are currently identified and stated within this agreement and/or PAYOR's policies, procedures, the PROVIDER shall follow the federal and/or state direction and guidance as it relates to the COVID-19 State of Emergency.

    Pursuant to the MDHHS/PIHP Master Agreement ~~(XVIII(B))~~ if MSHN, the Michigan Department of Health & Human Services (MDHHS), Center for Medicare and Medicaid Services (CMS), the Office of Inspector General (OIG), the Comptroller General, and their designees (hereinafter referred to as the "Requesting Parties") request access to books, documents, and records of the parties hereto at any time within ten (10) years from the final date of the contract period or from the date of completion of any audit that occurs within such ten (10) year period , whichever is later, in accordance with Section 952 of the Omnibus Reconciliation Act of 1980 [42 USC 1395x(v)(1)(I)], 42 CFR 438.230(c)(3), and the regulations adopted pursuant thereto, the parties hereto agree to provide such access to the extent required. Furthermore, the parties agree that any contract between either of them and any other organization to which it is to a significant extent associated or affiliated with, owns or is owned by or has control of or is controlled by (hereinafter referred to as "Related Organization"), and which performs services on behalf of it or the other party hereto, will contain a clause requiring the Related Organization to similarly make its books, documents, and records available to the Requesting Parties.

20. 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, 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.

21. **Program**[KJ60][KZ61] **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 (~~Section 33.0:~~ 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**[KJ62][KZ63]**-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 sanctions upon written notification of the sanction from MDHHS-OIG to MSHN. MSHN may pursue additional measures/remedies independent of the State.

22. **Disclosure of Litigation, or Other Proceeding**[KZ64]**.** 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[KJ65] 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[KJ66] **and Treatment:** PROVIDER is solely responsible for all decisions regarding the medical care and treatment of MSHN consumers that are referred for 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.

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

C. Advertising[KJ67][CT68]**:** 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[KJ69][CT70] **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.

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

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

A. **Scope**[KJ71][CT72] **and Terms of the Agreement:** MSHN hereby retains PROVIDER to provide Covered Services for consumers under the terms and conditions set forth in this Agreement. PROVIDER will make substance use disorder treatment decisions and provide advice for purposes of diagnosis and treatment of covered consumers. MSHN will make benefit determinations with respect to covered consumers. MSHN will perform quality assurance and utilization review functions with respect to Covered Services provided or arranged by PROVIDER. PROVIDER understands that MSHN is dependent upon MDHHS for accuracy and timeliness of Medicaid eligibility data.

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

B. **Acceptance**[KJ73][KZ74] **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**[KJ75][SP76]**:** PROVIDER shall ensure that all consumers are able to receive services in accordance to the access standards (~~Attachment P4.1.1~~ "Access Standards" of PIHP/MDHHS contract) set forth by the Michigan Department of Health and Humans Services (MDHHS). PROVIDER also ensures services are delivered in a manner that takes into consideration the consumer's ethnicity, cultural differences, language proficiency, communication abilities, and physical limitations. PROVIDER 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.

D. **Referral**[KJ77] **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**[KJ78][KZ79]**, 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 42CFR 431.200-250 and 42CFR 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. **Consumer**[KJ80][KZ81] **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 (clinician) to the extent feasible.

G. **Consumer**[KJ82][KF83][SP84] **Eligibility:** PROVIDER is responsible for identifying a consumer's active eligibility for Medicaid/HMP reimbursement through the REMI system at the time of admission to treatment and every 30 days thereafter. PROVIDER is responsible for assisting any non-insured or under-insured consumer with Medicaid/HMP eligibility application within 30-days of admission (or within 30-days of loss of coverage). Block grant eligibility shall be determined at the time of admission to services. Financial information needed to determine ongoing ability to pay (financial responsibility) must be reviewed every 90 days~~annually~~ 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. **Compensation**[KJ85]**:** PROVIDER hereby agrees that in no event, including but not limited, to non-payment by insolvency or breach of this Agreement, shall PROVIDER bill, charge, collect from, seek compensation, remuneration or reimbursement from, or have any recourse against consumers or persons other than MSHN acting on the consumers' behalf for services provided pursuant to this Agreement. PROVIDER shall look solely to MSHN and not to any Covered consumer for payment for all Covered Services provided (excluding patient pay amount) to covered consumers under this Agreement. PROVIDER shall be responsible for paying for all costs that it incurs in providing Covered Services under this Agreement. PROVIDER shall defend, indemnify, and hold harmless covered consumers, Medicaid/HMP, MDHHS, and MSHN against any and all such claims.

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

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

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.

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

V. Medicaid Responsibilities of MSHN

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

1. **Access**[KJ86] **Center Phone Number:** An access center telephone number will be available twenty-four (24) hours per day, seven (7) days per week for network referrals. During standard business hours, Monday-Friday 8am to 5pm inquiries related to access to services should be directed to the MSHN Utilization Management toll-free phone number: 1-844-405-3095. Inquiries related to access to services that occur outside of standard business hours (evenings, weekends, holidays) should be directed to the Access Center for the Community Mental Health Services Program in the corresponding county.

2. **Eligibility**[KJ87][SP88] **Data Systems:** MSHN shall maintain a current eligibility data system with mechanisms for PROVIDER access and a process for reconciliation of

errors. PROVIDER understands that MSHN is dependent upon MDHHS representatives for the accuracy and timeliness of Medicaid eligibility data.

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

VI. CONTRACTUAL PROVISIONS

A. General Responsibilities of the PROVIDER

1. **Publication**[KJ89][CT90] **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.

2. **Record**[KJ91][KZ92] **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. Provider shall not store consumers data, nor backup files, in any location that is outside the continental United States. 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**[KJ93][CT94] **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**[KJ95][CT96] **to MSHN:** PROVIDER shall notify MSHN within seven~~teen~~ (7~~10~~) business days of any of the following events: (i) of any civil, criminal, or other action brought against it for any reason or any finding of any licensing/regulatory body or accrediting body, the results of which suspend, revokes, or in any way limits PROVIDER authority to render Covered Services: (ii) of any actual or threatened loss, suspension, restriction or revocation of PROVIDER license or ability to fulfill its obligations under this agreement; (iii) of any malpractice action filed against PROVIDER; (iv) of any charge or finding 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**[KJ97][CT98] **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. ~~.~~

6. **Research**[KJ99][KZ100] **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.

