The Medicaid Managed Specialty Supports and Services Concurrent 1915(i)/(c), 1115 Waiver Program(s), the 1115 Healthy Michigan Plan and Substance Use Disorder Community Grant Programs Agreement

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Between

Mid-State Health Network

And

«Name_of_Organization»~~BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY~~
(as a "Subrecipient" as that term is defined in OMB 2 CFR 200 Subpart A)

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Effective October 1, 2021~~0~~ through September 30, 2022~~1~~

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THIS AGREEMENT, made and entered into this 1st day of October, 2021~~0~~ between the Mid-State Health Network (MSHN), whose administrative offices are located at 530 W. Ionia Street, Suite F, Lansing, Michigan 48933 (hereinafter referred to as the "MSHN", "PIHP", or "Payor"), and «Name of Organization»~~BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY~~, whose administrative offices are located at «Office Address 1»~~201 Mulholland~~; «City»~~Bay City~~, «State»~~MI~~ «Zip»~~48708~~, as the subrecipient as defined in OMB 2 CFR 200 Subpart A (hereinafter referred to as the "Provider" and/or "CMHSP").

WHEREAS, on February 6, 2013, the Michigan Department of Health and Human Services (hereinafter referred to as the "MDHHS") issued an Application for Participation (AFP) as the process for selecting specialty Prepaid Inpatient Health Plans for Medicaid (which hereafter shall be understood to include the Healthy Michigan Program [HMP]) mental health and substance abuse services and supports effective January 1, 2014; and

WHEREAS, pursuant to Section 204(b)(1) of Act 258 of the Public Acts of 1974, as amended MCL 330.1001 et seq., (hereinafter referred to as the "Mental Health Code"), Bay-Arenac Behavioral Health, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Community Mental Health Authority, Tuscola County Community Mental Health Authority, Huron County Community Mental Health Authority, Ionia County Community Mental Health Authority, LifeWays Community Mental Health Authority, Montcalm County Community Mental Health Authority, Newaygo County Community Mental Health Authority, Saginaw County Community Mental Health Authority, and Shiawassee County Community Mental Health Authority thereafter entered into a Regional Entity arrangement under Section 204(b) et seq. of the Mental Health Code, for the purpose of the preparation, submission, and implementation of an Application to the MDHHS for a Medicaid Prepaid Inpatient Health Plan (PIHP); and

WHEREAS, pursuant to the bylaws dated July 1, 2013, established under 204(b) et seq. of the Mental Health Code the said Regional Entity is hereinafter known as the Mid-State Health Network and is designated by the community mental health services programs as constituted under the Mental Health Code to be the Medicaid PIHP; and whereas the individual County governments represented by the respective CMHSP's delineated herein have designed Mid-State Health Network as the Substance Use Disorder Coordinating Agency; and whereas it is the purpose of Mid-State Health Network to carry out responsibilities assigned to it under the Mental Health Code, the Public Health Code and related administrative rules; and

WHEREAS, thereafter the MDHHS approved the Mid-State Health Network as the specialty PIHP to contractually manage the Specialty Services Waiver Programs approved by the Federal government and implemented concurrently by the State of Michigan (hereinafter referred to as the Concurrent Programs) in the designated Medicaid services area of the Counties of Arenac, Bay, Clare, Clinton, Eaton, Gladwin, Gratiot, Hillsdale, Huron, Ingham, Ionia, Isabella, Jackson, Mecosta, Midland, Montcalm, Newaygo, Osceola, Saginaw, Shiawassee, and Tuscola to provide a comprehensive array of Medicaid mental health and substance abuse services and supports effective January 1, 2014; and

WHEREAS, under the authority granted by Section 116 (2)(b) and 3(e) and Section 228 of the Mental Health Code, the MDHHS has offered and entered into, effective January 1, 2014, a MDHHS/ PIHP Managed Specialty Supports and Services Contract between MDHHS and Mid State Health Network (hereinafter referred to as "MSHN"), as amended, (hereinafter referred to as the "MDHHS/PIHP Contract"); and

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WHEREAS, under the authority granted by Section 116 (2)(b) and 3(e) and Section 228 of the Mental Health Code, the MDHHS has offered and entered into, effective October 1, 2018, a separate MDHHS/CMHSP Managed Mental Health Supports and Services Contract for General Funds with «County»~~Bay, Arenac~~ County Community Mental Health Authority as the CMHSP of the County of «County»~~Bay, Arenac~~.

WHEREAS, under the MDHHS/PIHP Contract, the MSHN serves as the managed care entity designated to carry out managed care responsibilities in the PIHP Medicaid specialty service area for a comprehensive array of Medicaid mental health specialty supports and services to eligible persons covered as Medicaid eligibles under the Concurrent Waiver Programs and who meet the service eligibility criteria requirements of the MDHHS/PIHP Contract and of the Mental Health Code, Public Health Code and Administrative Rules; and

WHEREAS, the MSHN has the right under the Mental Health Code, Public Health Code and Administrative Rules to direct-operate and/or to subcontract for the provision of such Medicaid mental health specialty supports and services to such Medicaid eligibles as to the Medicaid service area of Counties of Arenac, Bay, Clare, Clinton, Eaton, Gladwin, Gratiot, Hillsdale, Huron, Ingham, Ionia, Isabella, Jackson, Mecosta, Midland, Montcalm, Newaygo, Osceola, Saginaw, Shiawassee, and Tuscola (hereinafter referred to as the "PIHP Medicaid specialty service area"); and

WHEREAS, in order to maintain a level of local accountability and control, Mid-State Health Network (MSHN) (hereinafter referred to as "Payor") desires to subcontract, the actual provision of mental health specialty supports and services to the Provider, as a CMHSP for Medicaid eligibles within the County of «County»~~Bay, Arenac~~ the PIHP Medicaid Specialty Service Area in accordance with section XIII of this agreement;

NOW, THEREFORE, in consideration of the above and in consideration of the mutual covenants and conditions hereinafter contained, **THE PAYOR AND THE PROVIDER AGREE** as follows:

I. CONTRACT AUTHORITY.

A. This Agreement is entered into pursuant to the authority granted to each party hereto under the Mental Health Code; Public Health Code, and Administrative Rules.

B. This Agreement is in accordance with the rules, regulations, and standards (hereinafter referred to as the "Rules") of the MDHHS adopted and promulgated in accordance with the Mental Health Code; Public Health Code and Administrative Rules. This Agreement is in accordance with the requirements of the Balanced Budget Act of 1997 (BBA), as amended, and said BBA final rules, regulations, and standards, and with the requirements of the Concurrent Waiver Programs.

This Agreement is in accordance with the standards as contained in the aforementioned Application for Participation (AFP) as they pertain to the provisions of specialty services to Medicaid eligibles and the plans of correction and subsequent plans of correction submitted by the PIHP and approved by the MDHHS and any stated conditions, as reflected in the MDHHS approval of the application, unless prohibited by Federal or State law.

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C. The Mental Health Code, the Public Health Code and Administrative Rules, the MDHHS Rules, and the MDHHS/PIHP contract, and applicable State and Federal laws shall govern the expenditure of funds and provisions of services hereunder and shall govern in any area not specifically covered by this Agreement.

II. AGREEMENT CONTINGENT UPON FUNDING.

A. This Agreement is expressly contingent upon receipt by the Provider of its own State general funds and local funds, upon the terms of such funding as appropriated, authorized and amended, upon continuation of such funding, and when appropriate, upon sufficient collections by Payor of consumer fees and third-party reimbursements.

B. This Agreement is expressly contingent upon receipt by the Payor of Medicaid capitation funds, upon the terms of such funding as appropriated, authorized and amended, and upon continuation of such funding.

C. Either party shall provide immediate notice to the other party of any material reduction or loss of the funding upon which this Agreement is contingent.

III. COMPLIANCE WITH THE MDHHS/PIHP CONTRACT.

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

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

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

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

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

IV. AGREEMENT TERM.

A. The term of this Agreement shall be from October 1, 2021~~0~~ through September 30, 2022~~1~~. Consistent with the MDHHS/PIHP Contract, this Agreement may be extended, in increments no longer than twelve (12) months, with the mutual written consent of the Payor and the Provider pursuant to Section "XXXIII AMENDMENT" of this Agreement. And,

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consistent with the MDHHS/PIHP Contract, no more than three (3) one-year extensions of this Agreement after September 30, 20224 shall occur.

V. TERMINATION OF AGREEMENT.

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A. This Agreement shall terminate immediately upon the revocation, restriction, suspension, discontinuation or loss of any certification, accreditation, or authorization, or license required by Federal, State and local laws, ordinances, rules and regulations for either party hereto to operate and/or to provide Medicaid programs and supports/services within the State of Michigan.

B. This Agreement shall terminate immediately upon any termination of the MDHHS/PIHP Contract for Medicaid capitation funds.

C. This Agreement may terminate immediately upon any termination of the Providers status as a Community Mental Health Services Program organized and operated as county mental health authority, agency, or organization under the authority granted by Section 116 (2)(b) and 3(e) and Section 228 of the Mental Health Code and in accordance with section 2.5 of the MSHN Bylaws.

D. Any material breach of this Agreement in which individuals are at imminent risk of harm may result in either party's right to terminate this Agreement upon sixty (60) calendar day prior written notice.

E. Notwithstanding any other provisions in this Agreement to the contrary, either party hereto may terminate this Agreement for any reason by providing the other party with ninety (90) calendar days prior written notification in accordance with Article X sections 10.2-10.3 of the MSHN Operating Agreement.

Either party contemplating terminating the agreement shall immediately notify the other party and begin discussions to either salvage the contractual relationship or to transition services contemplated hereunder to an alternative provider. The MSHN shall ensure that any transition plans to alternative care providers comply with all applicable notice requirements of the Balance Budget Act.

F. Any termination of this Agreement shall not relieve either party of the obligations incurred prior to the effective date of such termination. In addition, the Provider shall cooperate with the Payor to implement a transition plan for recipients which shall seek to assure continued care for individuals served.

G. Consistent with the MDHHS/PIHP Contract, the following contract closeout actions shall be completed if this Agreement is terminated or is not renewed

(1.) Within thirty-eight (38) days (interim) and eighty-three (83) days (final), following the date of termination of this Agreement, the Provider shall provide the Payor with all financial, performance, and other reports required under this Agreement.
(2.) A final contract reconciliation shall be completed by the Payor and the Provider in accordance with the requirements of Subsection I. Contract Reconciliation of Section XIV. CONSIDERATION AND PAYMENT PROCEDURES of this Agreement.

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(3.) All financial, administrative, and clinical records under the Provider's responsibilities must be retained by the Provider in accordance with Michigan Department of Attorney General State Operations Division General Schedule #20 Community Mental Health Programs Dated March 2, 2007; the MDHHS/PIHP contract and/or 42 CFR 438. 230(c)(3)(iii) as applicable. unless these records are transferred to a successor organization or the PIHP is directed otherwise by the MDHHS.

