Fiscal Year 2027 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; Assistance Listings #: 93.959)

For the purpose of:

Treatment

Payment by:
Fee-for-Service

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ACRONYM AND GLOSSARY DEFINITIONS

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

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.

Adverse Benefit Determination: A decision that adversely impacts the Medicaid enrollee's claim for services due to 42 CFR 438.400:

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. (42 CFR 438.400(b)(1))
- Reduction, suspension, or termination of a previously authorized service. (42 CFR 438.400(b)(2))
- Denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an ABD. (42 CFR 438.400(b)(3))
- Failure to make a standard Service Authorization decision and provide notice about the decision within 7 calendar days from the date of receipt of a standard request for service. (42 CFR 438.210(d)(1))
- Failure to make an expedited Service Authorization decision within seventy-two (72) hours after receipt of a request for expedited Service Authorization. (42 CFR 438.210(d)(2))
- Failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning (PCP) meeting and as authorized by the PIHP. (42 CFR 438.400(b)(4); 42 CFR 438.20).
- Failure of the PIHP to resolve standard appeals and provide notice within 30 calendar days from the date the standard appeal request is received by the PIHP. (42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2))
- Failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date the expedited appeal request is received by the PIHP. (42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3))
- Failure of the PIHP to resolve grievances and provide notice within 90 calendar days of the date the grievance is received by the PIHP. (42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1)).
- For a resident of a rural area with only one Managed Care Organization (MCO), the denial of the enrollee's request to exercise the enrollee's right under 438.52(b)(2)(ii), and to obtain services outside the network. (42 CFR 438.400(b)(6))
- Denial of the enrollee's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial responsibility. (42 CFR 438.400(b)(7))

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 (defined below) of an Adverse Benefit Determination, as defined above. 42 CFR 438.400(b).

ASAM The American Society of Addiction Medicine (ASAM) Criteria is the nationally recognized framework used to assess individuals and determine appropriate level of care based on a multidimensional clinical assessment. Providers shall utilize the current edition of the ASAM Criteria as adopted by MDHHS.

Assessment A clinical process used to evaluate an individual's strengths, needs, functioning, and substance use patterns to establish diagnosis and inform level of care and treatment planning.

Care Coordination: System-level activities that organize and integrate services across providers and systems to ensure continuity of care.

Care Management means the application of systems, science, incentives, and information to improve practice and assist Individuals 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 Individual service that assists individuals in accessing, coordinating, and monitoring services to support recovery and functional improvement.

Clean Claim means a claim that can be processed without obtaining additional information from 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 PROVIDER if PROVIDER is under investigation for fraud or abuse, or a claim under review for medical necessity.

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

Continued Service Criteria is when, in the process of Individual 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 an Individual's status in each of the six assessment dimensions of ASAM's Level of Care (LOC) criteria 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 those individuals 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.

Individual 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 Individuals 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 (defined below) to Individuals 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 Individual, in accordance with MSHN policies and procedures in return for payments by the MSHN under this Agreement and listed on Attachment B.

Critical Incident is an event, which is reviewed to determine whether it meets the criteria for sentinel event. Incidents include but are not limited to those identified by MDHHS/MSHN including the death of a recipient, a serious physical illness requiring admission to a hospital, an accident resulting in an injury to recipient requiring emergency room visit, urgent care, or hospital admission, an arrest or conviction, a serious challenging behavior, or a medication error. This applies to 24-hour specialized residential substance use disorder treatment settings.

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 Individual'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 Individual, an Individual self-rating score, description of the treatment and non-treatment goals attained while the Individual 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 an Individual'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.

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 an Individual.

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 shall 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 Medicare, Medicaid, or any other Federal health care programs. Basis for exclusion include convictions for program-related fraud and patient abuse, licensing board actions, and default on Health Education Assistance loans.

Expedited Appeal is the expeditious review of an Adverse Benefit Determination, requested by the enrollee or the enrollee's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the enrollee requests the expedited review, the PIHP determines if the request is warranted. If the enrollee's provider makes the request, or supports the enrollee's request, the PIHP must grant the request. (42 CFR 438.410(a); 42 CFR 438.210)

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

Fraud means an intentional deception or misrepresentation made 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. 42 CFR 455.2.

FSR means Financial Status Report.

Grievance is an Individual's expression of dissatisfaction with the PIHP and/or the provider about any matter other than an adverse benefit determination. Grievance may include, but is not limited to, any aspect of the operations, activities, or behavior of PIHP or its Provider Network, regardless of whether remedial action is requested. Specific examples include the quality of care or services provided, problems getting an appointment or having to wait a long time for an appointment, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's right to dispute an extension of time proposed by the PIHP to make a service authorization decision. (42 CFR 438.400(b))

Grievance and Appeal System is the process 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.

Harm Reduction/Overdose Prevention MOUD An evidence-based approach focused on reducing the negative consequences of substance use and supporting engagement in care.

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.

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

LOS means Length of Stay.

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

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.

Medication for Opioid Use Disorder (MOUD): The use of FDA-approved medications (e.g., methadone, buprenorphine, naltrexone) to treat opioid use disorder.

Michigan Mission Based Performance Indicator System (MMBPIS): Indicators established by MDHHS with domains for access to care, adequacy and appropriateness of services provided, efficiency (administrative cost vs. service costs), and outcomes (employment, housing inpatient readmission).

Medical Necessity means determination that a specific service is medically (clinically) appropriate and necessary to meet an Individual's treatment needs, consistent with the Individual'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 shall be met:

1. Individual is experiencing a SUD 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 Individual'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 Individual's immediate condition based on The ASAM Criteria (current edition as adopted by MDHHS).

Medically Necessary Services means SUD treatment services that are necessary for screening and assessing the presence of a mental illness, developmental disability or SUD, and/or are:

1. Required to identify and evaluate a mental illness, developmental disability or SUD that is inferred or suspected;
2. Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability, or substance abuse including impairment on functioning;
3. Expected to arrest or delay the progression of a substance use disorder and to forestall or delay relapse;
4. Designed to provide rehabilitation for the Individuals to attain or maintain an adequate level of functioning; and/or
5. Symptom alleviation alone is not sufficient for purposes of admission.

MSHN means Mid State Health Network, which is a Prepaid Inpatient Health Plan (PIHP) responsible for twenty-one counties in the MSHN region as of January 1, 2014.

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.

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

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

MSHN-SUDSP MANUAL which is incorporated into this Agreement by reference and made a part hereof, means policies, procedures, and standards established by MSHN and titled "Mid-State Health Network Substance Use Disorder Services Provider Manual (MSHN-SUDSP Manual), which governs the provision of services covered by this plan by the PROVIDER to the covered Individual. 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 A process of change through which individuals improve health and wellness, live self-directed lives, and strive to reach their full potential.

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

Request for Service means a formal, documented request made by a provider, patient, or other authorized party to begin the process of accessing a specific service available through MSHN's network or systems. The request is typically initiated through Access during the initial call and must be properly recorded and processed in accordance with MSHN policies and applicable state requirements.

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

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

ROSC refers to a coordinated network of services and supports that is person-centered, strength-based, and focused on long-term recovery to achieve improved health, wellness, and quality of life.

Sentinel Event is 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.

Service Authorization is the process of requesting an initial and/or continued authorization of services, either approving or denying as requested or authorizing in an amount, duration, or scope less than requested, all as required under applicable law, including but not limited to 42 CFR 438.210.

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:

1. 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."
2. Contemplation: "People have become aware that a problem exists, may be beginning to

recognize that their behavior is problematic and that they shall 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."

3. 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."
4. 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."
5. 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 is an impartial state-level review of a Medicaid Individual's appeal of an adverse benefit determination presided over by a MDHHS administrative law judge. Also referred to as "Administrative Hearing". The State Fair Hearing process is set forth in detail in Subpart E of 42 CFR Part 431.

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

Substance Use Disorder (SUD) is defined in MCL 330.1100d(12) of the Michigan Mental Health Code.

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

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

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

Transfer is the movement of the Individual 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.

Warm Transfer is a real-time connection between providers or services to ensure successful linkage to care.

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 2027 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, 2026, through September 30, 2027.

I. GENERAL CONTRACT SUMMARY

MSHN and PROVIDER wish to enter into this Agreement whereby the PROVIDER will render treatment to Individuals 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 Individual, to any other Individual or entity, or to the public at large.

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

a. Statement of Work: PROVIDER agrees to undertake, perform and complete the services described in Attachment A that is hereby incorporated into this Agreement. Additionally, PROVIDER agrees to follow all MDHHS Policies, Procedures and Technical Advisories that are relevant to identified services for which it is contracted**.**

b. Stop Work Order: Mid-State Health Network may suspend any portion or all activities under the Contract at any time. Mid-State Health Network will provide Contractor a written stop work order detailing the suspension and any pertinent instructions. Contractor must comply with the stop work order upon receipt. If the cause of the stop work order is reinstated, Mid-State Health Network will issue a supplemental notice authorizing Contractor to resume work along with any new conditions or funding levels. Mid-State Health Network will not pay for contract activities, contractor's lost profits, penalties, or any additional compensation or costs incurred during a stop work period.

c. Method of Payments and Performance Measures: The payment procedures and performance measures shall be followed as described in Attachment B that is hereby incorporated into this Agreement.