7. **DDCAT**[KJ101] **& TIC:** All SUD Treatment Providers under contract with MSHN shall complete the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Assessment and the Trauma Informed Care (TIC) Organizational Survey. Both documents shall be uploaded to Box, with supporting documentation for all items on the DDCAT uploaded to Box and labeled appropriately. All contracted SUD Treatment service providers shall set goals for improvement in both categories annually and report progress. All contracted SUD Providers are expected to meet criteria for dual diagnosis capability (co-occurring capability). The Trauma Informed Organizational Survey will be utilized as a self-assessment and completed every three year.

B. Assurances of PROVIDER

1. **Compliance**[KJ102][KZ103] **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 general administrative requirements such as grant/Agreement principles, and audit requirements, in carrying out the terms of this Agreement.

2. **Non**[KJ104][KZ105]**-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, ethnicity or national origin, age, height, weight, marital status, partisan considerations, any physical or mental unrelated to the individual's ability to perform the duties of the particular job or position, ~~disability~~ or sex including discrimination based on pregnancy, sexual orientation, gender identity, transgender status or ~~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.

3. **Ownership**[KJ106][CT107] **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.

4. **Prohibited**[KJ108][CT109] **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.

5. **Debarment**[KJ110][CT111] **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 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.

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.

7. 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.

8. **Exclusions**[KJ112][CT113] **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 here in 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.

9. **Disclosure**[KJ114][CT115] **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.

10. **Notice**[KJ116][CT117] **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 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)).

11. **Acceptance**[KJ118] **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.

12. **Subcontracts**[KJ119][CT120]**:** 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[KJ121] all subcontracting requirements of the MDHHS/PIHP Contract, under applicable sections~~,~~ "Subcontract" ~~"SUBCONTRACTING" Part I, Section 38.0 and Part II, Section 11.0~~.

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.

10. **Health**[KJ122][KZ123] **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.

11. **Tobacco**[KJ124][CT125]**-free Environment Federal Requirement/Pro-Children Act:** The PROVIDER also assures, in addition to compliance with P.L. 103-227, any services or activity funded in whole or in part through this Contract will be in a smoke-free facility or environment. Smoking shall not be permitted anywhere in the facility, or those parts of the facility under the control of the Contractor. If activities or services are delivered in facilities or areas that are not under the control of the Contractor (e.g., a mall, restaurant or private work site), the activities or services shall be smoke-free.

C. Block[KJ126][KJ127][SP128] 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;
   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[KJ129][CT130]

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.

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**[KJ131] **Reporting Upon Termination:** Should this Agreement be terminated by either party, within sixty (60) days after the termination, PROVIDER shall provide MSHN with all financial, performance, and other reports required as a

condition of this Agreement. MSHN will make payments to PROVIDER for allowable reimbursable costs not covered by previous payments or other State or Federal programs. PROVIDER shall immediately refund to MSHN any funds not authorized for use and any payments or funds advanced to PROVIDER in excess of allowable reimbursable expenditures. Any dispute arising as a result of this Agreement shall be resolved in the State of Michigan.

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

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

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

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

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

e. **Conflict**[KJ132] **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. Provider shall not store consumers data, nor backup files, in any location that is

outside the continental United States.

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

E. Continuation[KJ133][CT134] 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[KJ135][CT136] Insurance

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

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

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

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

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G. Resolution[KJ137][CT138] 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**[KJ139][KJ140][SP141] **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**[KJ142]**/HMP:** Sub-acute withdrawal management and residential treatment services may be provided to eligible consumers who reside in the PIHP region and request the services. Sub-acute withdrawal management and residential services will be authorized based on medical necessity utilizing ASAM Criteria 3rd edition, as well as considering the individual needs of the person receiving services.

3. **Accepted**[KJ143][KZ144] **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**[KJ145] **to Full-Service Array:** MSHN requires of its substance use disorder Treatment 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**[KJ146] **Inclusive Policy:** PROVIDER is expected to adopt a MAT-inclusive treatment 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**[KJ147] **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**[KJ148] **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 plan of correction 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: Contract Compliance Procedure. [KZ149]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.~~i. For sanctions related to all other contract non-compliance issues, MSHN may delay the scheduled payment to the PROVIDER until after compliance is achieved. MSHN may add time to the delay on subsequent uses of this provision. (NOTE: MSHN may apply this sanction in a subsequent payment cycle and will give prior written notice to the PROVIDER).
   ~~f.~~e. Reduction in the PROVIDER authorization/budget in the amount directly related to the MSHN loss of funds due to non-compliance.
   ~~g.~~f. Recoupment of monies from disbursement;
   ~~h.~~g. Revocation or suspension of identified applicable delegated functions and/or authorizations until such time as the non-compliance issue(s) have been corrected;
   ~~i.~~h. Contract termination in instances of material breach, or where the identified steps above have not resolved the deficiency.

2. **Delinquent**[KJ150][KZ151] **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 FY2022~~1~~" 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 2022~~1~~" 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 2022~~1~~" 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**[KJ152] **Plan Guidelines:** PROVIDER will comply with the requirements of the Annual Plan Guidelines communicated to PROVIDER by MSHN.

2) MSHN-SUDSP MANUAL[KJ153][CT154]**:** 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**[KJ155] **and Priority Admission Requirements:** PROVIDER must screen all eligible consumers requesting services to determine priority population. Priority for admission should be given to (i) Pregnant Injecting Drug User; (ii) Pregnant with Substance Use Disorder; (iii) Injecting Drug User; (iv) Parent at Risk of Losing Children; (v) Individual Under Supervision of MDOC and Referred by MDOC or Individual Being Released Directly from an MDOC Without Supervision and Referred by MDOC; (vi) All Others. Screening for history of injecting drug use, regardless of county of residence, within the past thirty (30) days, and if identified as so, must admit them within fourteen (14) days or if not possible, provide interim services. Interim services minimally include a referral for counseling and education about HIV/AIDS, tuberculosis and hepatitis, the risk of needle sharing, transmission to sexual partners and children, steps that can be taken to ensure that HIV/AIDS transmission does not occur, referral to HIV/AIDS and tuberculosis services if necessary, and early intervention clinical services. The interim service efforts must be documented in the consumer case record. Screening to determine if a consumer has a history of injecting drug use is the responsibility of Access, Assessment and Referral Services or approved PROVIDER. PROVIDER must screen all eligible women requesting services, regardless of county of residence, to determine if she is pregnant. If identified as so, the consumer must be given priority for admission to treatment. If admission does not occur within twenty-four (24) hours, interim services must be made available. Interim services for pregnant injecting drug users listed above should be followed with additional interim services to include effects of alcohol and drug use on the fetus and referral for pre-natal care. For pregnant non-injecting drug users interim services should begin within 48 hours and include counseling and education on HIV, TB, risks of transmission to sexual partners and infants, and effects of alcohol and drug use on the fetus, referral for pre-natal care, and early intervention clinical services.

   a) PROVIDER must screen all eligible consumers requesting treatment services to determine if he/she is a parent whose child has been removed from the home under the Child Protection Laws or is in danger of being removed from the home under the Child Protection Laws because of the parent's substance use, and if identified as so, provide priority for treatment admission. Interim services including early intervention clinical services must begin within 48 business hours.

   b) PROVIDER must offer an individual under supervision of MDOC and referred by MDOC or an individual being released directly form an MDOC without supervision and referred by MDOC interim services within 48 business hours including early intervention clinical services and recovery coach services.