H. Changes in CMHSP's membership within the PIHP may be proposed to the MDHHS. All changes in CMHSP members must have prior approval of the MDHHS. Such changes are at the sole discretion of the MDHHS and MDHHS shall determine what procedures the CMHSP and the PIHP shall follow for closeout. Unless such a change occurs, the following contract closeout actions also shall be completed if this Agreement is terminated or is not renewed:

(1.) The Medicaid portion of all reserve accounts accumulated by the Provider that were funded with MDHHS funds under this Agreement and related interest are owed to the Payor within ninety (90) days, less amounts needed in order to cover outstanding claims or liabilities, unless otherwise directed in writing by the MDHHS.
(2.) Reconciliation of equipment with a value exceeding $5,000, purchased by the Provider with Medicaid funds provided under this Agreement since January 1, 2014, will occur as part of settlement of this Agreement. Thereto, the Provider shall submit to the Payor an inventory of equipment meeting the above specifications within forty (40) days following the date of termination of this Agreement. The inventory listing shall identify the current value and proportion of Medicaid funds used to purchase each item, and also whether or not the equipment is required by the Provider as part of continued service provision to the continuing service population. Thereto, the Payor shall provide written notice, within forty (40) days or less following the date of termination of this Agreement, of any reconciliation of equipment needed concerning the portion of Medicaid funding ending. If the Provider disposes of the equipment, the appropriate Medicaid portion of the value must be used hereunder to offset Medicaid costs in a final contract reconciliation pursuant to this Section of this Agreement.

VI. SERVICE AREA.

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A. For the purposes of the MDHHS/PIHP Master Contract and this Agreement, the County of «County»~~Bay, Arenac~~ shall constitute the PIHP Medicaid Managed Specialty Supports and Services, the Healthy Michigan Program and Substance Use Disorder Community Grant area of the Payor.

B. For the purposes of this Agreement, the Provider shall receive Medicaid subcapitated funding from the Payor for providing Medicaid Managed Specialty Supports and Services and Healthy Michigan Program services to Medicaid-eligible residents of the County of «County»~~Bay, Arenac~~ within said PIHP Medicaid specialty service area.

C. For the purposes of this Agreement, the Provider shall receive Substance Use Disorder program funding from the Payor for providing Access, Emergency, Referrals, Coordination, Customer Service and Behavioral Health Prevention to the eligible residents of the County of «County»~~Bay, Arenac~~ within said PIHP service area.

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D. Exceptions to the above cited service area provisions and any waiver of the service access/admittance and service payment restrictions hereunder may only be granted, with prior authorization, by the Payor's Chief Executive Officer (hereinafter referred to as the "Payor's CEO").

VII. **TARGET SERVICE GROUP AND ELIGIBILITY CRITERIA FOR SERVICES.** The target service group and eligibility criteria for Medicaid Managed Specialty Supports and Services, the Healthy Michigan Program and Substance Use Disorder Community Grant services hereunder are as specified in the MDHHS/PIHP Contract, which is incorporated by reference into this agreement and made a part hereof.

VIII. **ADMINISTRATIVE SERVICES PER THE MEDICAID PRE-PAID INPATIENT HEALTH PLAN.** The Payor is required under the MDHHS/PIHP Contract to perform or cause to be performed by subcontract PIHP administrative services. The Provider's services and responsibilities under this Agreement with the Payor do not include PIHP non-delegated administrative services.

If the Payor elects, pursuant to the MDHHS/PIHP Contract, to subcontract certain PIHP non-delegated administrative services by purchasing them from this CMHSP, the Payor shall purchase such PIHP non-delegated administrative services via a separate subcontract with this CMHSP. Delegated administrative services shall be paid with Medicaid and Health Michigan sub-capitation funds and Substance Use Disorder Community Grant program funds received by the provider.

If the Payor purchases such PIHP non-delegated administrative services, via a separate subcontract with this CMHSP, the Payor shall account for and report its expenditures for the purposes thereto as PIHP indirect administrative costs of the Payor, pursuant to the requirements of Federal OMB Circular 2 CFR 200 Subpart E Cost Principles

Therefore, the Provider's services and responsibilities under this Agreement with the Payor do not include such PIHP non-delegated administrative services herein.

IX. **PROVIDER SERVICES AND RESPONSIBILITIES.**

A. Pursuant to the Medicaid and Healthy Michigan subcapitation and the Substance Use Disorder Community Grant funding from the Payor the Provider shall perform or cause to be performed the services specified in Exhibit A (PROVIDER SERVICES & RESPONSIBILITIES AND DELEGATION GRID) and Exhibit H (TECHNICAL REQUIREMENT CMHSP RESPONSIBILITIES FOR 24/7/365 ACCESS FOR INDIVIDUALS WITH PRIMARY SUBSTANCE USE DISORDERS), which are both incorporated by reference into this Agreement and made a part hereof.

B. For provision of the services required hereunder, the parties hereto agree that the Provider, may direct operate and/or may subcontract with its own subcontractors as independent provider(s) of such services. However, any such subcontract shall be consistent with any agreed upon regionally standardized templates as noted in the delegated managed care grid (Exhibit A) and shall not terminate the legal responsibility of the Provider to assure that all services required of it hereunder are fulfilled.

C. The Provider agrees that any such subcontract shall:

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

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

D. Pursuant to the MDHHS's requirements of the Payor under the MDHHS/PIHP Contract, the Provider, shall furnish the Payor with provider information profiles that contain a complete listing and description of the Provider's subcontractors available to provide services to Medicaid eligibles under this Agreement.

X. STAFFING AND TRAINING REQUIREMENTS.

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A. The Provider, pursuant to this Agreement, shall ensure that:
(1.) All services by the Provider's staff and the staff of the Provider's subcontractors are provided in a manner that demonstrates cultural competency; and,
(2.) Staffing level adequacy, consistency and programming continuity are maintained in the provision of services under this agreement.

B. The Provider shall provide notice to the Payor immediately whenever services, and/or staffing of services required hereunder have not been or cannot be provided.

C. The Provider shall ensure that the Provider's staff and the staff of the Provider's subcontractors, when performing services required hereunder, comply with all applicable provisions and requirements for services in the Mental Health Code, Public Health Code and Administrative Rules, the MDHHS Rules, Medicaid regulations, and the MDHHS/PIHP Contract.

D. The Provider shall ensure that orientation of and ongoing training of the Provider's staff and the staff of the Provider's subcontractors shall, at a minimum, include those offerings/courses as identified on the attached "MSHN Minimum CMHSP Training Requirements" The Provider assures the Payor that, pursuant to this Agreement, all individuals employed by the Provider or the Provider's subcontractors shall receive training related to recipient rights protection before or within thirty (30) days after the commencement of such employment/contract.

XI. PROVIDER SERVICE ACCESS, PROVIDER PREAUTHORIZATIONS, AND PROVIDER UTILIZATION MANAGEMENT

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A. Pursuant to the Medicaid subcapitation funding as reimbursement from the Payor under this Agreement, the Provider, shall perform and be responsible for Provider service access

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assurance, service preauthorizations, services, and utilization management for Medicaid-eligibles in the County of «County»~~Bay, Arenac~~ within the PIHP Medicaid specialty service area.

B. All Medicaid services hereunder must meet the eligibility/medical necessity requirements of and the duty to treat and referral requirements, access standards and treatment deadlines of the Payor pursuant to this Agreement and the MDHHS/PIHP Contract and in compliance with the Mental Health Parity and Addictions Equity Act of 2008, 42 CFR Parts 438, 440, 456, and 457. Out of State placements require written MDHHS and Payor approval prior to placement.

C. Pursuant to the Medicaid subcapitation funding from the Payor, all Medicaid services required of the Provider under this Agreement must be authorized by its Chief Executive Officer (hereinafter referred to as the Provider's CEO) or designated representative.

XII. LICENSES, ACCREDITATIONS, AND CERTIFICATIONS; CREDENTIALING AND PRIVILEGING REQUIREMENTS.

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

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

~~B.~~

C. The Provider shall ensure, through credentialing, that the Provider's staff professionals and the Provider's subcontractors and their staff professionals have obtained and maintain all approvals, accreditations, certifications and licenses required by Federal, State and local laws, ordinances, rules and regulations to practice their professions in the State of Michigan and to perform Medicaid supports/services hereunder. CMHSP shall ensure credentialing and re-credentialing processes do not discriminate against:

(1.) A health care professional solely on the basis of license, registration or certification;

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

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

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

F. CMHSP shall obtain Disclosure of Ownership, Control and Criminal Convictions for all of their providers at the time of application, upon execution of provider agreements, during

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re-credentialing, contract renewal or within thirty-five (35) days of any change in ownership of a disclosing agency.

G. The PIHP shall work in coordination with the CMHSP as the responsible contractor responsible for removing, if necessary, disqualified participants from the network.

XIII. FIDUCIARY RESPONSIBILITIES; RECEIPT, MANAGEMENT, AND DISTRIBUTION OF FUNDING AS APPLICABLE.

A. The Payor, as the designated PIHP, shall maintain the fiduciary responsibilities for the receipt, management, and distribution of Medicaid capitation funds and Substance Use Disorder Community Grant program funds as appropriated pursuant to the MDHHS/PIHP Contract.

B. The Provider hereto shall maintain its own fiduciary responsibilities for the receipt, management, and distribution of State general funds as appropriated pursuant to its own MDHHS/Community Mental Health Services Program (CMHSP) Managed Mental Health Supports and Services Contract for General Funds.

C. The Provider shall maintain its own fiduciary responsibilities for the receipt, management, and distribution of local funds, including local funding appropriations from the county that established it and collections of consumer fees and third-party reimbursements.

D. For the purposes of this Agreement, the receipt, management, and distribution of each source of funds as applicable per each party hereto and applicable procedures thereto are as follows: Within five (5) business days after receipt of prepaid capitation of Medicaid (Federal share and State share) funds per month from the MDHHS, the Payor shall initiate a payment transaction of subcapitated Medicaid (Federal share and State share) funds per month to the Provider, pursuant to Section XIV. Consideration and payment procedures of this Agreement, by completing a ~~wire~~ transfer of said pre-paid funding to the designated bank account of the Provider. The Payor shall provide immediate notice hereunder to the Provider if, for any reason, the Payor does not receive pre-paid Medicaid (Federal share and State share) funds per month from the MDHHS as scheduled and, in such instance, subsequent notice to the Provider upon Payor's subsequent receipt of said capitation funds from the MDHHS.

E. For the purpose of SUD program funds 1/12th of the approved budget for 24/7/365 activities will be provided within five (5) business days after receipt of prepaid capitation of Medicaid (Federal share and State share) funds per month from the MDHHS.

XIV. CONSIDERATION AND PAYMENT PROCEDURES. The terms and conditions for consideration and payment procedures under this Agreement are as follows:

A. Medicaid Sub-Capitation Funding Methodology and Payments. Given the requirements and limitations of the MDHHS/PIHP Contract, the Payor has elected under this Agreement to subcontract the actual provision of mental health specialty supports and services to the Provider, as a CMHSP, for the Medicaid eligibles within the County of «County»~~Bay, Arenac~~ in the PIHP Medicaid specialty service area on the reimbursement basis of a prepaid sub-capitation funding methodology subject to net cost settlement with

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the return of unspent Medicaid funds to the Payor per fiscal year.

The Payor shall provide both the federal and State shares of Medicaid funds, as sub-capitation funding to the Provider for the Medicaid eligibles within the County of «County»~~Bay, Arenac~~ in the PIHP Medicaid specialty service area, for all Medicaid program services and non-retained and/or delegated PIHP Medicaid administrative services and costs thereto of the Provider pursuant to this Agreement based upon the Per Eligible Per Month (PEPM) sub-capitation methodology as negotiated by the parties and set forth in this Agreement.