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

e. Additional Attachments: PROVIDER is required to comply with language in all attachments to this contract as they apply, incorporated by reference and made a part hereof.
Attachment A - Statement of Work
Attachment B - Cost Reimbursement
Attachment C - Performance Measures

Attachment D - Business Associate Agreement
Attachment E - Reporting Requirements for MSHN SUD Providers FY 2027 (Sent as a separate attachment)
Attachment F - MSHN Training Requirements (Sent as a separate attachment)

II. TREATMENT SERVICE OBLIGATIONS OF THE PROVIDER

A. General Provisions

1. **Authorization:** MSHN shall not make any payment for PROVIDER services rendered to persons who are not eligible for services; for services to eligible Individuals 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's obligation to pay any claim shall be subject to MSHN verification of an Individual's status as a Medicaid/HMP beneficiary or verification of financial eligibility at the time the service was rendered. If the Individual did not meet eligibility criteria and is not a Medicaid or Healthy Michigan Plan covered Individual at the time the service was delivered, PROVIDER may bill the Individual for the service. In no case shall a Medicaid or Healthy Michigan Plan covered Individual be billed for any service or for any portion of a service. PROVIDER must use REMI's SUD request for services (RFS) and level of care (LOC) 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. Providers shall ensure timely access to services consistent with MDHHS standards. Services shall be initiated following screening when clinically appropriate. Authorization processes shall support access to care and shall not delay initiation of medically necessary services, including MOUD.

2. **Access to Service:** MSHN, in partnership with its SUDSP network and CMHSP network, maintains a regional 24/7/365 access system for SUD services. All services for withdrawal management, residential, and recovery housing require a prior authorization from MSHN Access Department. A warm transfer to MSHN Access Department shall occur if a person calls one of these levels of care directly. For all other levels of care, PROVIDER shall ensure that all Individuals are able to receive services in accordance with the access standards (Attachment "Access Standards" of MDHHS contract with the PIHP ("MDHHS Contract")) set forth by MDHHS and the MDHHS Substance Use, Gambling and Epidemiology (SUGE). 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 when a person requests outpatient services. Those documents will be completed by the MSHN Access Department for all other levels.
Requirements of PROVIDER pertaining to after-hours access include:

   a. Provider phone systems must route after-hours calls consistent with the MSHN Access process. Residential treatment, withdrawal management,

and recovery housing providers must forward after-hours calls to the MSHN SUD Access Department at (844) 405-3095, or ensure their automated message clearly instructs callers to contact (844) 405-3095 for after-hours access and assistance. Calls to (844) 405-3095 automatically connect to Protocall during non-business hours. CMHSPs and outpatient providers must maintain their existing access processes for outpatient levels of care (ASAM 1.0 and 2.1).

b. CMHSP and PROVIDER establish a written after-hours protocol for handling referrals during non-business hours.

c. Providers shall ensure real-time access to services whenever possible, including use of warm transfer practices. Passive referrals shall be avoided unless clinically appropriate and documented.

3. **Equity and Access for Underserved Populations:** PROVIDER shall ensure equitable access to services for all individuals, including those from underserved and historically marginalized populations.

a. Culturally and Linguistically Appropriate Services**:** PROVIDER shall deliver services in a manner that is culturally responsive and linguistically appropriate, including provision of interpreter services where needed.

b. Welcoming Environment**:** PROVIDER shall maintain policies and practices that promote a welcoming, inclusive, and trauma-informed environment.

c. Barriers to Access**:** PROVIDER shall identify and address barriers to care, including transportation, stigma, childcare, and financial constraints.

d. Outreach and Engagement**:** PROVIDER shall conduct outreach and engagement efforts to populations with lower service penetration or higher unmet need.

e. Non-Discrimination**:** Services shall be provided without discrimination and in compliance with all applicable civil rights laws.

4. **Utilization 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.

Utilization management shall support access to medically necessary services and shall not impose barriers to care. Providers shall not deny, delay, or discontinue services based solely on:

- continued substance use
- positive drug screens

- lack of participation in counseling

All determinations shall be based on medical necessity and ASAM Criteria.

5. **Admission Preference:** Persons presenting with Medicaid or Healthy Michigan Plan (HMP) are entitled to medically necessary SUD services. Preference for treatment admission shall be applied in the following order (from highest priority to lowest): (i) pregnant injecting drug users; (ii) pregnant substance user; (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 individual being released directly from an MDOC facility without supervision AND referred by MDOC.; and (vi) all others. Individuals 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. Persons accessing services utilizing available block grant funds must follow the same preference for treatment admission priorities. Priority population requirements must not delay access for other individuals when clinically urgent needs exist; all determinations must be guided by medical necessity and risk.

B. Interim Services: Interim services must be provided as defined by the MDHHS Substance Use, Gambling and Epidemiology (SUGE) Access Standards (MDHHS Contract).Interim services shall be provided when immediate admission is not available. These services shall include: harm reduction, overdose prevention, naloxone access, and engagement and referral support.

1. **Waiting List:** A waitlist is defined as any delay beyond MDHHS access standards. Providers must report waitlist status and mitigation strategies to MSHN. Outpatient, Residential and Withdrawal Management PROVIDER shall notify the Access Department and lead treatment specialist 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.

2. **Residency**: PROVIDER may not limit access to the programs and services funded by this portion of the Agreement only to the residents of the PROVIDER's region, because the funds provided 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.

3. **Biopsychosocial 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. Only the ASAM

Continuum is approved 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 are 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, PROVIDER must comply with MSHN and MDHHS data collection requirements. Individuals in services for over 12 months, shall receive an annual assessment with use of the appropriate tool (ASAM Continuum for adults; GAIN-I-Core for adolescents) to assist with medical necessity and ongoing treatment planning. For those in service over 12 months, a BH TEDS S-record must be completed. Providers must accept prior assessments from other qualified providers when clinically appropriate and avoid duplicative assessments.

4. **Medication for Opioid Use Disorder (MOUD):** PROVIDER shall ensure access to FDA-approved medications for opioid use disorder (MOUD), including methadone, buprenorphine, and naltrexone, consistent with current federal and state requirements.

    a. Medication Access**:** MOUD shall be made available to eligible individuals without delay when clinically indicated. Access to medication shall not be contingent upon participation in counseling or other ancillary services.

    b. Assessment and Initiation**:** PROVIDER may initiate MOUD following an initial screening when clinically appropriate. A comprehensive assessment shall be completed within fourteen (14) calendar days of initiation.

    c. Continuation of Care: PROVIDER shall not discontinue MOUD solely based on continued substance use, non-participation in counseling, or positive drug screens.

    d. Care Coordination: PROVIDER shall coordinate MOUD services with other behavioral health, physical health, and recovery support services to ensure continuity of care.

    e. Take-Home Medication: Where applicable, PROVIDER shall follow federal and state guidance regarding take-home medication and ensure decisions are individualized and clinically appropriate.

5. **Drug Testing:** Drug testing shall be used as a clinical tool to inform treatment and shall not be used in a punitive manner.

6. **Prescribers of Controlled Substances – Required Training:** Additional training for all professionals who will be prescribing controlled substances, including training of Centers for Disease Control and Prevention (CDC) prescribing guidelines (Michigan's 1115 Implementation Plan, pg. 122).

a. Prescribers review the CDC prescribing guidelines: Guideline Recommendations and Guiding Principles | Overdose Prevention | CDC

b. Prescribers complete the Medication Access and Training Expansion Act Requirements: Diversion Control Division | Medication Assisted Treatment

C. Billing Provisions

1. **Invoicing:** PROVIDER will follow procedures outlined in the MSHN-SUDSP MANUAL for billing and submitting claims to MSHN. PROVIDER shall generate a claim using REMI requesting reimbursement for authorized services.

2. **Cost Reimbursement for Treatment 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, 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 an 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 Individuals 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 Individual 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 an individual were billed under block grant funding, and it was later determined that the Individual was Medicaid/HMP eligible, any co-pay amounts collected by the PROVIDER must be refunded to the Individual. 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 Individual 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 Individuals 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 Individuals or persons other than MSHN acting on MSHN Individuals' 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 Individual and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between PROVIDER and MSHN Individual or person acting on MSHN Individual’s behalf.

NOTE: If an Individual is receiving residential treatment services or recovery housing services, PROVIDER shall not bill MSHN for days the Individual 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, PROVIDER shall notify the MSHN UM Department of the reason for the gap in service.

PROVIDER Appeal Process: If MSHN shall 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. Shall 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's policies and procedures and Medicaid Plan in effect for each Individual, 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 Individual or MSHN eligible Individual, 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 Individuals receiving treatment until implementing and completing an approved transition plan which may include referral to another appropriate service or an orderly discharge. 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 Individuals 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 Individual's subscriber agreement. The provisions of this Agreement shall remain in effect until the transition plan has been fully executed.

D. Other Provisions

1. **Quality Assurance:** PROVIDER shall cooperate with MSHN and participate in and comply with all peer review program, utilization review, quality assurance and/or total quality management programs, audit systems, site visits including fiscal monitoring, grievance procedures, satisfaction surveys and other procedures as established from time to time by MSHN, or as required by regulatory or accreditation agencies. PROVIDER must participate in MSHN Quality Improvement Program aligned with MDHHS QI requirements, including performance indicators, outcome monitoring, and corrective action processes. 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 Individuals.

2. **Rendering Provider Credentialing and Recredentialing:** PROVIDER agrees to meet MSHN and MDHHS credentialing and recredentialing requirements, required criminal background checks, and accepts and shall abide by all credentialing policies and procedures. Providers must comply with MDHHS SUD Credentialing & Staff Qualification policy, including supervision, scope of practice, and certification requirements.