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

   ~~d) PROVIDER[KJ156][SM157][SP158][CT159] must refer all consumers for Hepatitis B surface antigen and core or surface antibody testing, and PROVIDER must refer all consumers who are injecting drug users for Hepatitis C antibody testing (See Prevention Policy #2 of Attachment PII.B. A of MDHHS/PIHP Master Agreement).~~

4) **Fee**[KJ160][KF161][SP162] **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.

5) **Communicable**[KJ163][KZ164] **Diseases:** P.A. 368 requires that health professionals comply with specified reporting requirements for communicable diseases and other health indicators. PROVIDER is required to ensure the confidentiality of identified HIV-positive consumers and must have procedures

and/or policies to ensure protection of the consumer's HIV status. PROVIDER must assure that all treatment staff attend communicable diseases trainings. The Level One training can be found online. PROVIDER must assure all consumers entering residential treatment will be tested for TB upon admission and the test result is known within five (5) days of admission. High-risk TB consumers should be treated using Universal Precaution Practices until test results are known. Consumers who exhibit symptoms of active TB need to be given a surgical mask to wear and placed in respiratory isolation immediately. If respiratory isolation is not available, consumer should be moved to another location until test results are known. All pregnant women presenting for treatment must have access to STD/I's and HIV testing. PROVIDER must assure each person entering SUD treatment is appropriately screened for risk of HIV/AIDS, STD/I's, TB, and hepatitis and that they are provided basic information about the risk. For people entering SUD treatment identified with high-risk behaviors, additional information about the resources available, and referral to testing and treatment must be made available

6) **Care**[KJ165][SP166] **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 patient engagement,
   b) Conducting screening, record review and documentation as part of Evaluation and Assessment,
   c) Tracking and facilitating follow up on referrals and post discharge,
   d) Care Planning,
   e) 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.
   f) Address social supports and making linkages to services addressing housing, food, etc., and
   g) Monitoring, Reporting and Documentation.

7) **Primary**[KJ167][SP168] **Care Coordination:** PROVIDER must assure that substance use disorder treatment services are coordinated with primary health care. Treatment files must include the physician's name and address, a signed waiver release or a statement that the consumer refused to sign. PROVIDER must ensure that anyone who does not have a primary care physician will be provided a referral for a primary care physician and document the referral in the treatment file.

8) **Consumer**[KJ169][SG170][KZ171] **Satisfaction Surveys:** Treatment PROVIDER is required to participate in a Consumer Satisfaction Survey process for all consumers funded by MSHN. MSHN will compile and publish survey results. Provider is required to identify actions/steps for areas requiring improvement.

9) **Data**[KJ172][SG173][SP174][CT175] **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 ~~Medicaid Managed Specialty Supports and Services , the Healthy Michigan Program, the Flint 1115 Waiver and Substance Use Disorder Community Grant Programs~~ MDHHS/PIHP Master Agreement. ~~between MSHN and MDHHS.~~

10) **Cooperation**[KJ176][SP177][KZ178] **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.

11) **Notice**[KJ179] **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.

12) **MDOC**[KJ180][SP181][KZ182]**/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.

When individuals who are on parole or probation are referred for mandated treatment by the Michigan Department of Corrections (MDOC), the individual's supervising parole/probation agent will send a written referral (MDOC Form CFJ-306) to the PROVIDER. The PROVIDER is required to utilize the Level of Care Determination in REMI at the time of the request for services to document screening activity and medical necessity for the appropriate Level of Care. The PROVIDER may not deny an individual an in-person assessment via phone screening. Individuals under supervision of MDOC are considered a priority population and should be offered admission within 14 days of the request for service, provided they meet medical necessity for services.

Further, it is understood and agreed by PROVIDER and MSHN that;

- MSHN/PROVIDER will not honor Supervising Agent requests or proscriptions for level or duration of care, services, or supports and will base admission and treatment decisions only on medical necessity criteria and professional assessment factors.
- In the case of MDOC individuals, assessments should include consideration of the individual's presenting symptoms and substance use/abuse history prior to and during incarceration and consideration of their SUD treatment while incarcerated.
- All MDOC referred individuals will be provided with an assessment. If the individual does not meet medical necessity for any SUD services, the PROVIDER will give information regarding community resources such as AA/NA or other support groups.
- To the extent consistent with HIPAA, the Michigan Mental Health Code and 42 CFR Part 2, and with the written consent of the individual, the PROVIDER will provide notice of an admission decision to the Supervising Agent within one business day.
- The PROVIDER agrees to inform the Supervising Agent when Medication Assisted Treatment (MAT) is included in the consumers treatment plan. If the medication type changes, the provider must inform the Supervising Agent.

In addition, PROVIDER shall have on file and maintain a current consumer signed Release of Information utilizing the MDHHS Form 5515. The release shall allow for the following reports, notices, and information to be transmitted to the consumer's MDOC Supervising Agent;

For consumer's receiving Residential Treatment Services:

- If an individual referred for residential does not appear for or is determined not to meet medical necessity for that level of care, PROVIDER will notify the Supervising Agent within one business day.
- Individuals participating in residential services may not be given unsupervised day passes, furloughs, etc. without PROVIDER consultation with the Supervising Agent.
- PROVIDER shall notify/coordinate the Supervising Agent of any leaves for any non-emergent medical procedures.
- If an individual leaves an off-site supervised therapeutic activity without proper leave to do so, the provider must notify the Supervising Agent by the end of the day on which the event occurred.
- Residential providers may require individuals to submit to drug screening when returning from off-property activities and any other time there is a suspicion of use. Positive drug screen results and drug screen refusals MUST be reported to the Supervising Agent.
- Additional reporting requirements for residential providers:
    - Death of an individual under MDOC supervision
    - Relocation of an individual's placement for more than 24 hours

- The provider must immediately and no more than one hour from awareness of the occurrence, notify the MDOC Supervising Agent of any sentinel event by or upon an individual under MDOC supervision while on the treatment premises or while on authorized leaves.
- The provider must notify the MDOC Supervising agent of any criminal activity involving an MDOC supervised individual within one hour of learning of the activity

- PROVIDER will complete monthly progress reports on each MDOC supervised individual on the template supplied by MDOC. Provider will ensure it is sent via encrypted/secured email to the Supervising Agent by the 5th day of the following month.
- The PROVIDER must not terminate any MDOC referred individual from treatment for violation of program rules and regulations without prior notification to the individual's Supervising Agent, except in extreme circumstances.
- The PROVIDER must collaborate with MDOC for any non-emergency removal of the MDOC referred individual and allow the MDOC time to develop a transportation plan and a supervision plan prior to removal
- PROVIDER will ensure a recovery/discharge plan is completed and sent to the Supervising Agent within five (5) business days of discharge. The plan must include the individual's acknowledgement of the plan and the aftercare referral information.