(1.) For the purposes of Medicaid payments from the Payor to the Provider, the prepaid sub-capitation funding methodology under this Agreement is as follows: MSHN will use the MDHHS PEPM rates, net of any required taxes and fees that must be paid to the State of Michigan, paid to this PIHP as the basis for the payment to each CMHSP. The only additional modification to this rate will be the application of a PIHP indirect administration cost adjustment, on a projected cost basis.
(2.) The MDHHS/PIHP Contract, requires that contracts include a description of the method of payment for Medicaid funds to be used by the PIHP and assumptions used that such payments to a Provider are at a level that will meet the needs of beneficiaries residing in that county(ies) of that CMHSP. Thereto, for the purposes of Medicaid payments from the Payor to the Provider, the prepaid sub-capitation funding methodology under this Agreement is as follows:

Payor will use the aforementioned MDHHS PEPM net capitation rates paid to this PIHP as the basis for the payment to each CMHSP. The only modifications to this rate will be the application of a PIHP indirect administration cost adjustment, on a projected cost basis. In addition to the aforementioned sub-capitation PEPM rates base methodology, a one-time (i.e. non-base funding applicable only to this fiscal year for the purposes of consumers' benefit stabilization) Medicaid funding increase for this Provider will be as indicated in Exhibit B (Funding Exhibit) of this ~~Agreement, and~~Agreement and has been included hereunder as to funding methodology and the amount of estimated payments.

The Payor shall provide the Provider monthly with HIPAA compliant copies of the source documents (DEG's, 834/820 eligibility files, etc.) utilized by the Payor in determining the Medicaid eligibles within the County of «County»~~Bay, Arenac~~ in the PIHP Medicaid specialty service area and payment distributions as to the ~~per~~ Per Eligible Per Month (PEPM), given the sub-capitation methodology hereunder

The PEPM payments will be inclusive minus any withholds by the Payor hereunder as allowable by the MDHHS for Provider contract nonperformance. The monthly PEPM sub-capitation payment schedule may be adjusted by the Payor subject to any capitation payment schedule adjustment made by the MDHHS to the PIHP in accordance with Section 8 and Section 9 of the MDHHS PIHP Master Agreement

a. Planned Funding Decreases or Increases**.** During the fiscal year hereunder, and in order to maintain a stable benefit, subcontract payment amounts of Medicaid from the Payor to the Provider specified in Subsection A of this Section of this Agreement may be increased or decreased for that fiscal year, pursuant to Section XXXII AMENDMENT hereunder, through the methodology for

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subcapitation funding and payments set forth in Subsection A of this Section of this Agreement with the mutual written consent of the Payor and the Provider.

b. Unanticipated Funding Decreases or Increases. During the fiscal year hereunder, and in order to maintain a stable benefit, subcontract payment amounts of Medicaid from the Payor to the Provider specified in Subsection A of this Section of this Agreement may be increased or decreased, through the subcapitation funding methodology and payments methodology set forth in Subsection A of this Section of this Agreement, , or increases and decreases in contractual payment amounts specified in the MDHHS/PIHP Contract for Medicaid funding, due to unanticipated legislative appropriations, executive orders, or changes in Federal and/or State funding levels or benefit. The Provider may seek a modification of contractual support/service requirements from the Payor if reductions in contractual funding are made pursuant to this Subsection of this Agreement.

c. Changes in funding methodology shall require written amendment to this Agreement in accordance with Section XXXIII of this Agreement

Unless otherwise specified in such an amendment to this Agreement, the Payor shall furnish the Provider with a final reconciliation of the Medicaid sub-capitation obligation and the monthly prepayments hereunder in order for a final contract reconciliation of revenues and expenditures per fiscal year to be completed as required under Subsection I Contract Reconciliation of this Section of this Agreement. Such planned Medicaid funding increase or decrease shall be only for that fiscal year and therefore any such changes to funding shall become incorporated into the next fiscal year's funding as may be appropriate.

Within ninety-two (92) days after the conclusion of each fiscal year of this Agreement, the Payor shall furnish the Provider with a final reconciliation of the Medicaid sub-capitation obligation and the monthly prepayments hereunder in order for a final contract reconciliation of revenues and expenditures per fiscal year to be completed as required under Subsection I Contract Reconciliation of this Section of this Agreement.

B. SUD Community Grant Program Funding Allocation:

(1.) Funding Decreases or Increases**.** During any fiscal year hereunder, 24/7/365 SUD program funds from the Payor to the Provider specified in Subsection A of this Section in this Agreement may be increased or decreased for that fiscal year, through a written request for a change in program funding to the Chief Executive Officer as specified by MSHN funding request process.

(2.) Unanticipated Funding Decreases or Increases. During any fiscal year hereunder, subcontract payment amounts of 24/7/365~~b~~SUD program funds from the Payor to the Provider specified in Subsection A of this Section of this Agreement may be increased or decreased, through the 24/7/365 SUD program funds funding methodology and payments. The Payor or Provider may seek a modification of contractual support/service requirements from the Payor if reductions in contractual funding are made pursuant to this Subsection of this Agreement.

(3.) Changes in funding methodology shall require written amendment to this Agreement in accordance with Section XXXIII of this Agreement.

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C. Administrative Services and Cost Allocations. The costs of Medicaid administrative services of the Provider under this Agreement are being applied and reported by the Provider with Medicaid program services costs to the Payor.

For the PIHPs purposes of determination of service administrative costs under the MDHHS/PIHP Contract, the total Medicaid costs of Medicaid program services and non-PIHP Medicaid administrative services performed by the Provider under this Agreement shall be accounted for and reported by the Payor as direct costs of the Payor, pursuant to the requirements of Federal OMB Circular 2 CFR 200 Subpart E Cost Principles ~~and the MDHHS Standard Cost Allocation guidelines~~.

For the PIHPs purposes of determination of Managed Care Administrative Costs under the MDHHS/PIHP Contract, the actual costs of the delegated PIHP administrative services performed by the Payor or retained by the Payor and subsequently purchased by the Payor via subcontracting, including but not limited to any such PIHP administrative services purchased via a separate subcontract with this affiliate CMHSP, shall be accounted for and reported by the Payor as indirect administration costs of the Payor, pursuant to the requirements of Federal OMB Circular 2 CFR 200 Subpart E Cost Principles ~~and the MDHHS Standard Cost Allocation guidelines~~.

D. Local Obligations – Requirements

If Required by Section 928 of Public Act 207 of 2018, the Payor and Provider will comply with local match obligations for Medicaid as required by the MDHHS Medicaid contract per Article IV section 4.6 of the MSHN Operating Agreement.

E. Local Obligations - Requirement Exceptions. Pursuant to the MDHHS/PIHP Contract, the Payor and the Provider shall not be required under this Agreement to provide a local obligation for the Medicaid specialty supports and services that the Payor purchases and the Provider provides hereunder, as follows:

(1.) Programs for which responsibility are transferred by the State to the PIHP and the State is responsible for 100% of the cost of the program, consistent with the Michigan Mental Health Code, Public Health Code and Administrative Rules, including, but not limited to, Section 307 transfers and Medicaid hospital-based services.
(2.) Other Medicaid covered specialty services, provided under the current Medicaid program waivers approved by the Federal government and implemented concurrently by the State of Michigan, as determined by the MDHHS
(3.) Services provided to an individual under criminal sentence to a State prison.

Also, the parties hereto agree that the Provider shall retain, as unrestricted local funds of the Provider, any interest income on Medicaid subcapitation funding that the Provider receives under this Agreement, except as otherwise restricted by generally accepted accounting principles (GAAP) for governmental units or Federal OMB Circular 2 CFR 200 Subpart E Cost Principles.

F. Coordination of Benefits. The payments from the Payor to the Provider, of Medicaid sub-capitation funds under this Agreement are intended only to cover the allowable costs of Medicaid specialty supports/services net of and not otherwise covered by payments provided by other funding, entitlements or benefits and by liable third parties, as applicable,

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Commented [KJ28]: J. Obermesik 8.20.21: p.13 of the contract (p.114 of the OC packet) - I disagree with the two additions to require compliance with a MDHHS Standard Cost Allocation Guideline that is still in draft and has not been agreed to by CFI nor the PIHP negotiation team to my knowledge. As CFI has shared with the PIHP negotiations team, there is disagreement between the CFI negotiations team and MDHHS' regarding four issues pasted below and those issues will be discussed with Kendra Binkley at CFI negotiations. I cannot support inclusion of this SCA Guideline language in the FY22 CMHSP-PIHP contract ahead of those discussions. For Ops Council reference, I'm sharing those 4 CFI negotiation issues below:

1.It is key that the principles and constructs behind the emerging cost allocation system be clearly outlined and agreed upon prior to the development of mechanisms of such a system.

As an example, the allocation methodology, while providing uniformity, may actually provide less cost allocation detail for CMHs who rely upon such detail for the financial management of their operations. The relevant construct, in this example, may be "the unit costs that result from this uniform cost allocation system will not recognize the cost differences across units/cost centers within a CMH/provider organization (those based on staff compensation differences among staff working in different units or the differences in occupancy costs between the sites in which the staff work)" Note that this is an example of a construct that appears to underlie some of the work of the SCA effort and is neither recommended nor opposed by CFI.

2.Differing interpretations of the federal regulations related to the definitions of "provider" and "subcontractor" and their application to CMHs – a fundamental concern and equally fundamental construct behind the development of a sound cost allocation system.

3.Administrative functions v. managed care functions – changes in the proposal are needed because under the current proposal "general administration" costs are expected to be reported under managed care costs, while the role of the state's CMHs are as comprehensive providers (under the Code) and as per federal regulations (see item 1, above) making those costs provider and not managed care costs

4.While it is anticipated that there will be a significant burden to implement the proposed redesign, this burden is only appropriate when implementing a uniform cost allocation system that is sound, based on federal and state law and regulations, is value-added, and built with efficiency in mind is expected. Given this, it is key that the issues raised by the CFI Contract Negotiation Team and the CMHs represented by the team be addressed in the design of this uniform system and the contract language that describes it.

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for which each recipient of services hereunder may be eligible. This provision includes Certified Community Behavioral Health Centers (CCBHC) funding.

The coordination of benefit requirements of the subsections of this Section of this Agreement shall not supersede the separate requirements for separate State general funding, as appropriated, of the Provider under the Subsections of its own MDHHS/CMHSP Master Contract for General Funds.

Both parties to this Agreement understand and acknowledge that when the usage of Medicaid funds is strictly prohibited by the federal government and/or the State of Michigan for any costs pertaining to services to a Medicaid-eligible consumer or consumers hereunder, the Provider, at its discretion, may utilize its own General Funds or local funds to cover costs pertaining to such services to the Medicaid consumer or consumers.

And, both parties to this Agreement understand and acknowledge that, in accordance with the MDHHS/PIHP Contract, the MDHHS disallows the usage of General Funds by a CMHSP for Medicaid purposes in order to enable the PIHP to maximize Medicaid savings per the PIHP's Medicaid risk corridors under the MDHHS/PIHP Contract for Medicaid Funds

G. Third Party Resource Requirements. For the purposes of this Agreement, the Payor and the Provider shall abide by the requirements of the related sections of the MDHHS/PIHP Contract. Medicaid is a payer of last resort. PIHPs are required to identify and seek recovery from all other liable third parties in order to make themselves whole. Third party liability (TPL) refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan or commercial carrier, automobile insurance and workers compensation) or program (e.g., Medicare) that has liability for all, or part of a recipients covered benefit.

Therefore, under this Agreement, the Provider, shall ensure that it and/or its subcontractors pursue, recover and apply reimbursements from all liable third party resources, as applicable, for determining the net cost per fiscal year of Medicaid specialty services required of the Provider hereunder and rendered to Medicaid eligibles, in accordance with Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D, and the Michigan Mental Health Code, Public Health Code and Administrative Rules, as applicable.