   The following background checks are required initially for each new employee:

   a. Criminal history- Internet Criminal History Access Tool (ICHAT) or from a source that reveals substantially similar information found on an ICHAT. https://apps.michigan.gov

   b. Michigan Public Sex Offender Registry: https://mspsor.com

   c. National Sex Offender Registry: https://www.nsopw.gov/

   d. MDHHS Central Registry Check is required for staff working directly with children. https://www.michigan.gov/mdhhs/adult-child-serv/abuse-neglect/accordion/forms/central-registry-clearance-requests

   Use information from the Medicaid Provider Manual (General information for Providers; Section 6 – Denial of Enrollment, Termination, and Suspension; Item 6.1 Termination or Denial of Enrollment) and the Social Security Act (Subsection 1128(a)(b)), to determine whether to prohibit any employee from working within a publicly funded healthcare system.

   PROVIDER shall ensure, through credentialing, that PROVIDERS's staff professionals and 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; or

   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 an Individual to any practitioner who has not fully complied with credentialing process as outlined in the MDHHS Credentialing and Re-credentialing Process (Provider Credentialing), the MDHHS-BHDDA Substance Abuse Disorder Policy Manual – Credentialing and Staff Qualification Requirements, and MSHN Credentialing and Recredentialing policies and procedures. Providers must meet the qualifications outlined in MDHHS Behavioral Health Codes Sets, Charts, and Provider Qualifications.

   MSHN retains the right to approve, suspend or terminate providers from participation in the Medicaid-funded services (e.g., exclusions from

Medicare/Medicaid; specific regional performance issues and/or criminal convictions under sections 1128(a) and 1128(b)(1),(2), or (3).

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

3. **Consumer Satisfaction Surveys:** PROVIDER shall participate in the administration of the MSHN consumer satisfaction surveys. Provider shall identify sources of dissatisfaction, and identify systematic improvement opportunities, as a result of the findings.

4. **Sentinel Events:** Providers must comply with MDHHS Critical Incident Reporting timelines and definitions, including submission to state systems where required. Provider agrees to review Critical Incidents as defined by MDHHS. Within three business days of the Critical Incident, Provider will determine if the event is sentinel. If the Critical Incident is determined to be sentinel, a root cause analysis (RCA) is required to commence within 2 business days of the determination of the Sentinel Event. Sentinel Events and Critical Incidents are to be reported as indicated in the reporting requirements. Additional information relating to the type of incidents that qualify as sentinel events and reporting timeframes can be located in the Provider Manual.

5. **State Fair Hearing:** Medicaid Individuals who request or receive services that are paid for with Medicaid funds per Michigan's approved use of Section 1862(a)(1)(A) of the Social Security Act will be provided with an adverse benefit determination when services are denied, reduced, suspended or terminated. Individuals must exercise their right to a local appeal process before requesting their right to a State Fair Hearing.

6. **Covered Services:** PROVIDER represents and warrants to MSHN that Covered Services shall be provided to all eligible Individuals 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. Covered services include the full SUD continuum, including withdrawal management, residential, outpatient, recovery supports, peer services, and harm reduction services.

7. **Covered Individuals:** PROVIDER reserves the right to provide professional services to Individuals other than covered Individuals, however, they will not solicit, request, or require any covered Individual, as a condition of receiving medical services, to dis-enroll from the plan or MSHN and become a private Individual of PROVIDER or enroll in any Fee-For-Service health benefit plan or other health benefit plan in which PROVIDER participates.

8. **PROVIDER Training:** PROVIDER agrees to obtain, at its own expense, ongoing training, and supervision according to applicable medical, mental health and substance use disorder practices and the licensing, credentialing or other qualifications policies, procedures or regulations of the state of Michigan and/or MSHN as outlined in Attachment G - MSHN Training Requirements. PROVIDER shall furnish a written summary of such training and supervision efforts to MSHN

upon request.

9. **Record Transfer:** Providers must ensure continuity of care and timely information exchange, including coordination with physical health and other behavioral health providers. Upon receipt of written request, PROVIDER shall transfer to the provider, designated in the request, copies of all medical records, and other data in the possession or control of PROVIDER pertaining to the covered Individual preferably within 24 hours, but not to exceed three (3) days of such notice. PROVIDER will utilize, accept, and honor the approved MDHHS 5515 standard consent form to release SUD records.

10. **Health and Safety:** Covered Individuals 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 Individual's health or safety is in immediate jeopardy.

11. **Medical Records:** PROVIDER shall keep complete and accurate medical records for all covered Individuals. 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 Individuals under this Agreement. Documentation must support medical necessity, level of care determination, treatment planning, and outcomes consistent with Medicaid requirements.

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

12. **Record Availability:** PROVIDER shall make available to a covered Individual 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 Individual's' medical records to third parties. The provisions of this section shall survive the expiration or termination of this Agreement regardless of cause, including non-payment by MSHN, insolvency or breach of this Agreement by either party.

13. **Financial Review:** MSHN conducts annual reviews of all Subrecipients based on its fiscal monitoring and oversight procedure. PROVIDER must submit, no later than six (6) months following the close of 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 PROVIDER is not currently operating under a Corrective Action Plan (CAP) and its total MSHN payments for the fiscal year in question are less than $100,000.

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

15. **Accounting and Internal Controls:** PROVIDER shall ensure its accounting procedures and internal financial controls conform to generally accepted accounting principles in order that the costs allowed by this Agreement can be readily ascertained and expenditures verified there from. The parties understand and acknowledge that their accounting and financial reporting under this Agreement must be in compliance with MDHHS accounting and reporting requirements and OMB 2 CFR 200. PROVIDER shall submit, upon request from MSHN, complete and accurate equipment inventory listing itemizing any equipment purchases made through federal or state funds.

16. **Agency Credentialing Requirements:** PROVIDER agrees to meet criteria for acceptance in the MSHN provider network including compliance with all applicable federal and state laws, rules and regulations. PROVIDER shall obtain and maintain during the term of this Agreement all licenses, certifications, registrations, accreditations, authorizations, and approvals required by federal, state and local laws, ordinances, rules and regulations for the Provider to operate and/or to provide Medicaid programs and supports/services within the state of Michigan. PROVIDER must notify MSHN in the event any license, certification, registration, accreditation, authorization, or approval expires, lapses, or is not renewed. MSHN must recredential PROVIDER triennially. 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 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 PROVIDER from other PIHPs or CMHSPs, and MSHN may utilize such information in the exercise of its rights under this Agreement.

17. **ASAM Level of Care (LOC) Enrollment Requirements:** Providers must align with current MDHHS-adopted ASAM Criteria (including future updates) and demonstrate fidelity through policy, training, and documentation. 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. PROVIDER 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. ***NOTE:*** *For all new potential SUD Treatment Providers (Not previously enrolled in MSHN's SUD Provider Network), based on the MiCAL System for ASAM LOC enrollments, MSHN may execute a formal SUD Treatment Services agreement with the mutual understanding that services and fee schedules shall not be performed and made effective until such time as the provider has applied for* ***and*** *obtained the required ASAM LOC Designation from MDHHS.*

18. **Recovery-Oriented Systems of Care (ROSC):** PROVIDER shall deliver services consistent with a Recovery-Oriented System of Care (ROSC), emphasizing long-term recovery, person-centered planning, and community integration.
a. **Person-Centered Services:** All services shall be individualized, strengths-based, and responsive to the Individual's goals, preferences, and cultural context.
b. **Continuum Engagement:** PROVIDER shall support individuals across the full continuum of care, including transitions between levels of care and ongoing recovery support beyond acute treatment.
c. **Peer Recovery Services:** PROVIDER shall incorporate or coordinate access to peer recovery support services to enhance engagement, retention, and long-term recovery outcomes.
d. **Family and Natural Supports:** PROVIDER shall engage family members and natural supports, as appropriate and with consent, to support recovery.
e. **Recovery Planning:** Treatment planning shall include recovery goals that extend beyond symptom reduction to include housing, employment, social connectedness, and overall wellness.

19. **Harm Reduction and Overdose Prevention:** PROVIDER shall incorporate harm reduction principles into service delivery to reduce negative consequences associated with substance use and to promote engagement in care.

    a. Non-Punitive Approach: Services shall be delivered in a non-judgmental, non-punitive manner that supports continued engagement regardless of substance use status.

    b. Overdose Prevention: PROVIDER shall ensure access to overdose education and naloxone distribution, directly or through referral, for individuals at risk of overdose.

    c. Engagement Strategies: PROVIDER shall utilize evidence-based engagement strategies to maintain contact with individuals who may not be ready for abstinence-based treatment.

    d. Infectious Disease Prevention: PROVIDER shall provide education and referral related to prevention of communicable diseases associated with substance use, including HIV and hepatitis.

    e. Service Continuity: Individuals who return to use shall not be discharged solely for that reason and shall be reassessed to determine appropriate level of care.

20. **Compliance with the MDHHS Contract:** It is expressly understood and agreed by the parties hereto that this Agreement is subject to the terms and conditions of the MDHHS Contract. PROVIDER shall comply with any applicable terms or

conditions of such contract. The MDHHS Contract is incorporated by reference into this Agreement, and by such incorporation, is made part of this Agreement. Amendments to the MDHHS Contract are also terms of this Agreement. The provisions of this Agreement shall be applicable unless a conflict exists between this Agreement and the provisions of the MDHHS Contract. In the event that any provision of this Agreement is in conflict with the terms and conditions of the MDHHS Contract, the terms of the MDHHS Contract shall prevail. 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 Contract;

b. restates provisions of the MDHHS Contract to afford MSHN the same or substantially the same rights and privileges as the MDHHS; or,

c. requires PROVIDER to perform duties and/or services in less time than required of MSHN in the MDHHS 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.