For all Levels of Care (LOC) Services, including Residential:

- PROVIDER will complete monthly progress reports on each MDOC supervised individual on the template supplied by MDOC. Provider will ensure it is sent via encrypted/secured email to the Supervising Agent by the 5th day of the following month.
- The PROVIDER agrees to inform the Supervising Agent when Medication Assisted Treatment (MAT) is included in the consumers treatment plan. If the medication type changes, the provider must inform the Supervising Agent.
- The PROVIDER must not terminate any MDOC referred individual from treatment for violation of program rules and regulations without prior notification to the individual's Supervising Agent, except in extreme circumstances.
- The PROVIDER must collaborate with MDOC for any non-emergency removal of the MDOC referred individual and allow the MDOC time to develop a transportation plan and a supervision plan prior to removal
- PROVIDER will ensure a recovery/discharge plan is completed and sent to the Supervising Agent within five (5) business days of discharge. The plan must include the individual's acknowledgement of the plan and the aftercare referral information.

13) **Case**[KJ183] **Management Services:** Services that assist PROVIDER in designing and implementing strategies for obtaining services and support that are goal oriented and individualized and that assist consumers with access to needed health services, financial assistance, housing, employment, education, social services and other services. PROVIDER must comply with MSHN Case Management Policy and in accordance with the MSHN-SUDSP Manual.

14) **Hypodermic**[KJ184] **Needles**: PROVIDER assures that no Federal or State public funds will be used to provide consumers with hypodermic needles or syringes enabling such consumers to use illegal drugs.

15) **Charitable**[KJ185][KZ186] **Choice (Faith-based PROVIDER Only):**

a) 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.

b) 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**[KJ187][SP188] **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**[KJ189] **Requirement:** A transportation log must be included in the consumer chart for MSHN women's specialty designated Providers, MSHN outpatient Providers and other qualified providers whose consumers are utilizing transportation services. 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. Transportation needs must be identified in the Plan of Service and clearly documented within the consumer's individualized treatment plan. PAYOR strives to reduce transportation barriers to accessing services, using the best quality, consumer-friendly, cost-efficient means possible. Please refer to the Provider Manual for the full transportation requirements (Appendix G; Page 106).

18) **Peer**[KJ190]**[SP191] 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.

Billable[KJ192] services are based on face-to-face encounters. 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.

19) **Integrated**[KJ193] **Treatment/Co-occurring Capable**: Treatment PROVIDER will document Integrated Services planning efforts for treating consumers with co-occurring substance and mental health disorders. Identified co-occurring disorder treatment issues must be addressed in the assessment and as goals in the individualized treatment plan.

Co-occurring capable programs are defined as programs that address mental health and substance use disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning.

20) **Fetal**[KJ194] **Alcohol Spectrum Disorders (FASD)**: Treatment PROVIDER that serves individuals with minor children should have policies and procedures in place to:
   a) Prescreen for potential FASD of all dependent children
   b) Prescreen for potential FASD for all children with whom PROVIDER has contact,
   c) Prescreen for potential FASD when family situations or histories may indicate a need for a referral for a diagnostic evaluation. The possibility of prenatal exposure should be considered for children in

families who have experienced one or more of the following (i) Premature maternal death related to alcohol use (either disease or trauma) (ii) Living with an alcoholic parent (iii) Current or historical abuse or neglect (iv) Current or historical involvement with Child Protective Services (v) History of transient care giving institutions or (iv) Foster or adoptive placements (including kinship care) and

d) Include FASD prevention into treatment regimen. Including providing education on the risks of drinking during pregnancy.

PROVIDER[KJ195][CT196] must make FASD screening evaluations, when appropriate. MDHHS BSAAS Treatment Policy #11 requirements must be met in full. Charts should document individual FASD-related screens, referrals and services.

21) **ROSC**[KJ197] **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) Providers will act consistent with collaboration and cooperation of efforts in order to effect positive change in communities/counties.
   b) Providers support a process of community ~~change thatchange that~~ engages critical thinking and collaboration with community partners.
   c) Providers support 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 PROVIDERS, peer support specialists, community-based support services, and others.

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

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

22) **Customer**[KJ198][DD199][KZ200] **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 that consumers can view. 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." ~~Attachment P6.3.1.~~
   e) 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." ~~attachment P6.3.1.~~
   g) Upon request, Customer Service staff shall assist beneficiaries 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 Customer Services 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.
   i) Telephone calls to Customer Service shall be answered by a live voice during business hours. Telephone menus are not acceptable.

23) **Appeal**[KJ201][DD202][KZ203] **and Grievance:** PROVIDERS must maintain Appeal and Grievance records with (at minimum) the following information and the recordkeeping must be accurately maintained in a manner accessible to MSHN and available upon request:
   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.
   e)
   f) Name of the covered person for whom the appeal or grievance was filed.

24) **Recovery**[KJ204][SG205] **Assessment**: Providers are required to participate in a regional process to assess the recovery environment utilizing a standardized tool.

25) ~~25)~~ **Sentinel**[KJ206][SG207] **Events**: Providers must have a process to review, analyze, and report all required critical incidents, and identified sentinel event as ~~and report all incidents as~~ indicated in the SUD Provider Manual.

~~25)~~26) **Project**[KJ208] **ASSERT & SBIRT Programs**: For agencies who engage in Project ASSERT or SBIRT programs in their communities, the PROVIDER will now be required to support data collection and data entry of encounters into the MSHN REMI system. PROVIDERs should utilize the H0002 Brief Screen code for authorization and reimbursement for the initial face-to-face screening contact they have with an individual. The H0002 code is an encounter code that is utilized to report peer recovery coach interactions with individuals when the focus of the encounter is screening, brief intervention, and referral to treatment services. For providers to utilize the H0002 code, the peer recovery coach supporting Project ASSERT or SBIRT activities must be appropriately trained according to Medicaid guidelines and be either CCAR trained or State Certified. Following the initial face-to-face screening encounter, Project ASSERT & SBIRT peer recovery coaches will continue efforts to follow-up with the individual over the course of the next 30-90 days. Follow-up phone calls that do not result in a face-to-face encounter would not be reported in REMI, but through an alternate outcome reporting process.