The Provider shall not apply Medicaid subcapitation funds to cover costs of specialty supports/services rendered to Medicaid eligibles per fiscal year under this Agreement in any instance(s) in which the Provider receives or establishes an accounts receivable in anticipation of receiving monies directly for them from a third-party resource that provides for, reimburses, offsets, or otherwise covers payment retroactively, currently, or subsequently for said costs of supports/services.

When a Medicaid eligible is enrolled in Medicare also, Medicare will be the primary payer ahead of Medicaid subcapitated funding payments, if the service provided under this Agreement is a covered benefit under Medicare.

For Medicaid eligible recipients who have Medicare coverage, the Provider, shall be responsible for applicable Medicare co-insurance, co-pays, and deductible payments, using Medicaid subcapitated funds under the requirements of this Section, for services

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that the Provider is responsible for pursuant to this Agreement and for Medicare-covered services where the authorizations of such Medicare-covered services are not the responsibility of the PIHP, pursuant to the requirements of the MDHHS/PIHP Contract.

H. Payment in Full. The payments from the Payor to the Provider, of Medicaid subcapitation funds hereunder, as specified in Subsection A of this Section of this Agreement for the services required of the Provider hereunder shall constitute payment in full.

From the Medicaid subcapitation funding from the PIHP for the services required of the Provider, the Provider shall be reimbursed for the allowable Medicaid costs of the Provider's direct-operated programs and shall reimburse the Provider's subcontractors for the allowable Medicaid costs of the services performed by the Provider's subcontractors.

Pursuant to the Medicaid subcapitation funding as reimbursement from the Payor, the Provider, shall be solely responsible for the Provider's service payment obligations and payments to the Provider's subcontractors for performing Medicaid services required of the Provider hereunder. Payments from the Provider, to the Provider's subcontractors for performing Medicaid services required of the Provider hereunder shall be made on a timely basis and on a valid claim basis pursuant to the timeliness and clean claim requirements of the PIHP in accordance with the MDHHS/PIHP Contract. The Provider may utilize a post-payment review methodology to assure that the Provider's payments to the Provider's subcontractors for performing Medicaid services required of the Provider hereunder have been paid appropriately.

Pursuant to the MDHHS/PIHP Contract, the Provider ensures the PIHP under this Agreement that:

(1.) The Provider and the Provider's subcontractors shall not require any co-payments, recipient pay amounts, or other cost sharing arrangements unless specifically authorized by State or Federal regulations and/or policies.
(2.) The Provider and the Provider's subcontractors shall not bill individuals for any difference between a service charge of the Provider and/or of a subcontractor of the Provider and the Provider's payment for the Provider's services and/or for the services of a subcontractor of the Provider.
(3.) The Provider and the Provider's subcontractors shall not seek nor accept additional supplemental payments from the individual, his/her family, or representative, for the Provider's services and/or for the services of a subcontractor of the Provider.

I. SUD Services – Cost Settlement. For 24/7/365 SUD program funds, a cost settlement process will be utilized. A comparison of allowable costs to reimbursement received; if the costs exceed reimbursement received, a settlement is received; if the costs are less than the reimbursement received, it is required that the difference be paid back. Cost-Settlement means that total cost estimate is determined before contract work commences. PROVIDER cannot exceed the maximum without written approval of MSHN. The final pricing is determined when PROVIDER submits Financial Statement Report, as detailed by Mid-State Health Network, including year-end settlement and reconciliation.

Performance Bonus Incentive Funds. Any performance bonus incentive funds earned by the PIHP will be fully distributed as restricted local funding to the participating PROVIDERs in the region consistent with EXHIBIT A (PROVIDER SERVICES &

Commented [AK30]: See previous SUD comment. Any changes needed to the cost settlement process if CMHSPs are treated as SUD providers?

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RESPONSIBILITIES AND DELEGATION GRID), the operating agreement and related MSHN policies and procedures.

J. Implementation of or Continuing Participation in Pooled Funding Arrangements. Pursuant to the MDHHS/PIHP Contract, Medicaid subcapitation funds received from the Payor under this Agreement may be utilized by the Provider for the implementation of or continuing participation in locally established multi-agency pooled funding arrangements developed to address the needs of beneficiaries served through multiple public systems. Medicaid funds supplied or expensed to such pooled funding arrangements must reflect the expected cost of covered Medicaid services for Medicaid eligibles participating in or referred to the multi-agency arrangement or project. Services provided in Pooled Funding arrangements must be reported to MDHHS through the encounter data reporting system. Medicaid funds cannot be used to supplant or replace the service or funding obligation of other public programs.

K. Contract Reconciliation. Upon conclusion of each fiscal year of this Agreement, a final contract reconciliation shall be completed as a net cost settlement wherein the Medicaid subcapitated funding and SUD funding prepaid by the Payor to the Provider, and the total of the Provider's expenditures pursuant to this Agreement shall be reviewed and reconciled in direct accordance with the service and financial provisions hereunder in order to assure that the Payor's payments to the Provider have not exceeded the Payor's obligations under this Agreement.

Said fiscal-year contract reconciliation of this Agreement shall be completed annually in full compliance with MDHHS requirements and in accordance with the revenue and expenditure reconciliation process and requirements of the MDHHS/PIHP Contract, except that Medicaid funds unexpended by the Provider under this Agreement shall be returned to the Payor. Thereto, the revenue and expenditure reconciliation process and requirements for said fiscal year contract reconciliation of this Agreement on a net cost settlement basis shall meet the MDHHS's financing, accounting, and reporting requirements of the PIHP as specified in the MDHHS/PIHP Contract.

The contract reconciliation for each fiscal year under this Agreement shall be completed in accordance with the following procedures:

(1.) Within the earlier of one hundred eighty (180) days after the conclusion of each fiscal year of this Agreement or ten (10) business days prior to the MDHHS due date, the Provider shall furnish the Payor with any service and financial reports, detailed revenue and expenditure summaries, service and/or financial records, and related source documents required by the Payor for the purposes hereunder.
(2.) The Provider shall submit a preliminary fiscal year end reconciliation proposal to the Payor no later than ten (10) business days prior to the MDHHS due date.
(3.) Within five (5) business days of receipt by the Payor of the MDHHS response to the fiscal year end preliminary reconciliation proposal, the Payor shall provide the Provider with a formal response to the reconciliation proposal.
(4.) Within the earlier of ten (10) business days prior to the MDHHS due date or one hundred eighty (180) days after the end of each fiscal year of this Agreement the Provider shall submit a final reconciliation proposal to the Payor
(5.) The Payor shall make a final determination of the final contract reconciliation within forty-five (45) business days of the submission to MDHHS of the fiscal year end reports.

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This determination is subject to adjustment should the final reports require re-submission for any reason.
(6.) Any amount due to the Payor or to the Provider as a final contract reconciliation of each fiscal year of this Agreement shall be paid within thirty (30) days after notification of the Payor's final determination hereunder.
(7.) Upon notification of the acceptance of the final cost settlement between the PIHP and MDHHS, the Payor shall determine if adjustments are necessary to the final cost reconciliations with the Provider as determined in subsection (5) above. Any adjustments shall be paid as required within 30 days of Provider notification.

L. Application of Medicaid Funds. Given the requirements and limitations set forth in the MDHHS/PIHP Contract, Medicaid expenditures (Federal share and State share) incurred by the Provider per fiscal year under this Agreement shall be applied against costs in the following order:

(1.) Prior year Medicaid Savings.
(2.) Current year prepaid Medicaid funds (Federal share and State share) received by the Provider from the Payor pursuant to Subsection A of this Section of this Agreement.
(3.) If all Medicaid funds are exhausted, the Payor's Internal Service Fund may be used at the Payor's discretion pursuant to the MDHHS/PIHP Contract for Medicaid funding.

M. Reserve Fund Accounts. Pursuant to the requirements and limitations of Federal and State laws, the Provider may set up and/or maintain reserve fund accounts utilizing Medicaid funds in the same proportion that Medicaid funds relate to all revenue sources with the consent of the Payor, pursuant to the requirements of the Federal and State funding and the consent of the MDHHS. Any reserve funds other than Compensated Absences, Employee Retirement, or Post Employment Health Insurance established and audited prior to the creation of MSHN, should be prior approved by the Payor and have actuarial substantiation in accordance with GASB.

N. Assessments of Financial Penalties and Obligations of the Provider. Should the Provider fail to fulfill its obligations as required under this Agreement, thereby resulting in assessment(s) by MDHHS and/or the Federal government of financial penalties against Payor under the MDHHS/PIHP Contract as to Medicaid funding, the Payor shall, in turn, exact an assessment(s) of financial penalties against the Provider, as follows:

(1.) If an assessment by the MDHHS and/or the Federal government of financial penalties against the Payor is exacted through MDHHS's withholding of a specific amount of Medicaid (Federal share and State share) capitation funding for any month under said MDHHS/PIHP Contract, the Payor shall, in turn, exact an assessment of financial penalties against the Provider, for the Provider's failure to fulfill its obligations as required hereunder, through withholding of the same amount of Medicaid (Federal share and State share) subcapitation funding to the Provider under this Agreement; and/or,
(2.) If an assessment by the MDHHS and/or the Federal government of financial penalties against the Payor under said MDHHS/PIHP Contract must be reimbursed by the Payor with local non-matchable funds (i.e., the sources of such funds are not Federal funds and/or State funds), the Provider shall, in turn, reimburse the Payor with local non-matchable funds as financial payback as to the Payor's assessment of financial penalties of the same amount against the Provider, for the Provider's failure to fulfill its obligations as required hereunder.

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(3) The Provider ensures that no services that would otherwise be provided according to medical necessity criteria and best standards will be withheld from individuals as a result of any sanctions the provider is subjected to by the PIHP.

O. Unallowable Services/Costs and Financial Paybacks. Should the Provider fail to fulfill its obligations as required under this Agreement, thereby resulting in unallowable Medicaid services and/or cost claims, it shall not be reimbursed by the Payor hereunder for any such services and/or cost claims; thereto, the Provider shall repay to the Payor any Medicaid (Federal share and/or State share) payments made by the Payor to the Provider for such unallowable services and/or cost claims. This revenue reimbursement requirement shall survive the termination of this Agreement and repayment shall be made by the Provider to the Payor within sixty (60) days of the Payor's final disposition notification to the Provider that the Payor has made unallowable Medicaid (Federal share and/or State share) payments to the Provider for unallowable services and/or cost claims and, thereby, financial payback by the Provider is required.

P. Disallowed Expenditures and Financial Repayments. In the event that the MDHHS, the Payor, the State of Michigan, or the Federal government ever determines in any final revenue and expenditure reconciliation and/or any final finance or service audit that the Provider has been paid inappropriately per the Payor's expenditures of Medicaid (Federal share and/or State share) funds pursuant to this Agreement for services claims and/or cost claims of the Provider which are later disallowed, the Provider shall repay the Payor for such disallowed payments within sixty (60) days of the Payor's final disposition notification of the disallowances, unless the Payor authorizes, in writing, additional time for repayment.

XV. NOTICE OF MATERIAL CHANGE IN FINANCIAL POSITION.

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A. Each party hereto shall furnish the other party with immediate notice of any change in financial position material to its ability to pay debts when due per Federal and State requirements, regardless of whether its assets exceed liabilities, and thereto its continuing in operation as a going concern at any time during the term of this Agreement.