PROVIDER shall follow federal and/or state direction and guidance as it relates to any State of Emergency.

Pursuant to the MDHHS Contract, if MSHN, MDHHS, Center for Medicare and Medicaid Services (CMS), the Office of Inspector General (OIG), the Comptroller General, and their designees (hereinafter referred to collectively 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. MDHHS, the Centers for Medicare & Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the PIHPs contract with the MDHHS.
The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members.
The delegate agrees that the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

If MDHHS, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the MDHHS, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time

21. **Investigations and Proceedings**: PROVIDER's CEO shall promptly 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. PROVIDER shall also immediately inform, in writing, MSHN's CEO of any subsequent findings, recommendations, and results of such notices, inquiries, or investigations.

    The parties agree to cooperate fully in any investigation or prosecution by any duly authorized government agency, whether administrative, civil or criminal. Such cooperation must include providing, upon request, information, access to records and access to interview employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation or prosecution.

22. **Program Compliance:** PROVIDER shall implement and maintain a compliance and program integrity plan ("Compliance 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 Contract.

    a. The Compliance Plan must meet the requirements within the MSHN Compliance Plan and include, at a minimum, all of the following elements:

        i. Written policies, procedures and standards of conduct that articulate the PROVIDER'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 (15 business days) response to detected offenses, and for development of corrective action initiatives.

b. Upon request, PROVIDER will promptly 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 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. PROVIDER agrees not to investigate or resolve the alleged fraud and/or abuse, until guidance has been given by MSHN, and agrees to fully cooperate with any investigation by MSHN, its payors and/or 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 a licensed independent practitioner or an 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). 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) or the Attorney General.

f. PROVIDER will submit information on program integrity activities, when requested, to comply with requirements of the OIG (Program Integrity Section of the MDHHS Contract). This may include, but is 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. PROVIDER must maintain a list that contains all facility locations where

services are provided, or business is conducted. This list must contain Billing Provider NPI numbers assigned to the entity, what services the entity is subcontracted to provide, and provider email address(es).

h. MDHHS-OIG Sanctions: When MDHHS-OIG sanctions a provider, including for a credible allegation of fraud under 42 CFR 455.23, MSHN must, at a minimum, apply the same sanctions upon written notification of the sanction from MDHHS-OIG to MSHN. MSHN may pursue additional measures/remedies independent of the state.

21. **Disclosure of Litigation, or Other Proceeding.** PROVIDER must notify MSHN within 10 calendar days of receiving notice of any litigation, investigation, arbitration, or other proceeding (collectively, "**Proceeding**") involving PROVIDER, a subcontractor, or an officer or director of PROVIDER or subcontractor, that arises during the term of the Agreement, 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; (3) any complaint related to the services provided in this Contract filed in a legal or administrative proceeding alleging Contractor or its subcontractors discriminated against its employees, subcontractors, vendors, or suppliers during the performance of Contract activities and during the term of this Contract: or (e) a Proceeding involving any license that Contractor is required to possess in order to perform under this Agreement.

III. General Provisions for MSHN

A. Payment Timelines:

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

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

B. Care and Treatment: PROVIDER is solely responsible for all decisions regarding the medical care and treatment of MSHN Individuals that are referred for treatment. The traditional relationship between PROVIDER and Individual 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 Individual that the service is not a Covered Service and that MSHN Individual will be solely responsible for the cost thereof.

C. Advertising: MSHN will include PROVIDER's name, address, phone number and areas

of specialization in any directories that it may produce and publish for use by Individuals who may directly avail themselves of substance use disorder services that are Covered Services. PROVIDER may include, in its advertising, that it is an authorized PROVIDER of Covered Services for MSHN subject to the provisions of section VI.A.1 of this Agreement. PROVIDER may not finance any advertising using MSHN funding.

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

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

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

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

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

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

A. Scope and Terms of the Agreement: MSHN hereby retains PROVIDER to provide Covered Services for Individuals under the terms and conditions set forth in this Agreement. PROVIDER will make SUD treatment decisions and provide advice for purposes of diagnosis and treatment of covered Individuals. MSHN will make benefit determinations with respect to covered Individuals. 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 Individuals 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 Individuals enrolled in the plan and its list of covered Individuals are and shall remain the exclusive property of MSHN, and the use thereof for any purpose shall be subject to MSHN's exclusive control.

B. Acceptance of Individuals: PROVIDER shall accept Individuals 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 Individual and other Individuals in the quality of the behavioral health care services rendered.

C. Accessibility: PROVIDER shall ensure that all Individuals are able to receive services in accordance with the access standards ("Access Standards" of MDHHS Contract) set forth by MDHHS. PROVIDER also ensures services are delivered in a manner that takes into consideration the Individual'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 Individual. PROVIDER shall maintain adequate facilities and sufficient personnel to provide

Individuals with timely access to Covered Services. ***PROVIDER agrees to notify MSHN of any material additions, reductions, reduced capacity or elimination of services as soon as possible***. PROVIDER shall not offer hours of operation that are less than the hours of operation offered to commercial members or not comparable to Medicaid Fee-For-Service, if PROVIDER serves only Medicaid members.

D. **Referral of Individuals:** When an Individual requires services that PROVIDER does not customarily render, or where otherwise required by law or ethical professional practice, PROVIDER shall abide by the procedures in transferring the Individual to an appropriate source of care. When an Individual requires services, in addition to services that PROVIDER does customarily render, PROVIDER shall abide by the procedures relating to dually enrolled Individuals and/or Care Coordination. Please refer to the MSHN-SUDSP Manual for additional procedural guidance regarding integrated coordination of care, transfer, and warm transfer.

E. **Grievance, Appeals, and Fair Hearings:** PROVIDER will assure that Individual rights to a grievance, appeals, and/or fair hearing are provided. PROVIDER agrees to comply with applicable sections of federal law 42 CFR 431.200-250 and 42 CFR 438.400-438.424 regarding grievance, appeals, and fair hearings. SUD 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. **Individual Choice:** PROVIDER must assure that Individuals are given a choice in the selection of a qualified treatment program. This choice must be documented in the Individual's file. Individuals are to be given a choice of rendering provider (clinician) to the extent feasible.

G. **Individual Eligibility:** PROVIDER is responsible for identifying an Individual's active eligibility for Medicaid/HMP reimbursement through the REMI system at the time of admission to treatment and every thirty (30) days thereafter. PROVIDER is responsible for assisting any non-insured or under-insured Individual with Medicaid/HMP eligibility application within thirty (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 ninety (90) days or at a change in an individual's financial status, whichever occurs sooner, and uploaded into REMI. Please see MSHN website Finance Policies and Procedures for the most current version of the SUD Income Eligibility & Fees Policy and Procedure.

H. **Compensation:** PROVIDER hereby agrees that in no event, including but not limited, to non-payment by insolvency or breach of this Agreement, shall PROVIDER bill, charge, collect from, seek compensation, remuneration or reimbursement from, or have any recourse against Individuals or persons other than MSHN acting on the Individuals' behalf for services provided pursuant to this Agreement. PROVIDER shall look solely to MSHN and not to any covered Individual for payment for all Covered Services provided (excluding patient pay amount) to covered Individuals 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 Individuals, 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 Individual;

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

3. This provision shall not apply to charges for services that are not Covered Services which are requested by an Individual, or an Individual's parent or legal guardian, after the Individual or Individual's parent or legal guardian have been informed, orally and in writing, at least twenty-four (24) hours in advance of such services, that the services are not Covered Services.

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

V. Care Coordination and Physical Health Integration

PROVIDER shall coordinate care across behavioral health, physical health, and social service systems to ensure comprehensive and integrated service delivery.

1. Coordination with Healthcare Providers: PROVIDER shall coordinate with primary care providers, specialty care providers, and other treatment providers to support whole-person care.

2. Information Sharing: PROVIDER shall ensure timely sharing of relevant clinical information, consistent with confidentiality requirements, to support continuity of care.

3. Transitions of Care: PROVIDER shall actively manage transitions between levels of care, including hospital discharge, residential treatment, and outpatient services.

4. Co-Occurring Conditions: PROVIDER shall assess and address co-occurring mental health and physical health conditions as part of treatment planning.

5. Social Determinants of **Health:** PROVIDER shall identify and address social needs, including housing, employment, and transportation, through coordination and referral.

VI. Medicaid Responsibilities of MSHN

A. MSHN shall furnish the following to PROVIDER:

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

2. **30-day Notice:** Thirty (30) 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.

VII. CONTRACTUAL PROVISIONS

A. General Responsibilities of PROVIDER

1. **Publication Rights:** Where activities supported by this Agreement produce books, films, or other such copyrighted materials issued by PROVIDER, 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 Individual 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. PROVIDER shall give recognition to the MSHN in any and all publication papers and presentations arising from the program and this Agreement.

   In all cases, whether the material is copyrighted or not, 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 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 Individuals 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 and MSHN's record retention policy.

3. **Notification of Modification:** PROVIDER shall ensure at least 60 days notification to 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 Agreement, its attachments, and referenced documents.