ATTACHMENT[KJ209] B: COST REIMBURSEMENT
FY 20221 SERVICES AND 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 Grant funds, Provider shall fulfill the expectations and standards of the NOA & FOA as highlighted below;

- SOR sub-grantees must utilize third party and other revenue realized from the provision of services to the extent possible and use SAMHSA 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 also expected to facilitate the health insurance application and enrollment process for eligible uninsured clients.
- SOR sub-grantees' performance will be monitored by MSHN via monthly progress/outcomes reports.
- Criminal background checks must be part of SOR sub-grantees' condition for employment. ~~(this is part of your MSHN contract as well).~~
- SOR sub-grantees 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 must operate within a recovery-oriented system of care that will improve retention in care.
- SOR sub-grantees ~~receiving SOR funds~~ must meet obligations under the Government Performance and Results (GPRA) Modernization Act of 2010.
- ~~SOR sub-grantee prevention providers must employ evidence-based practices (Botvin's LifeSkills, Prime for Life, etc.) and use them with fidelity to the model. MSHN will monitor for fidelity.~~
- SOR sub-grantee treatment providers 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 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 federal grant.

SUD Services (By Fund Type)	
Fee-For-Service	«FFS_SERVICES»
Cost Reimburse (Block Grant; Medicaid; Healthy Michigan; PA2)	«CR_SERVICES»
SOR Grant (Assistance Listings # 93.788)	«SOR_SERVICES»

The SOR NOA & FOA attachments can be found on the MSHN website.

ATTACHMENT B.1: FEE FOR SERVICE
FY20224 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 - REMI.

«FFS_SERVICES»

SUD Services Funding (By Fund Type)	
Fee-For Service	Rates pursuant to the rates included in the attached "Provider Fee Schedule Report"
Cost Reimbursement (Block Grant)	$«BLOCK_GRANT»
Cost Reimbursement (Medicaid; Healthy Michigan)	$«MedicaidHMP»
SOR Grant (Assistance Listings # 93.788)	$«SOR»
PA2	$«PA2»
GRAND TOTAL COST REIMBURSEMENT ALLOCATION	**$«TOTAL_APPROVED_TREATMENT_FUNDING»**

ATTACHMENT[KJ210][SG211] C: PERFORMANCE MEASURES

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.

Exception: MMBPIS indicator 4b has a state required standard of 95% or above and will not be monitored for improvement only.

MEASURE

1) SUD Detox Re-Admission:
   a) Percentage of SUD Detox discharges with a subsequent SUD Detox Admission within 30 days of the previous SUD Detox Discharge
   b) Percentage of SUD Detox discharges with a subsequent SUD Detox Admission within 60 days of the previous SUD Detox Discharge
   c) Percentage of SUD Detox discharges with a subsequent SUD Detox Admission within 90 days of the previous SUD Detox Discharge

   Scope: Inclusive of all persons discharged from a SUD Detoxification Unit who then had a re-admission to detoxification (within 30 days, 60 days, or 90 days) to any SUD provider.

   REVIEWED: Quarterly

2) Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence:
   a) Percent Initiation: Percent of new AOD episodes where treatment was initiated within 14 days of the diagnosis

   Scope: Inclusive of all persons (adolescents 13 years or older and adult) who request a new SUD treatment/service and receives that service/encounter within 14 days. This includes inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication assisted treatment.

   b) Percent Engagement: Percent of new AOD episodes where treatment was initiated and there were two or more additional services with a diagnosis of AOD within 30 days of the initiation visit

   Scope: Inclusive of all persons (adolescents 13 years or older and adult) who had treatment/service initiated, followed by two or more services within 30 days of the first treatment. This includes AOD services and medication assisted treatment.

   REVIEWED: Quarterly

3) Michigan Mission Based Performance Indicators (MMBPIS) (as defined in the MMBPIS Codebook):[SG212]
   a) Indicator 2e~~.b~~.: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders.

   Scope: All new persons approved/authorized for SUD services (including Medicaid and Non-Medicaid)

   Note: "New" is defined as either never seen by the PIHP for SUD services, or the person does not have an open admission at this provider or was discharged from this SUD provider more than 60 days ago.

   b) Indicator 4.b.: The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.

Scope: All Medicaid eligible persons who are seen by a Substance Use Professional within seven (7) days from date of discharge from a substance use detox provider.

Standard: 95% or above

REVIEWED: Quarterly

ATTACHMENT[KJ213][CT214] 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 [KJ215][CT216] E: DISCLOSURE OF OWNERSHIP & CONTROLLING INTEREST STATEMENT

Mid-State Health Network (MSHN) is required to collect disclosure of ownership, controlling interests, and management information from providers that are credentialed or otherwise enrolled to participate in the Medicaid program and/or the Pre-Paid Inpatient Health Plan (PIHP). This requirement is pursuant to a Medicaid and/or PIHP State Contract with the State Agency and the federal regulations set forth in 42 CFR Part §455. Required information includes: 1) the identity of all owners and others with a controlling interest of 5% or greater; 2) certain business transactions as described in 42 CFR §455.105; 3) the identity of managers and others in a position of influence or authority; and 4) criminal convictions, sanctions, exclusions, debarment or termination information for the provider, owners or managers. The information required includes, but is not limited to, name, address, date of birth, social security number (SSN) and tax identification (TIN).

Completion and submission of this Statement is a condition of participating as a credentialed or enrolled provider in the MSHN for services to members under Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Wavier Program. Failure to submit the requests information may result in a refusal of participation in MSHN or denial of a claim.

This statement should be submitted at any of the following times: upon the submission of an application; upon execution of an agreement; during re-credentialing or re-contracting; within 35 days after any change in ownership of the disclosing entity. A Statement must be provided to MSHN within 35 days of a request for information by the US Department of Health and Human Services (HHS) or the State Agency. MSHN maintains policies and practices that protect the confidentiality of personal information, including Social Security numbers, obtained from its providers and associates in the course of its regular business functions. MSHN is committed to protecting information about its providers and associates, especially the confidential nature of their personal information.

Detailed instructions and a glossary for capitalized terms can be found at the end of this form. If attachments are included, please indicate to which section those attachments refer.