B. Any breach of this section shall be regarded as a material breach of this Agreement and may be a cause for termination thereof by the non-breaching party.

XVI. QUALITY IMPROVEMENT; PERFORMANCE INDICATORS; COMPLIANCE ACTIVITIES, CONSUMER ASSESSMENTS AND OUTCOMES MANAGEMENT STUDIES.

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A. The Provider shall maintain a fully operational internal Quality Improvement Program that meets the requirements of the MDHHS/PIHP Contract, the PIHP approved Quality Assessment and Performance Improvement Program and cooperate in the PIHP Quality Improvement Program pursuant to the Operating Agreement and related policies.

B. The Provider shall meet standards of the Michigan Mission Based Performance Indicator System (MMBPIS) in accordance with requirements of the MDHHS/PIHP contract.

C. The Provider shall cooperate fully in the implementation by the Payor of:

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(1.) Quantitative and qualitative member assessments periodically, including consumer satisfaction surveys and other consumer feedback methodologies; and,
(2.) Studies to regularly review outcomes for Medicaid recipients as a result of programs and services rendered pursuant to this Agreement.

D. The Provider shall retain a fully operational internal Compliance Program that meets the requirements of the MDHHS/PIHP contract and the PIHP approved Compliance Plan.

E. The Provider must have program integrity administrative and management arrangements or procedures and must include, but not limited to, all the requirements as defined in 42 CFR 438.608 and Program Integrity of the MDHHS/PIHP -contract.

F. Any breach of this section by the Provider shall be regarded as a material breach of this Agreement and may be a cause for termination thereof by the Payor.

XVII. REPORTING REQUIREMENTS; ACCOUNTING PROCEDURES AND INTERNAL FINANCIAL CONTROLS.

A. The Provider shall report financial, program, service and consumer data, as required by the MDHHS, and additional statistical and other management information to the Payor in the manner and at the times prescribed by the Payor's CEO, as indicated on the attached reporting requirements schedule (Exhibit G).

B. Pursuant to the PIHP's Master Contract with the MDHHS for Medicaid and SUD Funds (~~Attachment P7.7.1.1;~~ PIHP Reporting Requirements for Medicaid Specialty Supports and Services Beneficiaries), such reporting requirements for the Provider shall include those for encounter data, quality improvement reporting, sentinel event and critical incident reporting, OIG Program Integrity activity and Medicaid performance indicator data consistent with PIHP reporting requirements and expectation for cooperation with the Medicaid ~~sub-element~~ cost report, as applicable, and, pursuant to the PIHP's Master Contract with the MDHHS for Medicaid Funds, such reporting requirements for the Provider, shall include those for and a process for monitoring and tracking expenditures on State plan services and associated state waiver(s), as applicable commencing in 2013/14 fiscal year and continuing on a fiscal year basis thereafter.

C. Treatment Episode Data Set SUD (BH-TEDS) and Encounter Reporting Requirements. The PROVIDER is responsible for submitting timely reports to the PAYOR, as may from time to time be required by the PAYOR, complying with all reporting requirements as specified in MDHHS policies; reporting requirements and/or the MDHHS/PIHP contract (Uniform Data and Reporting of the contract and the finance reporting requirements); (Treatment Episode Data Set SUD (TEDS) and Encounter Reporting Requirements); Substance Abuse Disorder Policy Manual; See SUD Services Policy Manual/Section I Data Requirements: Substance Abuse Encounter Reporting HCPCS and Revenue Codes Chart.

D. The accounting procedures and internal financial controls of the parties hereto shall conform to generally accepted accounting principles (GAAP) for governmental units in order that the costs and expenditures allowed by this Agreement can be readily ascertained and verified.

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E. Each party hereto shall maintain accounts and source records in which any and all revenues received pursuant to this Agreement are ascertainable and verifiable and include date of receipt and sources of funds.

F. Under the MDHHS/PIHP Contract, the MDHHS requires the PIHP to utilize modified accrual accounting principles in reporting revenues and expenditures (except that Public Act 423 Funds must be reported on a cash basis of accounting). Each party hereto understands and acknowledges that its accounting and financial reporting under this Agreement must be in compliance with MDHHS accounting and reporting requirements for the Medicaid specialty supports and services that the Payor purchases and the Provider renders hereunder.

G. Each party shall maintain payroll records and other time keeping records, including any employee time allocation studies and any cost center(s) distribution formulae for costs of employees and subcontractors, sufficient to document the provision of services required under this Agreement.

H. Each party shall have a certified public auditing firm perform an annual independent audit of it in substantial conformance with the American Institute of Certified Public Accountants Guide to assess:
(1.) Compliance with the appropriate standard accounting practices and procedures;
(2.) Compliance with the terms of this Agreement, as to the accuracy of revenues, expenditures and cost allocations reported to each other and to the MDHHS; and,
(3.) Compliance with applicable Federal and state laws governing its operations.

Each party shall submit a complete and accurate copy of such independent audit for each fiscal year by no later than six (6) months after the close of said fiscal year.

XVIII. PROGRAM AND FINANCIAL BOOKS, DOCUMENTS, AND RECORDS; AUDITS; REVIEWS; AND, PROGRAM/SERVICE EVALUATIONS.

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A. Each party hereto, the MDHHS, and the State of Michigan or their designated representatives shall be allowed to review, copy, and/or audit all contract/financial records and license, accreditation, certification and program reports of the other party hereto and to review all program and clinical records of the other party hereto pertaining to performance of this Agreement, to the full extent permitted by applicable Federal and State laws. The Provider shall provide on a timely basis all documents and staff necessary for any external review. Said program, clinical, and contract/financial records and supporting documentation must be retained by each of the parties hereto and be available for such audit, review or evaluation purposes in accordance with Michigan Department of Attorney General State Operations Division General Schedule #20 Community Mental Health Programs Dated March 2, 2007 and 42 CFR 438.230(c)(3)(iii).

B. If the State, Center for Medicare and Medicaid Services, the Office of Inspector General, the Comptroller General, and their designees (hereinafter referred to as the "Requesting Parties") request access to books, documents, and records of the parties hereto at any time within ten (10) years from the final date of the contract period or from the date of completion of any audit that occurs within such ten (10) year period , whichever is later, in accordance with Section 952 of the Omnibus Reconciliation Act of 1980 [42 USC 1395x(v)(1)(I)], 42 CFR 438.230(c)(3), and the regulations adopted pursuant thereto, the

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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.

C. The Provider agrees to provide access to the Payor's CEO or his designated representative(s) to evaluate, through inspection or other means on a retrospective or current basis, the appropriateness, quality, and timeliness of services performed and compliance with program/service standards required hereunder.

D. The parties hereto agree that the State Medicaid Agency and the U. S. Department of Health and Human Services may evaluate, through inspection or other means, the appropriateness, quality, and timeliness of services performed under this Agreement.

E. The parties hereto agree that the right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later, in accordance with 42 CFR 438.230(c)(3)(iii).

F. The parties hereto agree to retain, as applicable, enrollee grievance and appeal records in 42 CFR 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

G. The parties agree that If MDHHS, CMS, Office of Inspector General, the Comptroller General, and their designees determines that there is a reasonable possibility of fraud or similar risk, MDHHS, CMS, Office of Inspector General and the Comptroller General may inspect, evaluate, and audit the subcontractor at any time, in accordance with 42 CFR 438.230(c)(3)(iv).

H. Refusal by either party hereto to allow the other party, the MDHHS, the State of Michigan, the Federal government or their designated representatives access to records, programs and services for audit, review, or evaluation shall be regarded as a material breach of this Agreement and may be a cause for termination thereof by the non-breaching party.

XIX. COMPLIANCE WITH APPLICABLE LAW.

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A. This Agreement shall be construed according to the laws of the United States and the laws of the State of Michigan as to the interpretation, construction and performance.

B. Each party hereto, and its officers, employees, and agents, shall perform all their respective duties and obligations under this Agreement in compliance with all applicable Federal, State, and local laws, ordinances, rules and regulations, including but not limited to, those Federal and State laws, rules and regulations specified in the MDHHS/PIHP Contract, and as may be amended by MDHHS and the PIHP.

C. Pursuant to the requirements of the MDHHS/PIHP Contract, the Payor and the Provider shall comply with the requirements of the Balanced Budget Act of 1997 (BBA), as

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amended, and said BBA final rules, regulations, and standards, and with the requirements of the Waiver Programs.

D. The Payor and the Provider shall comply with the requirements of the standards as contained in the aforementioned Application for Participation (AFP) as they pertain to the provisions of specialty services to Medicaid beneficiaries and the plans of correction and subsequent plans of correction submitted by the PIHP and approved by the MDHHS and any stated conditions, as reflected in the MDHHS approval of the application unless prohibited by Federal or State law.

E. If any laws or administrative rules or regulations that become effective after the date of the execution of this Agreement substantially change the nature and conditions of this Agreement, they shall be binding to the parties, but the parties retain the right to exercise any remedies available to them by law or by any other provisions of this Agreement.

F. Any breach of this section shall be regarded as a material breach of this Agreement and may be a cause for termination thereof by the non-breaching party.

XX. NONDISCRIMINATION.

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A. In performing their duties and responsibilities under this Agreement, the parties hereto shall comply with all applicable Federal and State laws, rules and regulations prohibiting discrimination.

B. Pursuant to the MDHHS/PIHP Contract, each of the parties hereto shall not discriminate against any employee or applicant for employment/contract with respect to hire, tenure, terms, conditions, or privileges of employment/contract or a matter directly or indirectly related to employment/contract because of race, color, religion, ethnicity or national origin, age, height, weight, marital status, partisan considerations, any physical or mental disability 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, sexual identity, transgender status or otherwise required by Michigan Constitution Article I, Section 26, the Elliot Larsen Civil Rights Act, 1976 PA 453, as amended, MCL 37.2201 et seq, and the Persons with Disabilities Civil Rights Act and Americans with Disabilities Act and Section 504 of the Federal Rehabilitation Act 1973, PL 93-112, 87 Stat. 394, ACA Section 1557, Executive Directive 2019-19.

Commented [AI43]: While I support this, I would like to know where this came from… source? Has this been added to PIHP contract?

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Additionally, assurance is given to the Payor that pro-active efforts will be made to identify and encourage the participation of minority-owned, women-owned, and handicapper-owned businesses in contract solicitations. The Provider shall incorporate language in all contracts awarded: (1) prohibiting discrimination against minority-owned, women-owned, and handicapper-owned businesses in subcontracting; and (2) making discrimination a material breach of contract.

C. Pursuant to the MDHHS/PIHP Contract, each of the parties hereto shall comply with the Americans with Disabilities Act of 1990 (ADA), P.L. 101-336, 104 Stat 328 (42 USCA 12101 et seq.), as amended. This includes but is not limited to adherence with all current controlling court cases and Federal regulations interpreting and implementing the ADA. For example, the Parties are currently required to comply and adhere to Olmstead

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v. L.C., 527 U.S. 581, 119 S. Ct. 2176 (1999) which requires that qualified individuals with mental disabilities be placed in community settings, rather than in institutions, whenever treatment professionals determine that such placement is appropriate, the affected persons do not oppose such placement, and the state can reasonably accommodate the placement, taking into account the resources available to the state and the needs of others with disabilities. The Department of Justice regulations implementing Title II of the ADA currently require public entities to administer their services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

D. Each of the parties hereto shall not refuse to treat nor will they discriminate in the treatment of any patient or referral, based on the individual's source of payment for services, or on the basis of age, sex including discrimination based on pregnancy, sexual orientation, sexual identity, transgender status, height, weight, marital status, sexual orientation, arrest record, race, creed, physical or mental disability, color, national origin or ancestry, religion, political affiliation or beliefs, or involuntary patient status. Each of the parties hereto shall assure equal access for people with limited English proficiency, as outlined by the Office of Civil Rights Policy Guidance in the Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency and also in accordance with the ACA Section 1557.