4. **Notices to MSHN:** PROVIDER shall notify MSHN within seven (7) business days of any of the following events: (i) 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, revoke, or in any way limits PROVIDER's authority to render Covered Services: (ii) actual or threatened loss, suspension, restriction or revocation of PROVIDER license or ability to fulfill its obligations under this Agreement; (iii) malpractice action filed against PROVIDER; (iv) of any charge or finding of ethical or professional misconduct by PROVIDER; (v) loss of PROVIDER professional liability insurance or any material change in PROVIDER liability insurance; (vi) 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's 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 incident involving a recipient of SUD services performed under the terms of this Agreement.

5. **Notification of Recipient Sentinel Event:** PROVIDER shall notify MSHN of all events that are sentinel including (but not limited to) all deaths that are the subject of recipient rights, licensing, or police investigation. Sentinel Events are to be reported to MDHHS via MSHN within 24 hours of the event or notification of the death. The following information is to be included in the notification: Name of beneficiary; Beneficiary ID number (Medicaid/MI Child); Individual ID if no beneficiary ID; Date, time, and place of death; Preliminary cause of death; Contact persons' name and Email address. Additional information relating to the type of incidents that qualify as sentinel events and reporting timeframes can be located in the SUD Provider Manual.

6. **Notification of Staffing Changes:** 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 Individual access to care. PROVIDER shall have procedures to address changes that negatively affect access to care. Changes in staff composition that MSHN determines to negatively affect recipient access to covered services may be grounds for sanctions such as a hold on new admissions.

7. **Research Restrictions on Human Subjects:** PROVIDER shall notify MSHN who will seek approval, from MDHHS, for any research involving human subjects as defined in the MDHHS Contract and within the MSHN research policy.

8. **DDCAT & 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 the criteria for dual diagnosis capability (co-occurring capability). The TIC Organizational Survey will be utilized as a self-assessment and completed every three years.

B. Assurances of PROVIDER

1. **Compliance with Applicable Laws:** PROVIDER shall comply with all 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-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 Individual, 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, or sex including discrimination based on pregnancy, sexual orientation, gender identity, transgender status 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 Agreement.

PROVIDER agrees to assure accommodation of physical and communication limitations for Individuals served under this Agreement.

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 this Agreement.

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

   a. Has not been convicted of certain crimes as described in section 1128(b)(8)(B) of the Act;

   b. Is not debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulations or from participating in non-procurement activities under the regulations issued under Executive Order No. 12549 or guidelines implementing Executive Order No. 12549;

   c. Is not excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act; and

   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 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 PROVIDER interacts with in any of the following capacities:

   a. A director, officer, or partner of PROVIDER;

   b. A subcontractor of PROVIDER;

   c. A person with beneficial ownership of five (5) percent or more of PROVIDER's 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 this Agreement.

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

a. May continue an existing agreement with PROVIDER unless the State directs otherwise; and

b. May not renew or otherwise extend the duration of an existing agreement with 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 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. Has not within a three-year period preceding this Agreement been convicted of or had a civil judgment rendered against it 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. Is not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state or local) with commission of any of the offenses enumerated in subsection (a) above, and;

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

6. MSHN requires the PROVIDER to provide prompt 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; or

d. Any party to an employment, consulting, or other agreement with PROIVDER for the provision of contract items or services.

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

a. When PROVIDER submits a proposal in accordance with MSHN's procurement process;

b. When PROVIDER executes a contract with MSHN;

c. When MSHN extends or renews any contract with PROVIDER; and

d. Within thirty-five (35) days after any change in ownership of PROVIDER.

8. **Exclusions Monitoring:** Prior to employment (direct hire, contracted, consulting arrangement or any other contractual agreement) PROVIDER must conduct checks to ensure prospective employees/contractors, provider entities, and any individuals with ownership or control interests in the provider entity (direct or indirect ownership of five percent or more or a managing employee) are not debarred, suspended, or otherwise excluded from participation in federal and state health care programs., 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; and

c. The Michigan Department of Health and Human Services (MDHHS) List of Sanctioned Providers https://www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/list-of-sanctioned-providers to ensure an individual or entity has not been sanctioned.

d. PROVIDER must conduct a monthly search for all excluded parties using the OIG database, The GSA database, and the MDHHS List of Sanctioned Providers . PROVIDER will maintain documentation of the completion of such checks and make them available to MSHN for inspection.

9. **Disclosure Requirements:** PROVIDER shall comply with federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions as specified in 42 C.F.R. §455.104-106. In addition, PROVIDER shall ensure that any and all contracts, agreements, purchase orders, or leases to obtain space, supplies, equipment or services provided under the Medicaid agreement require compliance with 42 C.F.R. §455.104-106. PROVIDER must require staff members, directors, managers, or owners or contractors, for the provision of items or services that are significant and material to PROVIDER obligations under its contract with MSHN, to disclose all felony convictions and any misdemeanors for violent crimes to PROVIDER. PROVIDER's employment, consulting or other agreements must contain language that requires prompt disclosure of any such convictions to PROVIDER.

10. **Notice Requirements:** PROVIDER must notify MSHN's CEO immediately if:

a. Any licensed independent health care practitioner, director, or manager of 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's 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 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:** PROVIDER shall not subcontract any portion of this Agreement without the written authorization of MSHN. Any 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 incorporate this Agreement into the subcontract, and

d. Contain all subcontracting requirements of the MDHHS Contract.

PROVIDER, as a prime subcontractor of MSHN, is responsible under this Agreement for primary verification that the PROVIDER's contracting procedures meet the MDHHS's requirements of MSHN as set forth in the MDHHS Contract and that each of the PROVIDER's subcontractors and each of its subcontracts therefore meets the requirements under this Agreement.

13. **Health Insurance Portability and Accountability Act:** To the extent that this Act is pertinent to the services that PROVIDER provides under this Agreement, 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 Individual handbooks and PROVIDER directories to Individuals, and/or the MSHN HIPAA Privacy Notice.

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

C. Block Grant Requirements

PROVIDER shall accept Individuals 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 Individual and other Individuals 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 a 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 21;

g. Pay the salary of an individual at a rate in excess of Level I of the Federal Executive Schedule, or approximately $235,100;

h. Purchase promotional items, including but not limited to clothing, commemorative items such as pens, mugs/cups, folders/folios, lanyards, and conference bags.

D. Termination

1. **By Either Party Without Cause:** This Agreement may be terminated by either party without regard to breach or other cause, and without liability by reason of such termination, upon sixty (60) days prior written notice to the other party. PROVIDER must make a good faith effort to give written notice of termination of a contracted service to each member who received his/her primary care from, or was seen regularly by, the terminating PROVIDER's program. Notice to the member must be provided by the later of thirty (30) calendar days prior to the effective date of termination, or fifteen (15) calendar days after receipt or issuance of the termination notice. Please note, MSHN recommends at least a 120-day notice from MOUD providers, especially Opioid Treatment Providers (OTPs) to allow sufficient time to transition individuals in services to other providers and resources.

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 any of its agents, directors, officers, or owners are 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 also be terminated immediately by MSHN without further liability in the event of unavailability, reduction or loss of funding whatever the cause.

    a. **Final Reporting Upon Termination:** Shall 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 PROVIDER, and not the responsibility of MSHN, if, the liability, loss, or damage is caused by, or arises out of, the actions or failure to act on the part of PROVIDER, any subcontractor, anyone directly or indirectly employed by PROVIDER, provided that nothing herein shall be construed as a waiver of any

governmental immunity that has been provided to PROVIDER or its employees by statute or court decisions.

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

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

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

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

g. **Confidentiality:** PROVIDER shall assure that medical services and information contained in medical records of Individuals 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 Individual 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 Individuals. 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 Individuals' data, nor backup files, in any location that is outside the continental United States.

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

E. Continuation of Contractual Agreement

In the event that it is the intent of MSHN to initiate a new agreement, and a new agreement is not executed by the expiration date of this Agreement, the terms, conditions, and funding levels for program(s) contained herein, may be extended as determined necessary by

written authorization from MSHN, subject to the availability of funds. This continuation period is not to exceed two consecutive ninety (90) day periods, unless otherwise specifically provided for.

F. Liability Insurance

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

Required Limits	Additional Requirements
Commercial General Liability Insurance	
Minimum Limits: $1,000,000 Each Occurrence $1,000,000 Personal & Advertising Injury $2,000,000 General Aggregate $2,000,000 Products/Completed Operations	
Automobile Liability Insurance	
If a motor vehicle is used in relation to the PROVIDER's performance, the PROVIDER must have vehicle liability insurance on the motor vehicle for bodily injury and property damage as required by law.	
Workers' Compensation Insurance	
Minimum Limits: Coverage according to applicable laws governing work activities	Waiver of subrogation, except where waiver is prohibited by law.
Employer Liability Insurance	
Minimum Limits: $500,000 Each Accident $500,000 Each Employee by Disease $500,000 Aggregate Disease	
Privacy and Security Liability (Cyber Liability) Insurance	
Minimum Limits: N/A	The PROVIDER shall maintain higher cover limits and/or such other insurance (e.g., Cyber Liability Insurance, Disability Insurance, etc.) as shall be necessary to insure PROVIDER against any claim(s) arising from this Agreement, including but not limited to claim(s) for damages. In the event the PROVIDER'S risk funding is inadequate to cover financial losses sustained, the PROVIDER shall suffer the loss separately and indemnify the PAYOR from any claims and damages.
Professional Liability (Errors and Omissions) Insurance	
Minimum Limits: $1,000,000 Each Occurrence	

$3,000,000 Annual Aggregate	

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

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

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

PROVIDER shall maintain 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 with an independent third party pursuant to the terms of an escrow agreement, as agreed upon by MSHN and PROVIDER.