Provider/Provider Entity Information

*Please fill out the entire section. Every field must be complete. If fields are left blank, the form will be returned for corrections/completeness. *These fields cannot be left blank; check appropriate box or use 'N/A'.*

Please choose appropriate category: ☐ Provider Entity ☐ Licensed Independent Practitioner ☐ Managing Employee ☐ HCBS Provider ☐ Other: **Group Affiliation?** [KJ217] ☐ Yes ☐ No **If yes,** do you have a private practice as well? ☐ Yes ☐ No	**Name of Person Completing the Form** **Name of Provider/Provider Entity:** **Title:** **Phone Number:** **Fax:** **Email:** **In which state(s) do you participate in Medicaid?**
Additional Addresses (list all Practice Locations) **Attaching list?** ☐ Yes ☐ No	

***SSN (if Individual Provider):** ☐ N/A ***Federal Tax ID# (if Entity):** ☐ N/A	☐ ***Medicaid ID#**: ☐ *Applied for Medicaid ID ☐ *Not applicable	☐ ***NPI#**: ☐ *Applied for NPI# ☐ *Not applicable

Section I: Individual Provider Ownership Information

1. Are there any individuals or corporation with a Direct or Indirect Ownership Interest of 5% or more in your entity/practice? ☐ Yes ☐ *No-Skip to #2* ☐ *N/A-Skip to #2*

See instructions for more information and examples

If yes, list the name, primary address, date of birth (DOB), and Social Security Number (SSN) for each person having an Ownership Interest in the Individual Provider of 5% or greater. List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having an Ownership Interest of 5% or greater. (42 CFR §455.104(b)(1)(i)). Attach additional sheets as necessary - ☐ Yes ☐ No

Name of Owner	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)			**SSN or TIN or both as applicable	% Interest
		Street:				
		C:	S:	Z:		
		Street:				
		C:	S:	Z:		
		Street:				
		C:	S:	Z:		

***SSN and TIN required under §455.104; See Sect 4313 of the Balanced Budget Act of 1997 amended Sect 1124 and Federal Register Vol. 76 No 22*

Section II: Ownership in Other Providers & Entities

2. Does the *Owner identified in Section I* have an Ownership or Controlling Interest in *any other* provider or disclosing entity? ☐ Yes ☐ *No-Skip to #3* ☐ *N/A-Skip to #3*

If yes, list the name and the SSN or TIN of the other provider or entity in which the *Owner identified in Section I* also has an Ownership or Controlling Interest (42 CFR §455.104(b)(3)).

Attach additional sheets as necessary - ☐ Yes ☐ No

Name of Owner from Section I	Name of Other Provider or Entity	Other Provider or Entity's SSN (indiv.) or TIN (entity)

Section III: Subcontractor Ownership

3. Do you, as the Individual Provider, have a Direct or Indirect Ownership Interest of 5% or more in any Subcontractor? ☐ Yes ☐ *No-Skip to #4* ☐ *N/A-Skip to #4*

If yes, does another individual or organization also have an Ownership or Controlling Interest in the same Subcontractor? ☐ Yes ☐ No

If yes, list the following information for each person or entity with an Ownership or Controlling Interest in any Subcontractor in which you *also have* Direct or Indirect Ownership Interest of 5% or more (42 CFR §455.104(b)(1)(iii)).

Attach additional sheets as necessary - ☐ Yes ☐ No

Legal Name of Subcontractor:		
Name of Subcontractors *Other Owner*:		*Other Owner's*:
Other Owner's Address:		City, State, Zip:
Other Owner's TIN:	*Other Owner's* SSN:	% Interest:

Section IV: Familial Relationships of All Owners

4. Are any of the individuals identified in Sections I, II, or III related to each other? ☐Yes ☐ *No – Skip to #5*

If yes, list the individuals identified and the relationship to each other (e.g. spouse, domestic partner, sibling, parent, child) (42 CFR §455.104(b)(2). Attach additional sheets as necessary - ☐Yes ☐ No

Name of Owner 1	Name of Owner 2	Relationship

Section V: Criminal Convictions, Sanctions, Exclusions, Debarment, or Terminations

5. Have you or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Individual Provider practice ever been indicted or convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, CHIP or Title XX program? ☐Yes ☐ *No-Skip to #6* ☐ *N/A-Skip to #6*

If yes, list those persons and the required information below. (42 CFR §455.106(1)(2)). Attach additional sheets as necessary - ☐Yes ☐ No

Name:	**DOB:**
Address:	**SSN (indiv.) or TIN (entity):**
City, State, Zip:	**State and Date of Conviction:**
Matter of the Offense:	**Date of Reinstatement:**

6. Within the preceding ten (10) years, have you or any person providing services under the Medicaid State Plan or waiver of the plan; any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Individual Provider practice ever been convicted of a felony or misdemeanor crime identified within the MDHHS Provider Enrollment Fitness Criteria? ☐Yes ☐ *No-Skip to #6* ☐ *N/A-Skip to #6*

If yes, list those persons and the required information below. (See "Exclusions" in glossary section)(42 CFR §455.106(1)(2)). Attach additional sheets as necessary - ☐Yes ☐ No

Name:	**DOB:**
Address:	**SSN (indiv.) or TIN (entity):**
City, State, Zip:	**State and Date of Conviction:**
Matter of the Offense:	**Date of Reinstatement:**

7. Have you or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Individual Provider practice ever been sanctioned, excluded, or debarred from Medicaid, Medicare, CHIP or Title XX program? ☐Yes ☐ *No-Skip to #7* ☐ *N/A-Skip to #7*

If yes, list those persons and the required information below. (42 CFR §455.106(1)(2) and 455.436). Attach additional sheets as necessary - ☐Yes ☐ No

Name:	**DOB:**
Address:	**SSN (indiv.) or TIN (entity):**
City, State, Zip:	**List all States where currently excluded:**
Reason for Sanction, Exclusion, or Debarment:	
Date(s) of Sanctions, Exclusions, or Debarments:	**Date of Reinstatement:**

8. Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity ever been **terminated** from participation in Medicaid, Medicare, CHIP or a Title XX program? ☐Yes ☐ *No-Skip to #8* ☐ *N/A-Skip to #8* **If yes,** list those person and the requirement information below. (42 CFR §455.106(1)(2) and 455.416). Attach additional sheets as necessary - ☐Yes ☐ No	
Name:	**DOB:**
Address:	**SSN (indiv.) or TIN (entity):**
City, State, Zip:	**Terminated from Medicare?** ☐Yes ☐ No
Reason for Termination:	**Date of Termination:**
State that originated Termination:	**Date of Reinstatement:**