E. Any breach of this section shall be regarded as a material breach of this Agreement and may be a cause for termination thereof by the non-breaching party.

XXI. HEALTH AND SAFETY OF CONSUMERS; RECIPIENT RIGHTS AND CONSUMER GRIEVANCE PROCEDURES.

A. The Provider shall monitor the health, safety, and welfare of each recipient of Medicaid services while he or she is under its service supervision pursuant to this Agreement. The Provider agrees to comply with critical incident~~s~~ and sentinel event reporting requirements in Schedule A ~~Part II(A) Section 6.1~~ (Critical Incidents) of the MDHHS PIHP Medicaid Contract.

B. The Provider shall strictly comply with all Recipient Rights provisions of the Mental Health Code, Public Health Code and Administrative Rules and the MDHHS Rules. Consumers shall be protected from violations of recipient rights while they are receiving services under this Agreement

C. The Provider hereto agrees to establish written policies and procedures concerning recipient rights pursuant to and in compliance with Section 752 of the Mental Health Code and to establish an office of recipient rights pursuant to Section 755 of said Code.

D. In addition, the Payor will be provided upon request, for the purposes of this Agreement, with copies of the Provider's policies and procedures dealing with recipients of Medicaid services and updates of those policies and procedures as they are promulgated. The Provider shall have policies and procedures in place to assure non-retaliation and protection from harassment for complainants and recipient rights staff.

E. The Provider ensures that its employees, its staff, and the Provider's subcontractors and their staff receive recipient rights training, as specified in Subsection D of Section X.

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Commented [SG46]: Pg. 34 Quality Assessment /Performance Improvement Program Standards
N. Provider Standards 12. Critical Incidents Pg 46. BTPR?

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STAFFING AND TRAINING REQUIREMENTS of this Agreement. The Provider shall maintain training records, for the purposes of this Agreement, for review by the Payor or the Payor's designee.

F. The Provider agrees to furnish the Payor's CEO with immediate notice of any severe incident involving any recipient of Medicaid services hereunder.

G. The Provider shall, as required by law, report incidents regarding Medicaid recipients to the (Adult and Children) Protective Services Division of the applicable department of the State of Michigan, law enforcement, and other public agencies. The Provider shall, upon request, provide the Payor for the purposes of this Agreement, copies of all investigative reports and summary reports involving recipients of Medicaid services hereunder.

H. A recipient of or an applicant for public mental health services may access several options to pursue resolution of complaints regarding services and supports managed and/or delivered under this Agreement. The options may be pursued simultaneously.

I. Each party hereto agrees to comply with said grievance procedures required by the Payor and the MDHHS for receiving, processing, and resolving promptly any and all complaints, disputes, and grievances for Medicaid recipients or potential consumers (See MDHHS/PIHP Contract).

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

K. Any breach of this section shall be regarded as a material breach of this Agreement and may be cause for termination thereof by the non-breaching party.

XXII. ESTABLISHMENT OF, RETENTION OF, AND ACCESS TO CONSUMER RECORDS, RELEASE OF CONSUMER INFORMATION AND CONFIDENTIALITY. The Provider shall establish and maintain a comprehensive individual service record system consistent with the provisions of MDHHS Medical Services Administration (MSA) Policy and appropriate State and Federal statutes, pursuant to the MDHHS/PIHP Contract.

The Provider shall serve as the holder of record for all consumer records maintained by the Provider under this Agreement for purposes of assuring that the Payor has full access to such records for services hereunder applicable to this agreement.

The Provider, an Affiliated Entity, and the Payor, hereby acknowledge that each entity is separately responsible for compliance with all Health Insurance Portability and Accountability Act (hereinafter referred to as the "HIPAA") regulations. To the extent that the HIPAA and, thereto, the Health Information Technology for Economic and Clinical Health Act (hereinafter referred to as the "HITECH Act") are pertinent to the services that the Payor purchases and the Provider provides under this Agreement, the Provider ensures that it is in compliance with the HIPAA and, thereto, the HITECH Act requirements pursuant to the

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MDHHS/PIHP Contract, and that it shall abide by the terms and conditions set forth in the attached document labeled "Exhibit C" ("BUSINESS ASSOCIATE AGREEMENT"), which is incorporated by reference into this Agreement and made a part hereof.

The Provider shall use Protected Health Information in accordance with the American Recovery and Reinvestment Act of 2009 Pub. L 111-5, as amended (ARRA), specifically the "HITECH ACT" and any associated federal rules and regulations. The HITECH Act now imposes data breach notification requirements for unauthorized uses and disclosures of "unsecured PHI." Under the HITECH Act "unsecured PHI" essentially means "unencrypted PHI." Any violation of the HITECH ACT shall be reported to the Payor immediately upon discovery. The Provider, and their subcontractors, will follow the Breach Notification Rule, 45 CFR 164.400-414, following a breach of unsecured protected health information.

All consumer information, medical records, data and data elements, collected, maintained, or used in the execution of this Agreement shall be protected by the Provider–from unauthorized disclosure as required by State and Federal regulations. The Provider must provide safeguards that restrict the use or disclosure of information concerning Medicaid eligibles to purposes directly connected with the execution of this Agreement. Provider shall not store consumers data, nor backup files, in any location that is outside the continental United States.

Because of the nature of the relationship between the parties hereto, there shall be an ongoing exchange of confidential information on Medicaid eligibles served under this Agreement.

Each party hereto, and its officers, employees, agents, and its subcontractors shall comply with all applicable Federal and State laws, rules and regulations, including the Mental Health Code (PA258 of 1974, as amended), Public Health Code (PA 368 of 1978, as amended), Administrative Rules, MDHHS Rules, and 42 CFR, Part 2 on confidentiality with regard to disclosure of any materials and/or information provided pursuant to this Agreement. Any release of information must be in compliance with Sections 748, 748a, and 750 of the Mental Health Code.

The Payor and the Provider shall assure that services and supports to, and information contained in the records of, Medicaid-eligibles 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 hereunder, shall be privileged communications. Privileged communication shall be held confidential and shall not be divulged without the written consent of either the Medicaid- eligible or a person responsible for the Medicaid-eligible, except as may be otherwise required by applicable law or regulation. Any release of privileged information must be in compliance with Sections 748; 748a; and 750 of the Mental Health Code.

XXIII. PROTOCOLS FOR THE IMPLEMENTATION OF AND COORDINATION OF DUTIES, RESPONSIBILITIES, SERVICES AND ADMINISTRATION.

The parties hereto shall abide by and execute specific Protocols, through policies and procedures, which will be jointly developed, whenever possible, and have been approved by the Payor for the purposes of this Agreement, for the implementation of and

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coordination of duties, responsibilities, services, and administration pursuant to this Agreement. It is understood by all parties that the Payor has the authority to make final decisions regarding protocols in order to ensure standardization and that all parties will comply with protocols, policies and procedures approved by the Payor.

XXIV. RELATIONSHIP OF THE PARTIES.

A. In performing their duties and responsibilities under this Agreement, it is expressly understood and agreed that the relationship between the parties hereto is that of an independent contractor.

B. This Agreement shall not be construed to establish any principal/agent relationship between the parties hereto.

C. In performing their duties and responsibilities under this Agreement, it is expressly understood and agreed that the relationship between the parties hereto is that of separate governmental entities and that, as separate, unrelated reporting entities, the parties shall execute and maintain arms-length transactions.

D. It is expressly understood and agreed that the MDHHS and the State of Michigan, are not parties to, nor responsible for any payments under this Agreement and that neither the MDHHS nor the Payor is party to any employer/employee relationship of the Provider.

XXV. STATUS OF EMPLOYEES.

A. It is expressly understood and agreed that the employees and agents of any of the parties to this Agreement shall not be deemed to be and shall not hold themselves out as the employees or agents of the other parties.

B. Each of the parties to this Agreement shall be responsible for withholding and payment of all income and social security taxes to the proper Federal, State, and local governments for its employees.

C. The employees of each of the parties hereto shall not be entitled to any fringe benefits otherwise provided by any of the other parties to its employees, such as, but not limited to, health and accident insurance, life insurance, paid vacation leave, paid sick leave, and longevity.

D. Each of the parties hereto shall carry workers' compensation and unemployment compensation coverage for its employees, as required by law.

XXVI. CONFLICT OF INTEREST.

A. It is expressly understood and acknowledged that this Agreement and each of the parties hereto is subject to conflict of interest provisions and requirements of Federal, State, and local laws, ordinances, rules and regulations, of the MDHHS/PIHP Contract, and of the policies of each party.

B. Ownership and Control Interests: The PROVIDER may not be any of the following, all

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of which are all specifically excluded from this contract:

(1.) An entity that could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual.

(2.) An entity that has a "substantial contractual relationship" either directly or indirectly, with:

a. An individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act;
b. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
c. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in the immediately preceding subsection, 2.b.;
d. An individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act; or
e. Any individual or entity that would provide those services through an individual or entity described in any of the immediately preceding four subsections, 2.b., c., or d.

A "substantial contractual relationship" is any contractual relationship that provides for one or more of the following services: (i) the administration, management, or provision of medical services; and/or (ii) the establishment of policies or the provision of operational support, for the administration, management or provision of medical services.

(3.) An entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one any individual or entity that is (or is affiliated, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person or entity that is):

a. Debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
b. Excluded from participation in any Federal health care program under section 1128 or 1128A of the Act; or
c. Any individual or entity that would provide those services through an individual or entity described in any of the immediately preceding two subsections, 3.a. or b.

(4.) To comply with 42 CFR 438.10, the PROVIDER may not knowingly have a "relationship" of the type described below with any of the following:

a. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under

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regulations issued under Executive Order No. 12549 or guidelines implementing Executive Order No. 12549;

b. An individual or entity who is an "affiliate", as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in the immediately preceding subsection 1.(a).

(5.) The PROVIDER will not have a "relationship" of the type described below (each a "prohibited relationship") with any individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act. For purposes of this section, a "relationship" means someone who the PROVIDER interacts with in any of the following capacities:

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

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

If the PAYOR finds that the PROVIDER has a "prohibited relationship", as defined above, the PAYOR:

e. May continue an existing agreement with the PROVIDER, unless MDHHS directs otherwise; and
f. May not renew or otherwise extend the duration of an existing agreement with the PROVIDER unless MDHHS provides to the PAYOR a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.

(6.) Federal regulations require PROVIDERs to disclose information about individuals with ownership or control interests in the PROVIDER. These regulations also require the PROVIDER to identify and report any additional ownership or control interests for those individuals in other entities, as well as identifying when any of the individuals with ownership or control interests have spousal, parent-child, or sibling relationships with each other.

The PROVIDER shall comply with the 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, the 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.