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G. Resolution of Disputes

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

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

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

H. Special Conditions

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

2. **Medicaid/HMP:** Sub-acute withdrawal management and residential treatment services may be provided to eligible Individuals who reside in MSHN's region and request the services. Sub-acute withdrawal management and residential services will be accessed and authorized through the MSHN Access Department based on medical necessity utilizing the current ASAM Criteria, as well as considering the individual needs of the individual.

3. **Accepted Proposal Applicability:** The proposal submitted by PROVIDER and accepted by MSHN describing the services and programs to be delivered under this Agreement are contractual obligations of PROVIDER. The accepted proposal is incorporated into this Agreement by reference and is a part hereof. Any expansions to the original proposal shall be submitted to MSHN for review and approval prior to implementation.

4. **Access to Full-Service Array:** MSHN requires of its SUD treatment provider network that no MSHN Individual is denied access to or pressured to reject the full-service array of evidence-based and potentially life-saving treatment options, including Medication for Opioid Use Disorder (MOUD , that are determined to be medically necessary for the individualized needs of that Individual.

5. **Medication for Opioid Use Disorder (MOUD) – Medication for Opioid Use Disorder (MOUD) Inclusive Policy:** PROVIDER is expected to adopt a MOUD-inclusive treatment philosophy in which 1) PROVIDER demonstrates willingness to serve all eligible treatment-seeking individuals, including those who are using MOUD (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, and 2) PROVIDER develops policies that prohibit disparaging, delegitimizing, and/or stigmatizing of MOUD either with individual Individuals or in the public domain.

6. **Access to Multiple Pathways of Recovery:** In the interest of Individual choice, MSHN will contract with abstinence-based (AB) providers who offer written policies and procedures stating the following:

a. If a prospective Individual, 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 Individual was informed in an objective way about other treatment options including MOUD, and the Individual is choosing an abstinence-based provider from an informed perspective. The informed consent must be initialed by the Individual 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 an Individual already on MOUD (or considering MOUD 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 MOUD as a choice, b) will not pressure the Individual to make a different choice, and c) will work with that Individual to do a "warm handoff" to another provider who can provide those ancillary services while the Individual pursues his or her chosen recovery pathway that includes MOUD.

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

J. Contract Remedies and Sanctions

1. **Contract Non-Compliance:** MSHN may use a variety of means to assure implementation of and compliance with contract and/or reporting requirements, policies, procedures, performance standards and indicators and other mandates of MSHN. 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 PROVIDER and/or its subcontractors, MSHN may take any of the following actions:

   a. Discussion with PROVIDER to identify potential barriers to effective performance and to identify and implement mutually agreeable solutions to performance problems**.**

   b. Require a corrective action/performance enhancement plan and specified status reports that become a contract performance expectation.

   c. Temporary hold on new Individual admissions in the event of continual contractual non-compliance and/or identified health or safety issues.

   d. The withholding of payment, in the event that the above noted items have not been successful. The withholding of payment shall be in accordance with MSHN Compliance: Provider Contract Non-Compliance Procedure. Prior to withholding payment, MSHN will give sixty (60) days' notice to

allow for a period of correction, except for occurrences of required reports not being submitted as outlined in Section I.2 – Delinquent Reports.

e. Voiding of claim and recoupment of monies from disbursement.

f. Revocation or suspension of identified applicable delegated functions and/or authorizations until such time as the non-compliance issue(s) have been corrected. Notwithstanding any relationship(s) that MSHN may have with any delegate (i.e., subcontractor), MSHN maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with MDHHS.

g. Contract termination in instances of material breach, or where the identified steps above have not resolved the deficiency.

2. **Delinquent Reports:** For sanctions related to required reporting compliance issues as indicated in the Delinquency Procedure for SUD Providers and on Attachment "Reporting Requirements for MSHN SUD Providers FY 20276" and/or other reporting requests with due date(s), and/or requested information with due date(s), MSHN may delay scheduled payment to PROVIDER if not submitted on time as indicated on Attachment "Reporting Requirements for MSHN SUD Providers FY 20276" 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 shall the required reports, as indicated on Attachment "Reporting Requirements for MSHN SUD Providers FY 20276" 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 it has reviewed and agrees to MSHN's MSHN-SUDSP MANUAL.

MSHN

By: _____

Its: Interim Chief Executive Officer

Printed Name: Amanda L. Ittner

Date: _____

«PROVIDER»

By: _____

Its: _____

Printed Name: _____

Date: _____

ATTACHMENT A: STATEMENT OF WORK

1. **Annual Plan Guidelines:** PROVIDER will comply with the requirements of the Annual Plan Guidelines communicated to PROVIDER by MSHN.

2. **MSHN-SUDSP MANUAL:** PROVIDER will comply with all requirements and procedures contained within the MSHN-SUDSP Manual, which is incorporated into this agreement by reference and made a part hereof.

3. **Screening and Priority Admission Requirements:** MSHN, retains responsibility for screening, access, and referral for Substance Use Disorder (SUD) for residential treatment, withdrawal management, and recovery housing services. PROVIDER shall accept referrals from MSHN Access and must admit individuals in accordance with established priority population requirements, consistent with the MDHHS/PIHP Contract. For all other levels of care, the PROVIDER must screen all eligible Individuals requesting services to determine priority population at the point of first contact. Priority for admission must be given in the following order: (i) Pregnant Injecting Drug User; (ii) Pregnant Substance User; (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 facility without Supervision and Referred by MDOC (referral shall include CFJ 306); (vi) All Others.

   In the State of Michigan, an injecting drug user is defined as anyone who has injected a drug within the last thirty (30) days. Individuals identified in priority groups i-v above are prioritized regardless of county of residence and must be admitted within the required admission timeframes:

Population	Admission Requirement	Interim Service Requirement
Pregnant Injecting Drug User	1) Screened and referred within 24 hours. 2) Detoxification, Methadone, or Residential – Offer admission within 24 business hours. Other Levels or Care – Offer admission within 48 business hours.	*Begin within 48 hours:* 1. Counseling and education on: a) human immunodeficiency virus (HIV) and tuberculosis (TB). b) Risks of needle sharing. c) Risks of transmission to sexual partners and infants. d) Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early intervention clinical services.
Pregnant Substance Use Disorders	1) Screened and referred within 24 hours. 2) Detoxification, Methadone, or Residential – Offer admission within 24 business hours. Other Levels or Care – Offer admission within 48 business hours.	*Begin within 48 hours:* 1. Counseling and education on: a) HIV and TB. b) Risks of transmission to sexual partners and infants. c) Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early intervention clinical services.

Injecting Drug User	Screened and referred within 24 hours. Offer admission within 14 days.	*Begin within 48 hours – maximum waiting time 120 days:* 1. Counseling and education on: a) HIV and TB. b) Risks of needle sharing. c) Risks of transmission to sexual partners and infants. 2. Early intervention clinical services.
Parent At-Risk of Losing Children	Screened and referred within 24 hours. Offer admission within 14 days.	*Begin within 48 business hours:* Early intervention clinical services.
Individuals Under Supervision of Michigan Department of Corrections (MDOC) and Referred by MDOC or Individuals Being Released Directly from an MDOC Without Supervision and Referred by MDOC	Screened and referred within 24 hours. Offer admission within 14 days.	*Begin within 48 hours:* Early intervention clinical services Recovery Coach services
All Others	Screened and referred within seven calendar days. Capacity to offer admission within 14 days.	Not required.

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

5. **Communicable 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 Individuals and must have procedures and/or policies to ensure protection of the Individual'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 Individuals entering residential or residential withdrawal management treatment will be tested for TB upon admission and the test result is known within five (5) days of admission. High-risk TB Individuals shall be treated using Universal Precaution Practices until test results are known. Individuals 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, Individual shall 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. MDHHS expectations for Communicable Disease screening, staff training, etc. Can be located in SUD Treatment Policy Communicable Disease - Prevention Policy #02.

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

a. Outreach and contacts/communication to support participant engagement,

b. Conducting screening, record review and documentation as part of Evaluation and Assessment,

c. Tracking and facilitating follow up on referrals,

d. Post discharge follow up,

e. Care Planning,

f. Managing transitions of care activities to support continuity of care, to include arranging for timely referral appointments and coordinating and transferring necessary information with appropriate consent(s) between internal and external providers,

g. Addressing social supports and making linkages to services addressing housing, food, etc., and

h. Monitoring, Reporting and Documentation.

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

8. **Consumer Satisfaction Surveys:** PROVIDER is required to participate in a Consumer Satisfaction Survey process for all Individuals funded by MSHN. MSHN will compile and publish survey results. Provider is required to identify actions/steps for areas requiring improvement.

9. **Data Reporting Requirements:** PROVIDER must comply with data reporting requirements contained in the MSHN-SUDSP Manual and in this Agreement. PROVIDER is responsible for submitting timely reports and/or other reporting requests with due date(s), and/or requested information with due date(s) to MSHN, and as may from time to time be required, to comply with all reporting requirements as specified in the MDHHS Contract.