**At any time during the Contract period, it is the responsibility of the Provider Entity to promptly provide notice upon learning of convictions, sanctions, exclusions, debarments and terminations (see Fed. Register, Vol. 44, No. 138)*

Section VI: Business Transaction Information

(NOTE: Pursuant to 42 CFR 455.105 Information shall be submitted within 35 days of request from the PIHP)

9. **Business Transactions – Subcontractors:** Has the Provider Entity had any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) month period? ☐Yes ☐ *No-Skip to #9* ☐ *N/A-Skip to #9* **If yes,** list the information for Subcontractors with whom the Provider Entity has had business transactions totaling more than $25,000 during the previous 12 month period ending on the date of this request (42 CFR §455.105(b)(1)) Attaching additional sheets as necessary - ☐Yes ☐ No	
Name of Subcontractor:	**Subcontractor's SSN or TIN:**
Subcontractor Address:	**City, State, Zip:**
Subcontractors Owner (SO):	**SO's SSN or TIN:**
SO's Address:	**City, State, Zip:**

10. **Significant Business Transactions – Wholly Owned Suppliers:** Has the Provider Entity had any Significant Business Transactions with a Wholly Owned Supplier exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period? ☐Yes ☐ *No-Skip to #10* ☐ *N/A-Skip to #10* **If yes,** list the information for any Wholly Owned Supplier with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past 5-year period (43 CFR §455.105(b)(2)). Attach additional sheets as necessary - ☐Yes ☐ No *See Glossary for definition.*	
Name of Supplier:	**Suppliers SSN or TIN:**
Suppliers Address:	**City, State, Zip:**

11. **Significant Business Transactions – Subcontractors:** Has the Provider Entity had any Significant Business Transactions with a Subcontractor totaling more than $25,000 in the past five (5) year period? ☐Yes ☐ *No-Skip to #11* ☐ *N/A-Skip to #11* **If yes,** list the information for Subcontractors with whom the Provider Entity had any Significant Business Transactions exceeding the $25,000 during the past 5-year period (42 CFR §455.105(b)(2)). Attach additional sheets as necessary - ☐Yes ☐ No	
Name of Subcontractor:	**Subcontractor's SSN or TIN:**
Subcontractor Address:	**City, State, Zip:**
Subcontractors Owner (SO):	**SO's SSN or TIN:**
SO's Address:	**City, State, Zip:**

This Section (VI) is not required to be completed at this time; however, this information must be provided and/or updated within 35 days of a request. Medicaid payments may be denied for services furnished during the period beginning on the day following the date the information was due until it is received (42 CFR §455.105).

Section VII: Management and Control

12. **Managing Employees:** Does the Provider Entity have any Managing Employees? ☐ Yes ☐ *No-Skip to #12* ☐ *N/A-Skip to #12*

If yes, list all Managing Employees that exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operations of Provider Entity (general manager, business manager, administrator or director), including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104(b)(4). Attach additional sheets as necessary - ☐ Yes ☐ No

Name	DOB mm/dd/yyyy	Complete Address	SSN	Title

13. **Agents:** Does the Provider Entity have any Agents? ☐ Yes ☐ *No* ☐ *N/A*

If yes, list all Agents that have been delegated the authority to obligate or act on behalf of Provider Entity, including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.101). Attach additional sheets as necessary - ☐ Yes ☐ No

Name	DOB mm/dd/yyyy	Complete Address	SSN

Through signature below, I hereby certify that any employees or contractors providing services pursuant to a contract with Mid-State Health Network are screened with the applicable background check including, but not limited to, verification against the OIG's List of Excluded Individuals & Entities (https://oig.hhs.gov/exclusions/index/asp) and the System for Award Management (SAM) www.sam.gov and any applicable state, federal or other governmental exclusion or sanction database and that the information provided herein is true, accurate and complete. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of a claim and/or termination of the contract.

Signature_____ Title_____

Print Name_____ Date_____

Phone Number Fax Number Email Address

Disclosure Instructions

If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the section number that is being continued. For example: Section I Ownership Information, continued. Please see Glossary for definition of capitalized terms.

Section I: Provider Entity Ownership Information: Please list the required information for each individual or organization that has a Direct or Indirect Ownership of 5% or more or has a Controlling Interest in your entity. If the Owner is a corporation: the primary business address must be listed and every business location and PO Box address. Provider members of a group practice who have ownership or a controlling interest in Provider Entity must submit a separate Statement.

Providing the SSN and TIN (as applicable) is required under 42 CFR 455.104; please see Section 4313 of the Balanced Budget Act of 1997, amended Section 1124, and the Federal Register Vol. 76 No. 22. Any form without the required SSN and TIN (as applicable) is incomplete and will not be processed.

Section II: Ownership in Other Providers & Entities: Please identify the other providers or entities that are owned or controlled at least 5% by the same individual or organization identified in Section I that has an Ownership or Controlling Interest in your entity. This information is to identify shared and interconnected ownership and controlling interests.

Section III: Subcontractor Ownership: If your entity has a Direct or Indirect Ownership of 5% or more in a Subcontractor and other individuals or entities also have a Direct or Indirect Ownership of that same Subcontractor, please identify the Subcontractor and provide the required information for the additional owners.

Section IV: Familial Relationships of All Owners: Report whether any of the persons listed in Sections I, II, and III are related to each other and identify the parties and their relationship. For the definition of domestic partner, refer to your state's laws. Provider members of a group practice who are related to the Provider Entity's owners or those with a controlling interest must submit a separate Statement.

Section V: Criminal Convictions, Sanctions, Exclusions, Debarment, and Terminations: List your own criminal convictions, sanctions, exclusions, debarments, and termination, *and* for any person who has an ownership or controlling interest, or is an agent or managing employee of your entity. List all offenses related to each person's or entity's involvement in any program under Medicare, Medicaid, CHIP, or the Title XX services since the inception of these programs. List all felony and/or misdemeanor convictions related to any offense identified within the MDHHS Provider Enrollment Fitness Criteria. Review all of the databases necessary to verify this information:

1. Exclusion status may be verified through the HHS-OIG List of Excluded Individuals/Entities (LEIE) at https://oig.hhs.gov/exclusions/index.asp
2. Sanction information is available in the GSA's SAM (System for Award Management) database www.sam.gov.
3. State specific exclusions/sanction databases may be accessed through the State Agency's website.

Section VI: Business Transaction Information: This information must be made available within 35 days of a request by the US Department of Health and Human Services (HHS), the State Medicaid Agency, and the Medicaid Managed Care Organization responding to an HHS or State request.