The PAYOR requires the PROVIDER to provide written disclosure in the case that any of the following is or becomes affiliated with any individual or entity that is

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debarred, suspended, or otherwise excluded from participating in procurement activities under the 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 PROVIDERs equity;
d. A network provider; and/or
e. Any party to an employment, consulting, or other agreement with the PROVIDER for the provision of contract items or services

(7.) The PAYOR requires the PROVIDER to disclose information on individuals or corporations with an ownership or control interest in the PROVIDER to the PAYOR at the following times:

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

C. PROVIDER Responsibilities for Monitoring Ownership and Control Interests Within Their Provider Networks

(1.) At the time of provider enrollment or re-enrollment in the PROVIDER's provider network, the PROVIDER must search the Office of Inspector General's (OIG) exclusions database to ensure that the provider entity, 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), have not been excluded from participating in federal health care programs. Because these search activities must include determining whether any individuals with ownership or control interests in the provider entity appear on the OIG's exclusions database, the PROVIDER must mandate provider entity disclosure of ownership and control information at the time of provider enrollment, re-enrollment, or whenever a change in provider entity ownership or control takes place.

(2.) The PROVIDER must search the OIG exclusions database monthly to capture exclusions and reinstatements that have occurred since the last search, or at any time providers submit new disclosure information. The PROVIDER must notify PAYOR immediately if search results indicate that any of their network's provider entities, or individuals or entities with ownership or control interests in a provider entity are on the OIG exclusions database.

D. PROVIDER Responsibility for Disclosing Criminal Convictions: PROVIDERs are required to promptly notify the PAYOR if:

(1.) Any disclosures are made by providers 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. (See42 CFR 1001.1001(a)(1): or

(2.) Any staff member, director, or manager of the PROVIDER, 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

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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))

(3.) The PROVIDER's contract with each provider entity must contain language that requires the provider entity to disclose any such convictions to the PROVIDER.

E. PROVIDER Responsibility for Notifying PAYOR of Administrative Actions That Could Lead to Formal Exclusion

The PROVIDER must promptly notify the PAYOR if it has taken any administrative action that limits a provider's participation in the Medicaid program, including any provider entity conduct that results in suspension or termination from the PROVIDER's provider network.

The United States General Services Administration (GSA) maintains a list of parties excluded from federal programs. The "excluded parties lists" (EPLS) and any rules and/or restrictions pertaining to the use of EPLS data can be found on GSA's web page at the following internet address: http://exclusions.oig.hhs.gov.

The state sanctioned list is at: www.michigan.gov/medicaidproviders click on Billing and Reimbursement, click on List of Sanctioned Providers. Both lists must be regularly checked.

F. Acceptance of Claims:

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(1.) PAYOR will not accept claims from PROVIDER for any items or services furnished, ordered or prescribed by excluded individuals or entities.

(2.) In the event PROVIDER has not made required disclosures, PAYOR will not be held financially liable to accept PROVIDER claims from excluded individuals or entities.

(3.) If payment had been disbursed to PROVIDER prior to PAYOR receiving required disclosures of excluded individuals or entities, PROVIDER shall reimburse PAYOR total actual cost(s) of identified claims.

XXVII. LIABILITY AND FINANCIAL RISK.

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A. All liability to third parties, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities to be carried out by the Payor in the performance of this Agreement shall be the responsibility of the Payor, and not the responsibility of the Provider, if the liability, loss, or damage is caused by, or arises out of, the actions or failure to act on the behalf of the Payor, its other subcontractors, and their officers, directors, employees and authorized representatives, provided that nothing herein shall be construed as a waiver of any governmental immunity that has been provided to the Payor or its officers and employees by statute or court decisions.

B. All liability to third parties, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities to be carried out by the Provider in the performance of this Agreement shall be the responsibility of the Provider, and not the responsibility of Payor, if the liability, loss, or damage is caused by, or arises out of, the actions or failure to act on the behalf of the Provider, its other subcontractors, and their officers, directors, employees

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and authorized representatives, provided that nothing herein shall be construed as a waiver of any governmental immunity that has been provided to the Provider or its officers and employees by statute or court decisions.

C. Each party to this Agreement must seek its own legal representative and bear its own costs including judgments in any litigation which may arise out of its activities to be carried out pursuant to its obligations hereunder. It is specifically understood and agreed that neither party will indemnify the other party in such litigation.

D. In the event that liability to third parties, loss or damage arises as a result of activities conducted jointly by the parties hereto in fulfillment of their responsibilities under this Agreement, such liability, loss, or damage shall be borne by each party in relation to each party's responsibilities under the joint activities, provided that nothing herein shall be construed as a waiver of any public or governmental immunity granted to any of the parties hereto as provided by applicable statutes and/or court decisions.

E. Under this Agreement, it is the intent of the parties that each of them shall separately bear financial risk and thereto shall be separately responsible for covering financial shortfalls and/or losses pursuant to the duties and responsibilities of each party hereto.

F. Pursuant to the MDHHS/PIHP Contract requirement that such contracts include a description of the PIHP's oversight to assure that a Provider is managing the services and the risk within the funding assumptions, the Payor shall require the Provider hereunder to submit budgetary information prior to the commencement of a fiscal year and shall monitor on an ongoing basis the Provider's financial reporting required hereunder in comparison with the Medicaid budgetary information and funding assumptions utilized by the PIHP hereunder.

And, pursuant to the MDHHS/PIHP Contract requirement that such contracts include a description of the method of payment for Medicaid funds to be used by the PIHP and assumptions used that such payments to Provider are at a level that will meet the needs of beneficiaries residing in that county(ies), each of the parties to this Agreement shall monitor payments of Medicaid funding from the Payor to the Provider in comparison to the assumptions used for such PIHP payments methodology to said Provider to be at a level that meets the needs of beneficiaries residing in the county(ies) of that Provider.

As specified in Subsection A of Section XIV: Consideration and Payment Procedures, this Agreement may be amended, with the mutual written consent of the parties hereto. Subcontract payment amounts of Medicaid from the Payor to the Provider may be increased or decreased with planned and/or unanticipated funding increases or decreases for the applicable fiscal year.

G. Under the MDHHS/PIHP Contract, total liability of the MDHHS is limited to the terms and conditions of said MDHHS/PIHP Contract and the MDHHS assumes no responsibility or liability for costs incurred by the PIHP prior to the effective date of the current Master Contract.

XXVIII. INSURANCE.

A. Each party hereto shall procure, pay the premium on, keep and maintain during the term of

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this Agreement either sufficient self-insured retention (SIR) policy and/or insurance coverage and/or bonding for funds and financial risk herein involved pursuant to its obligations.

B. Each party hereto agrees, that in the event its risk funding is inadequate to cover financial losses sustained, then such party shall suffer the loss separately pursuant to its obligations.

C. Each party hereto shall procure, pay the premium on, keep and maintain during the term of this Agreement other term insurance coverage in such amounts as necessary to cover all other claims which may arise out of activities to be carried out pursuant to its obligations. This shall include, but not be limited to, auto liability insurance for owned, non-owned, and hired vehicles with limits not less than one million ($1,000,000.00) dollars per occurrence.

D. Limits of each party's term general commercial liability insurance coverage shall not be less than one million dollars ($1,000,000.00) per occurrence and not be less than five million dollars ($5,000,000.00) annual aggregate

E. Each party, their elected and appointed officers, employees, servants, and agents shall be named as Additional Insured on the other party's liability insurance policies, as applicable.

F. The Provider shall ensure that all the Provider's subcontractors and their staff are covered by all appropriate term liability and malpractice insurance for the services which they perform.

G. By execution of this Agreement, each party hereto ensures to the other party that it maintains sufficient insurance coverage as required hereunder. Provider agrees to provide Payor evidence of such insurance upon request and thirty (30) days prior written notice of any material changes in such insurance.

H. Each party hereto shall provide the other party with written notice at least thirty (30) days prior to any reduction or termination of insurance coverage(s) required under this Agreement.

XXIX. MISCELLANEOUS PROVISIONS.

A. Notice. Any and all notices, designations, consents, offers, acceptances or other communications herein shall be given to either party, in writing, by receipted personal delivery or deposited in certified mail to the Chief Executive Officer at the address as shown in the introductory paragraph of this Agreement (unless notice of a change of address is furnished by either party to the other party hereto) and with return receipt requested, effective upon receipt.

B. **Relationships with Other Contractors.** The relationship of the Provider, pursuant to this Agreement, with other contractors of the Payor shall be that of independent contractor. The Provider and the Provider's subcontractors, in performing services required hereunder, shall fully cooperate with the other contractors of the Payor. The requirements of such cooperation shall not interfere with the Provider in the performing of the services required under this Agreement.

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C. **Information Requirements.** Informative materials intended to be distributed by the Provider or its subcontractors through written or other media to Medicaid eligibles or the broader community pursuant to this Agreement that describe the availability of covered services and supports and how to access those supports shall meet the standards required of the Payor under the MDHHS/PIHP Contract.

D. **Time of the Essence**. Time is of the essence in the performance of each and every obligation herein imposed.

E. **Further Assurances**. The parties hereto shall execute all further instruments and perform all acts, which are or may become necessary from time to time to effectuate this Agreement.

F. **Return of Property**. Upon the termination of this Agreement, each party hereto shall return immediately all documents, correspondence, files, records, papers or other property of any kind of the other party.

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

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

~~G.~~I.

XXX. MONITORING THE AGREEMENT.

A. The performance of the terms of this Agreement shall be monitored on an ongoing basis by the designated representatives of the Payor and of the Provider.

B. The Chief Executive Officer of each party hereto shall appoint administrative liaisons to be available to communicate with the liaisons of the other party.

C. In the event that circumstances occur that are not reasonably foreseeable or are beyond the control of the Payor and/or the Provider, that reduces or otherwise interferes with the ability of the Payor and/or the Provider to provide or maintain the specified services or operational procedures under this Agreement, such party shall immediately notify the other party. A meeting between the designated representatives of the Payor and of the

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Commented [KZ74]: New requirement for FY21 MDHHS/PIHP contract.

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Provider shall be convened as soon as possible in order to determine the immediate course of action and possible resolution of the situation.

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

(1.) PART 1: Prefatory steps related to non-compliance

a. Discussion with the Provider to identify potential barriers to effective performance and to identify and implement mutually agreeable solutions to performance problems.
b. Require a plan of correction and specified status reports that become a contract performance expectation.

(2.) PART 2: Pattern of non-compliance or lack of implementation of the correction action plan.

a. Prior to withholding payment as noted below, the PIHP will give sixty (60) day notice to allow for a period of correction.
b. The withholding of payment, in the event the above noted items have not been successful. The withholding of payment shall be in accordance with PIHP Compliance: Contract Compliance Procedure. Should the provider engage in "dispute resolution/appeal" any financial penalties/withholds would be delayed until final resolution;
c. Revocation of identified applicable delegated functions;
d. Contract termination in instances of material breach, or where the identified steps above have not resolved the deficiency.

XXXI. RESOLUTION OF CONTRACT ISSUES AND DISPUTES.

A. Contract issues between the parties hereto as to specific provisions of this Agreement and implementation thereof and/or service disputes hereunder shall be addressed by the designated representatives of said respective parties.

B. The Chief Executive Officer of the Provider will attempt to resolve the dispute through discussion with each other, as the case may be, and the Payor, as needed.

C. If the dispute remains unresolved, the Chief Executive Officer of the Provider or the of the Payor, as the case may be, will bring the matter to the Operations Council who will discuss the matter and render a written decision.

D. If the dispute continues to be unresolved to the satisfaction of the Provider or the Payor, the parties will provide a written description of the issue in dispute and propose a solution to the Payor Board of Directors. The Payor Board of Directors will have thirty (30) calendar days to provide a written decision.