10. **Cooperation with External Medicaid Evaluation:** PROVIDER is expected to cooperate with MSHN efforts in the external evaluation of Medicaid services. PROVIDER will assure compliance with the submission of necessary data and facilitate access to Individual files and other records as required.

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

12. **MDOC/MPRI Individuals:** MSHN will not subsidize the cost of treatment for Individuals 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 a duplication of payment for any Individual receiving funds under the MDOC/MPRI contracts. This includes state disability assistance.

When Individuals 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 an Individual'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 treatment by the Michigan Department of Corrections (MDOC), the individual's supervising parole/probation agent will send a written referral (MDOC Form CFJ-306) and release (MDHHS 5515 Consent to Share) to PROVIDER. PROVIDER will upload these forms to REMI once the person is admitted. PROVIDER is required to utilize the Level of Care Determination in REMI at the time of the request for outpatient services to document screening activity and medical necessity for the appropriate Level of Care. MSHN Access Department will complete the screening documents for all other levels of care (including recovery housing). PROVIDER may not deny an individual an in-person assessment via phone screening. Individuals under supervision of MDOC are considered a priority population and shall be offered admission within fourteen (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:

a. 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.

b. In the case of MDOC individuals, assessments shall 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.

c. All MDOC referred individuals will be provided with an assessment. If the individual does not meet medical necessity for any SUD services, PROVIDER will give information regarding community resources such as AA/NA or other support groups.

d. To the extent consistent with HIPAA, the Michigan Mental Health Code and 42 CFR Part 2, and with the written consent of the individual, PROVIDER will provide notice of an admission decision to the supervising agent within one business day.

e. To the extent consistent with HIPAA, the Michigan Mental Health Code and 42 CFR Part 2, and with the written consent of the individual, PROVIDER agrees to inform the supervising agent when Medication for Opioid Use Disorder (MOUD) is included in the Individuals treatment plan. If the medication type changes, PROVIDER must inform the supervising agent.

In addition, PROVIDER shall have on file and maintain a current Individual 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 Individual's MDOC supervising agent;

For Individuals receiving residential treatment services:

a. If an individual referred for residential services 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.

b. Individuals participating in residential services may not be given unsupervised day passes, furloughs, etc., without PROVIDER consultation with the supervising agent.

c. PROVIDER shall notify/coordinate with the supervising agent of any leaves for any non-emergent medical procedures.

d. If an individual leaves an off-site supervised therapeutic activity without proper leave to do so, PROVIDER must notify the supervising agent by the end of the day on which the event occurred.

e. 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.

f. Additional reporting requirements if PROVIDER is a residential provider:

   i. Death of an individual under MDOC supervision

   ii. Relocation of an individual's placement for more than 24 hours

   iii. 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.

   iv. PROVIDER must notify the MDOC supervising agent of any criminal activity involving an MDOC supervised individual within one hour of learning of the activity.

g. 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.

h. 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.

i. 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.

j. 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 ASAM LOC services, including residential:

a. 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.

b. PROVIDER agrees to inform the supervising agent when Medication for Opioid Use Disorder (MOUD) is included in the Individuals treatment plan. If the medication type changes, PROVIDER must inform the supervising agent.

c. 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.

d. 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.

e. 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. **Hypodermic Needles**: PROVIDER assures that no federal or state public funds will be used to provide Individuals with hypodermic needles or syringes enabling such Individuals to use illegal drugs.

14. **Charitable Choice (Faith-based PROVIDER Only):** Faith-based Providers receiving federal public funds for the delivery of substance use disorder (SUD) or behavioral health services shall comply with applicable federal Charitable Choice requirements under 42 CFR Part 54. Providers shall ensure transparency, protect individual autonomy, and support informed decision-making by clearly informing individuals seeking or receiving services whether, and in what manner, religious doctrine, beliefs, practices, or organizational value systems may inform or influence the services provided. Faith-based Providers shall provide all required notices and disclosures in accordance with federal requirements and shall ensure that participation in religious activities is voluntary and that access to publicly funded services is not conditioned upon participation in religious activities or adherence to religious beliefs. Providers are responsible for maintaining documentation sufficient to demonstrate compliance with applicable Charitable Choice requirements and MSHN contractual expectations. PROVIDER must comply with Disclosure of Faith-Based Treatment Orientation Procedure. Please see MSHN website Service Delivery Procedures for the most current version.

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. The faith-based organization must clearly inform prospective Individuals that services in that agency are informed by a specific religious framework at the first point of contact and before initiation of assessment, intake or signing of informed consent documentation.

iv. Individuals receiving services from a faith-based organization who object to the religious character have a right to notice, referral, and alternative services that meet the standards of timeliness, capacity, accessibility, and equivalency.

v. The transferring faith-based organization PROVIDER must notify the alternative provider through the process of a warm transfer and notify MSHN UM Department (Access Center, when appropriate) of the transfer.

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

i. Provide notice to all potential and actual Individuals of their right to alternative services.

ii. Refer program Individuals 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." 42 CFR Appendix to Part 54a

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

16. **Transportation Requirement:** A transportation log must be included in the Individual chart for MSHN women's specialty designated Providers, withdrawal management or residential providers and other qualified providers whose Individuals are utilizing transportation services. In accordance with the Medicaid Provider Manual - Non-Emergency Medical Transportation, individuals transporting Individuals 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 Individual's individualized treatment plan. MSHN strives to reduce transportation barriers to accessing services, using the best quality, Individual-friendly, cost-efficient means possible. Please refer to the Provider Manual for the full transportation requirements (Appendix G; Page 106).

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

    PROVIDER must comply with MSHN Peer Recovery/Recovery Support Policy. Recovery support services may be provided at the beginning, during, or at the end of treatment episodes.

18. **Integrated Treatment/Co-occurring Capable**: PROVIDER will document integrated services planning efforts for treating Individuals 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. It is the expectation from MSHN that all PROVIDERS are co-occurring capable by 10-1-26 to be in compliance with the implementation of the current ASAM Criteria.

19. **Fetal Alcohol Spectrum Disorders (FASD)**: PROVIDER that serves individuals with minor children must 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 shall 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 (vi) 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 must make FASD screening evaluations, when appropriate. MDHHS BSAAS Treatment Policy #11 requirements must be met in full. Charts shall document individual FASD-related screens, referrals and services.

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

a. Providers will act consistently with collaboration and cooperation of efforts in order to effect positive change in communities/counties.

b. Providers support a process of community change 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 requires that PROVIDER partners ~~to~~ participate in local ROSC meetings. Participation can be defined as in person, by phone, videoconference, or connection through email list-serve.

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

a. Distribute the Customer Handbook to individuals at intake, annually, and as requested by providing a physical copy or electronically, after obtaining the Individual's agreement to receive information electronically

b. Display the LARA "Know Your Rights" Recipient Rights poster in a common area within the location/building available to view by Individuals. 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 Individuals, as defined by LARA, in accordance with PROVIDER's LARA licensing requirements.

d. Ensure there is a designated function for "Customer Services" as defined by the State of Michigan in MDHHS Contract "Customer Services Standards."

e. Ensure Customer Services has staff to sufficiently meet the needs of the Individuals 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 Contract “Customer Services Standards.”

g. Upon request, Customer Service staff shall assist beneficiaries with filing grievances and appeals, accessing local dispute resolution processes, and coordinating, as appropriate, with the local recipient rights advisor.

h. PROVIDER shall sufficiently display and provide to Individuals 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.

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

23. **Appeal and Grievance:** PROVIDER must have processes in place to handle Medicaid adverse benefit determinations, grievances, and appeals to adverse benefit determinations. Processes are required to be completed as they occur through MSHN’s REMI system. Notices of adverse benefit determinations, grievances, and appeals are required to be provided to Medicaid beneficiaries. Completing the process through MSHN’s REMI system will enable providers to maintain records which include the required information of the name of the person for whom the appeal or grievance was filed, a general description of the reason for the appeal or grievance, date received, date of each review, date of resolution, and the resolution details of the appeal or grievance. The recordkeeping must be accurately maintained in a manner accessible to MSHN and available upon request.

24. **Recovery Assessment:** PROVIDER is required to participate in a regional process to assess the recovery environment utilizing a standardized tool.

25. **Sentinel Events:** PROVIDER must have a process to review, analyze, and report all required critical incidents, and identified sentinel event as indicated in the SUD Provider Manual.

26. **Project ASSERT & SBIRT Programs:** For agencies who engage in Project ASSERT or SBIRT programs in their communities, PROVIDER is required to support data collection and data entry of encounters into the MSHN REMI system. PROVIDER shall 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 PROVIDER 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.

27. **Prescriber Education and Controlled Substance Training Requirements:** PROVIDER shall ensure that all applicable prescribing professionals comply with current federal and state-controlled substance prescribing education and training requirements. At a minimum, PROVIDER shall ensure that all applicable DEA-registered practitioners:

    a. Review and maintain familiarity with current Centers for Disease Control and Prevention (CDC) Clinical Practice Guidelines and Guiding Principles related to opioid prescribing, pain management, overdose prevention, and risk mitigation;
    b. Complete all applicable Medication Access and Training Expansion (MATE) Act training requirements, including the federally required one-time training related to the treatment and management of patients with opioid or other substance use disorders;
    c. Maintain documentation demonstrating completion of required education and training activities, including applicable attestations, continuing education records, or training certificates;
    d. Participate in PROVIDER compliance monitoring and audit activities related to prescribing practices, controlled substances, opioid prescribing, and substance use disorder treatment requirements;
    e. Utilize prescribing practices that support patient-centered, clinically appropriate, trauma-informed, and evidence-based care.