1. List the Ownership of any Subcontractors that you have had business transactions totaling more than $25,000 within the last twelve (12) month period ending on the date of the request.
2. List any ***Significant Business Transactions*** between your entity and any Wholly Owned Supplier during the past 5 years.
3. List any ***Significant Business Transactions*** between your entity and any Subcontractor during the past 5 years.

Remember that a ***Significant Business Transaction*** is defined as any transaction or series of related transactions that exceeds the lesser of $25,000 or 5% of a provider's operating expenses during any one fiscal year.

Section VII: Management & Control

1. List the required information for all employees that hold a position of Managing Employee within your entity.
2. List the required information for all Agents that have the authority to obligate or act on behalf of your entity.
3. List the required information for all individuals on the governing board or board of directors if your entity is organized as a corporation. CMS requires the identification of officers and directors of a Provider Entity that is organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation.

Glossary

Agent: means any person who has been delegated the authority to obligate or act on behalf of a Provider Entity.

CHIP: means the Federal insurance program for children, Child Health Insurance Program, in Michigan this is known as MIChild.

Controlling Interest: means the operational direction or management of a disclosing entity which management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity; the ability or authority to nominate or name members of the Board of Directors or Trustees; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction; the ability or authority, expressed or reserved , to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership control.

Conviction: For the purposes of the excluded offenses referenced within the MDHHS Provider Enrollment Fitness Criteria (listed below under "Exclusions"), an individual or entity is considered to have been convicted of a criminal offense when;

a) A judgment of conviction has been entered against the individual or entity by a federal, state, tribal or local court regardless of whether there is an appeal pending;
b) There has been a finding of guilt against the individual or entity by a federal, state, tribal or local court;
c) A plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, tribal, or local court; or
d) The individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld.

Determination of ownership or control percentages:

a) *Indirect ownership interest.* The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to 4 percent indirect ownership interest in the disclosing entity and need not be reported.
b) *Person with an ownership or controlling interest.* In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Exclusions: MSHN must terminate or deny a provider or supplier's application for enrollment in MSHN's Provider Network for the following reasons:

1. The provider has been convicted of a relevant crime described under 42 USC 1320a-7(a)-7(b).
2. The provider's failure to comply with the enrollment requirements of the Social Welfare Act, Public Act 280 of 1939 (MCL 400.111b - 111e) and the provider screening and enrollment requirements pursuant to 42 CFR 455.416. The basis for termination or denial of enrollment under this section includes, but is not limited to the provider's:

    - Failure to submit timely and accurate information;
    - Failure to cooperate with MDHHS screening methods;
    - Failure to submit sets of fingerprints as required within 30 days of a CMS or MDHHS request;
    - Failure to permit access to provider locations for site visits;
    - Falsification of information provided on the enrollment application;
    - Inability to verify a provider applicant's identity; or
    - Failure to comply with Medicaid policies regarding submission of claims and billing Medicaid beneficiaries.

3. The provider is excluded from participation in Medicare, Medicaid or any other Federal health care programs.
4. The provider is convicted of violating the Medicaid False Claims Act, the Health Care False Claims Act, or a substantially similar statute, or a similar statute by another state or the federal government.
5. The provider has a federal or state felony conviction within the preceding 10 years, including, but not limited to:
    - Crimes as defined in the Public Health Code Act 368 of 1978, specifically, MCL 333.20173a(1);
    - Crimes involving state, federal, or local government assistance programs;
    - Crimes against a child as defined by MCL 750.135n et seq;
    - Crimes against a "vulnerable adult" as defined by MCL 750.145n et seq;
    - Violent crimes including, but not limited to: murder, manslaughter, kidnapping, arson, assault, battery and domestic violence;

- Financial crimes including, but not limited to: fraud, forgery, counterfeiting, embezzlement and tax evasion;
- Theft crimes including, but not limited to: larceny, burglary, robbery, extortion, false pretenses, false representation, and conversion;
- Sex crimes including, but not limited to: rape, sexual abuse, and prostitution;
- Drug crimes including, but not limited to: possession, delivery, and manufacturing;
- Inchoate crimes including, but not limited to: attempt, solicitation, and conspiracy; and
- Any other felony that places the health or safety of medically indigent individuals, the welfare of the public, and/or the funds appropriated for the Medicaid program at risk.

6. The provider has a federal or state misdemeanor conviction within the preceding 10 years, including, but not limited to:
   - Crimes as defined in the Public Health Code Act 368 of 1978, specifically, MCL 333.20173a(1);
   - Crimes involving state, federal, or local government assistance programs;
   - Crimes against a child as defined by MCL 750.135n et seq;
   - Crimes against a "vulnerable adult" as defined by MCL 750.145n et seq;
   - Financial crimes including, but not limited to: fraud, forgery, counterfeiting, embezzlement and tax evasion;
   - Theft crimes including, but not limited to: larceny, burglary, robbery, extortion, false pretenses, false representation, and conversion;
   - Sex crimes including, but not limited to: rape, sexual abuse, and prostitution;
   - Drug crimes including, but not limited to: possession, delivery, and manufacturing;
   - Inchoate crimes including, but not limited to: attempt, solicitation, and conspiracy; and
   - Any other misdemeanor that places the health or safety of medically indigent individuals, the welfare of the public, and/or the funds appropriated for the Medicaid program at risk.

Ownership Interest: means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Group Affiliation: Related to Physician as a part of a medical group comprised of several physicians operating out of the same group. While at the same, they may also have a private practice which would also need to be identified.

HCBS Provider: means a provider of Home and Community Based Services for Medicaid beneficiaries.

Indirect Ownership Interest: means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managing Employee: means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency.

Other Disclosing Entity: means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
b) Any Medicare intermediary or carrier; and
c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Person with an Ownership or Controlling Interest: means a person or corporation that;

a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
e) Is an officer or director of a disclosing entity that is organized as a corporation; or
f) Is a partner in a disclosing entity that is organized as a partnership.

Provider Entity: an individual or entity who operates as a Medicaid provider and is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services. For purposes of this Statement, the Providing Entity is the individual or entity identified on this form as the disclosing entity.

Significant Business Transaction: means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of twenty-five thousand dollars ($25,000) and five percent (5%) of a Provider's total operating expenses.

Subcontractor: means an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier: an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g. a commercial laundry, manufacturer of hospital beds, or pharmaceutical firm).

Wholly Owned Supplier: means a supplier whose total ownership interest is held by the provider or by a person(s) or other entity with an ownership or control interest in the provider.

ATTACHMENT F: REPORTING REQUIREMENTS FOR MSHN SUD PROVIDERS FY 202221
(SENT AS SEPARATE PDF ATTACHMENT)

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

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