    PROVIDER shall maintain policies and procedures supporting compliance with applicable DEA registration requirements, CDC prescribing guidance, and state and federal prescribing standards. Documentation of compliance shall be made available to MSHN, MDHHS, or other authorized oversight entities upon request.

28. **Reducing Health Disparities:** MSHN is charged with ensuring access to high-quality SUD services for all residents of our 21-county region, and with reducing health disparities for populations that have been historically underserved in part due to age, gender, disability, socioeconomic status, race, ethnicity, sexual orientation, gender identity, geography (urban/rural) or any other identifying characteristic(s). Towards that end:

    PROVIDER staff will participate in FY27 trainings that MSHN arranges such as interactive lunch & learn trainings. The expectation is that, at the very least, all public-facing staff, clinical staff and agency leadership will participate in trainings. Please find details in the FY27 SUD provider manual.

    PROVIDER will complete an organizational readiness assessment to determine gaps in preparedness to address issues like health disparities, stigma, bias, and cultural humility. These assessments will inform more detailed planning in FY28. Please find details in the FY27 SUD provider manual.

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ATTACHMENT B: COST REIMBURSEMENT
FY 2027 SERVICES AND FUNDING ALLOCATION SUMMARY
«PROVIDER»

Cost-Reimbursement
A total cost estimate is determined before contract work pursuant to this Agreement. PROVIDER cannot exceed the maximum without MSHN's permission. The final pricing will be determined when the Agreement is completed, or at some other previously established date in the contracting period.

If PROVIDER is awarded local or federal supplemental block grant funds, PROVIDER shall fulfill the expectations and standards of the notices of award(s) (NOA), as summarized below:

- PROVIDER must utilize third party and other revenue realized from the provision of services to the extent possible and use SAMHSA/other grant funds only for services to individuals who are not covered by public or commercial health insurance programs, individuals for whom coverage has been formally determined to be unaffordable, or for services that are not sufficiently covered by an individual's health insurance plan. PROVIDER is also expected to facilitate the health insurance application and enrollment process for eligible uninsured Individuals.

- PROVIDER performance will be monitored by MSHN via monthly progress/outcomes reports.

- Criminal background checks must be part of Providers' conditions for employment.

- Provider must have business practices and processes in place to ensure Individual confidentiality per Title 42 of the Code of Federal Regulations, Part II.

- PROVIDER must operate within a recovery-oriented system of care that will improve retention in care.

- PROVIDER must meet obligations under the Government Performance and Results (GPRA) Modernization Act of 2010

- PROVIDER must employ evidence-based practices (MOUD, Project ASSERT, etc.) and use them with fidelity to the model. MSHN will monitor for fidelity.

- Grant funds may not be used to supplant current funding of existing activities. "Supplant" is defined as replacing funding of a recipient's existing program with funds from a local or federal grant.

- Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . and public policy requirements."); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

- Grant funds for treatment and recovery support services shall only be utilized to provide services to individuals that specifically address opioid and stimulant misuse issues. If an opioid misuse problem (history) exists concurrently with other substance use, all substance use issues may be addressed. Individuals who have no history of or no current issues with opioid or stimulant misuse shall not receive treatment or recovery services with grant funds.

- PROVIDER may not use grant funds for (DATA 2000) Waiver Training Payment Program.

- PROVIDER is required to comply with all applicable requirements of Charitable Choice regulations. Provider must ensure that treatment Individuals and prevention services recipients are notified of their right to request alternative services. Notice may be provided by the AMS or by faith-based providers. The PIHP must assign responsibility for providing the notice to the AMS, to providers, or both.

- Funds may not be expended through the grant by PROVIDER which would deny any eligible Individual, patient or individual access to their program because of their use of FDA-approved medications for the treatment of substance use disorders (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine mono-product formulations, naltrexone products including extended-release and oral formulations or long-acting products such as extended release injectable or implantable buprenorphine.) Specifically, patients must be allowed to participate in methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an opioid treatment program and ordered by a physician who has evaluated the Individual and determined that methadone is an appropriate medication treatment for the individual's opioid use disorder. Similarly, medications available by prescription or office-based implantation must be permitted if it is appropriately authorized through prescription by a licensed prescriber or provider.

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»

- In all cases, (/Medication for Opioid Use Disorder (MOUD) must be permitted to be continued for as long as the prescriber or treatment provider determines that the medication is clinically beneficial. Recipients must assure that Individuals will not be compelled to no longer use MOUD as part of the conditions of any programming if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.

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

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 B.1: FEE FOR SERVICE
FY2027 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»

Direct Care Worker (DCW) premium payments have been Legislatively mandated and are now included in the reimbursement rates for eligible codes (See list below). PROVIDER is no longer required to submit separate requests for these funds. To ensure DCWs receive the legislatively mandated premium pay, providers must collect annual attestations from impacted employees confirming the following payment structure:

PROVIDER must document that eligible individuals are hired at PROVIDER's' established starting wage plus the legislatively mandated premium pay. In addition, all employees rendering DCW codes shall be reimbursed no less than the State of Michigan's prevailing minimum wage plus the legislatively mandated premium pay. There is to be no downward adjustment to the provider established starting wage schedule. The premium pay for FY 27 is To Be Determined.

ELIGIBLE SUD-SPECIFIC SERVICE CODES

H0010 (SUD Withdrawal Management)
H0012 (SUD Withdrawal Management)
H0014 (SUD Withdrawal Management)
H0018 (SUD Residential Treatment)
H0019 (SUD Residential Treatment)

ATTACHMENT 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 PROVIDER to show improvement from previous quarters or meet standard benchmarks. For providers who do not meet set benchmarks and do not show improvement, quality improvement initiatives will be required to be implemented.

MEASURE

1. **SUD Withdrawal Management Re-Admission:**

   a. Percentage of SUD Withdrawal Management discharges with a subsequent SUD Withdrawal Management Admission within thirty (30) days of the previous SUD Withdrawal Management Discharge

   b. Percentage of SUD Withdrawal Management discharges with a subsequent SUD Withdrawal Management Admission within sixty (60) days of the previous SUD Withdrawal Management Discharge

   c. Percentage of SUD Withdrawal Management discharges with a subsequent SUD Withdrawal Management Admission within ninety (90) days of the previous SUD Withdrawal Management Discharge

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

   REVIEWED: Quarterly

2. **Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET):**

   a. Percent Initiation: Percent of new AOD episodes where a beneficiary-initiated treatment within fourteen (14) calendar 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 fourteen (14) days. This includes inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or Medication for Opioid Use Disorder.

   MDHHS Standard: >=40%

   b. Percent Engagement: Percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or Medication for Opioid Use Disorder (MOUD) within thirty-four (34) calendar 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 thirty-four (34) days of the first treatment. This includes AOD services and Medication for Opioid Use Disorder.

   MDHHS Standard: >=15%

   REVIEWED: Quarterly

3. **Follow-up After Emergency Department Visit for Substance Use (FUA):**

Scope: Inclusive of all persons (stratified by age group) with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose who had a follow-up visit within thirty (30) days of an emergency department (ED) visit

a. FUA-30CH: The percentage of emergency department (ED) visits for members 13-17 years of age with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within thirty (30) days of the ED visit.

MDHHS Standard: >=35.6%

:

b. FUA-30AD: The percentage of ED visits for which members aged 18 or older, received follow-up within thirty (30) days of the ED visit

MDHHS Standard: >=36.30%

c. FUA-30TOT: The percentage of ED visits for which members 13 years or older received follow-up within thirty (30) days of the ED visit

4. Michigan Performance Indicator Access to Care Measure (ACC) (as defined in the Calendar Year (CY) 27 MDHHS PIHP Reporting Codebook Access to Care Measure):

a. ACC Metric: The percentage of persons during the quarter that receive a routine mental health or substance use service within ten (10) business days of their request for initial service.

Scope: All new persons approved/authorized for SUD services (Medicaid individuals only)

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 ninety (90) days ago.

FY 27 is a baseline collection year and no benchmarks have been established by MDHHHS for this measure at this time.

ATTACHMENT D: HIPAA/HITECH BUSINESS ASSOCIATE AGREEMENT

This HIPAA Business Associate Agreement ("Addendum") supplements and is incorporated into the Agreement between the MSHN ("Covered Entity") and _____ ("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"). Covered Entity and Business Associate shall be referred to collectively as the "Parties."

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;

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.

d. 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.

e. 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.

f. 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.

g. 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.

h. 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 fifteen (15) 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.

i. Business Associate's Agents. Business Associate shall ensure that any agents, including sub Providers, 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 sub Provider, to whom it provides ePHI received from Covered Entity agrees to implement reasonable and appropriate safeguards to protect it.

j. 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).

k. 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.

l. 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.

m. 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 fifteen (15) business days, to the Secretary for purposes of the Secretary determining the Covered Entity's compliance with HIPAA and the Privacy Rule.

n. 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 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 sub Provider, 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.

i. 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.

ii. 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.

Provider attests that a risk analysis has been completed as part of its security management process and is in accordance with 45 CFR 164.306 and 164.308 (a)(1)(ii)(A). Provider

ATTACHMENT E: REPORTING REQUIREMENTS FOR MSHN SUD PROVIDERS FY 2027
(SENT AS SEPARATE PDF ATTACHMENT)

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