E. If the Provider or the Payor remains dissatisfied after the written decision of the Payor Board of Directors, the Payor or the Provider may seek mediation or legal recourse as

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provided by law. Binding arbitration may be utilized only by joint agreement of the Payor and Provider specifying the specific matter agreed to be subject to arbitration.

F. Notwithstanding any other provision in this Agreement, the parties hereto agree that the payments of Medicaid subcapitation funds due and payable from the Payor to the Provider under this Agreement shall not be stopped, interrupted, reduced, or otherwise delayed as a consequence of the pendent status of any dispute arising under this Agreement.

XXXII. WAIVERS.

A. No failure or delay on the part of any of the parties to this Agreement in exercising any right, power or privilege hereunder shall operate as a waiver, thereof, nor shall a single or partial exercise of any right, power or privilege preclude any other further exercise of any other right, power or privilege.

B. In no event shall the making by the Payor of any payment to the Provider constitute or be construed as a waiver by the Payor of any breach of this Agreement, or any default which may then exist, on the part of the Provider, and the making of any such payment by the Payor while any such breach or default shall exist, shall in no way impair or prejudice any right or remedy available to the Payor in respect to such breach or default.

XXXIII. AMENDMENT. Modifications, amendments, or waivers of any provision of this Agreement may be made only by the written consent of all the parties to this Agreement.

XXXIV. ASSIGNMENT.

A. Neither this Agreement nor any rights or obligations hereunder shall be assignable by either party hereto without the prior written consent of the other party, nor shall the duties imposed herein be delegated by either party without the prior written consent of the other party.

B. Given the MDHHS's requirements of the Payor related to Provider Network Services in the MDHHS/PIHP Contract, the Provider shall notify the Payor, pursuant to this Agreement, within three (3) days of any changes to the composition of the provider network organizations that negatively affect access to care. Provider shall have procedures to address changes in its network that negatively affect access to care. Changes in provider network composition that Payor determines to negatively affect recipient access to covered services may be grounds for sanctions (42 CFR 438.207(c)(3)).

C. This Agreement shall be binding upon the parties hereto and their respective successors and permitted assigns.

XXXV. DISREGARDING TITLES. The titles of the sections in this Agreement are inserted for the convenience of reference only and shall be disregarded when construing or interpreting any of the provisions of this Agreement.

XXXVI. COMPLETENESS OF THE AGREEMENT. This Agreement, the attached Exhibits, and the additional and supplementary documents incorporated herein by specific reference contain all the terms and conditions agreed upon by the Payor and the Provider, and no

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Commented [AI89]: I believe this is good given we need to report with 5 days.

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other agreements, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind either the Payor or the Provider.

XXXVII. SEVERABILITY AND INTENT.

A. If any provision of this Agreement is declared by any Court having jurisdiction to be invalid, such provision shall be deemed deleted and shall not affect the validity of the remainder of this Agreement, which shall continue in full force and effect.

B. If removal of such provision would result in the illegality and/or unenforceability of this Agreement, this Agreement shall terminate as of the date in which the provision was declared invalid.

C. This Agreement is not intended by the parties hereto to be a third-party beneficiary contract and confers no rights on anyone other than the parties hereto.

XXXVIII. CERTIFICATION OF AUTHORITY TO SIGN THE AGREEMENT. The persons signing this Agreement on behalf of the parties hereto certify by said signatures that they are duly authorized to sign this Agreement on behalf of said parties and that this Agreement has been authorized by said parties pursuant to formal resolution(s) of the appropriate governing bodies.

IN WITNESS WHEREOF, the authorized representatives of the parties hereto have fully executed this Agreement on the day and the year first above written.

PAYOR: MID-STATE HEALTH NETWORK

BY: _____ 9.2.20
Date

«Name_of_Organization»~~BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY~~:

BY: _____ _____
Date

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EXHIBIT A
MSHN DELEGATION GRID

PIHP Functions- Simplified Form

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I. Customer Service

PIHP Activity	Retained or delegated?
Information Services: This component includes those information activities, brochures and material that pertain specifically to the CMHSP provider network.	☐Retained by MSHN ☒ Delegated to local CMHs
Customer Services: This component includes: • Maintaining an office(s) of Customer Service/Enrollee Rights and Recipient Rights in compliance with federal and state statutes. • Customer Services will operate minimally eight hours daily Monday through Friday and telephone calls will be answered through a dedicated toll-free customer services telephone line by a live representative. • Local communication with consumers regarding the role and purpose of the PIHP's Customer Services and Recipient Rights Office. • Development of local activities designed to engage consumers, and other stakeholders, including members of the general public, in decision-oriented activities throughout the CMHSP, including its sub-panel provider network. • Training and orientation of customers, to participate actively in Advisory Groups, task forces, working committees.	☐Retained by MSHN ☒ Delegated to local CMHs
Customer Recipient Rights Complaint, Grievance and Appeals and Second Opinion Processes. Each CMHSP shall be responsible for notification to both its staff and consumers of: • The PIHP's complaint, grievance and appeal, second opinion and recipient rights processes • Application and implementation of the PIHP policies and procedures related Grievance & Appeals, Second Opinion, Enrollee Rights, and Recipient Rights Procedures • Providing acknowledgement of grievance and appeals, Adverse Benefit Determination and disposition notices within timeframes specified by and according to PIHP Grievance and Appeals Policy ~~• Documenting and reporting Denials, Grievance & Appeals, Fair Hearings, Recipient Rights Complaints, and Second Opinion requests.~~	☐Retained by MSHN ☒ Delegated to local CMHs *PIHP remains responsible for oversight. Second opinion requests are handled by CMHSPs.

Commented [KJ99]: J. Obermesik 8.20.21: p.37 (packet 138) What was the impetus to insert "Enrollee Rights" this year? Are there requirements we were not previously delegated from 42 CFR 438.10?

Commented [KZ100R99]: There are no new requirements related to enrollee rights that have not been previously delegated. This was included here as HSAG recommended that MSHN create a separate policy related to enrollee rights. Enrollee rights was previously included throughout different MSHN Customer Services policies but now has a separate policy specific to enrollee rights.

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• Documenting and reporting the dispositions of all Grievance & Appeals, Fair Hearings, and Recipient Rights complaints~~, and Second Opinions (where applicable)~~.	
Information Requirements and Notices: Informative materials intended to be distributed through written or other media to beneficiaries or the broader community that describe the availability of covered services and supports and how to access those supports and services, including but not limited to provider directories, beneficiary handbooks, appeal and grievance notices, and denial and termination notices, must meet the following standards: ~~All informative materials intended to be distributed through written or other media to beneficiaries or the broader community that describe the availability of covered services and supports and how to access those supports and services shall meet the following standards:~~ • All such materials shall be written at the ~~4th~~6.9 grade reading level when possible. • The provider directory must be made available in paper form upon request and in an electronic form that can be electronically retained and printed. It must also be made available in a prominent and readily accessible location on the Contractor's website, in a machine-readable file and format. Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information. • All materials shall be available in the languages appropriate to the people served within the Contractor's area for specific Non-English Language that is spoken as the primary language by more than 5% of the population in the Contractor's Region. Such materials must be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2000 Federal Register Vol. 65, August 16, 2000). • All such materials must be available in alternative formats in accordance with the Americans with Disabilities Act (ADA), at no cost to the beneficiary. Beneficiaries must be informed of how to access the alternative formats. • If the Contractor provides information electronically, it must inform the customer that the information is available in paper form without charge and upon request and provides it upon request within five business days. ~~All materials shall be available in the languages appropriate to the people served within the PIHP's area for specific Non-English Language that is spoken as the primary language by more than 5% of the population in the PIHPs Region. Such materials shall be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance~~	☐Retained by MSHN ☒ Delegated to local CMHs *This section serves as a reminder that there is a need for a member handbook that includes common content.

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• ~~All such materials shall be available in alternative formats in accordance with the Americans with Disabilities Act (ADA). Beneficiaries shall be informed of how to access the alternative formats.~~ • All materials shall be available in a font size with a minimum font of 12pt and in large print in a font size no smaller than 18-p~~oin~~t. • Material shall not contain false, confusing, and/or misleading information. The CMHSP shall provide the following information to all consumers: • ~~A listing of contracted providers that identifies provider name as well as any group affiliation, locations, telephone numbers, web site URL (as appropriate), specialty (as appropriate), the provider's cultural capability, any non-English languages spoken, if the provider's office/facility has accommodations for people with physical disabilities, and whether they are accepting new beneficiaries. This includes any restrictions on the beneficiary's freedom of choice among network providers. The listing would be available in the format that is preferable to the beneficiary: written paper copy or on-line. The listing must be kept current and offered to each beneficiary annually.~~ A listing of contracted providers that identifies provider name as well as any group affiliation, locations, telephone numbers, web site URL (as appropriate), specialty (as appropriate), the provider's cultural capability, any non-English languages spoken, if the provider's office/facility has accommodations for people with physical disabilities, and whether they are accepting new beneficiaries. This includes any restrictions on the beneficiary's freedom of choice among network providers. The listing would be available in the format that is preferable to the beneficiary: written paper copy or on-line. The listing must be kept current and offered to each beneficiary annually. ~~A listing of contracted providers that identifies provider name as well as any group affiliation, street addresses, telephone numbers, web site URL (as appropriate), services they provide, the provider's cultural and linguistic capability, any non-English languages spoken (including American Sign Language), any specialty for which they are known, if the provider's office /facility has accommodations for people with physical disabilities, and whether they are accepting new beneficiaries. This list must include independent PCP facilitators. The list needs to include any restrictions on the beneficiary's freedom of choice among network providers. The listing would be available in the format that is preferable to the beneficiary: written paper copy or on-line. The listing must be kept current and offered to each beneficiary annually.~~ • • Enrollee rights and protections • Appeals, grievance and fair hearing procedures • Amount, duration, and scope of benefits available in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled. • Procedures for obtaining benefits, including authorization requirements. • The extent to which, and how, consumes may obtain benefits from out of network providers.	

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• The extent of which, and how, after hours and emergency coverage is provided and the extent to which, and how, after-hours crisis services are provided. • The CMHSP shall provide the Customer Handbook in person, via mail, email or online to each enrollee at the time of service enrollment, and annually thereafter. • Written notice of any significant change must be provided to the consumer at least 30 days before the intended effective date of the change for the following information {as specified in 438.10 (f)(6)} • CMHSP shall make a good faith effort to give written notice of termination of a contracted provider (organizational) within 15 days after receipt or issuance of the termination notice, to each consumer who received his or her services from the terminated provider. • Written notice of the law and a summary of the right to develop an advance directive in accordance with 42 CFR 422.128; 42 CFR.6 and the MDHHS/PIHP Contract	
Tracking, monitoring, trending and reviewing all Denial, Grievance and Appeals, -Recipient Rights and Second Opinion data submitted by each local CMHSP.	☒Retained by MSHN ☐ Delegated to local CMHs
Annually (e.g., at the time of person-centered planning) provide to the beneficiary the estimated annual cost of each covered support and service he/she is receiving.~~Annually provide to the beneficiary the estimated annual cost of each covered support and services he/she is receiving in compliance with Technical Requirement P 6.3.2.1.B.i~~	☐Retained by MSHN ☒ Delegated to local CMHs
Provide Explanation of Benefits (EOBs) to 5% of the consumers receiving services. The EOB distribution must comply with all State and Federal regulations regarding release of information as directed by MDHHS.~~5% Explanation of Benefit, in compliance with Technical Requirement P 6.3.2.1.B.ii of the MDHHS PIHP contract.~~	☐Retained by MSHN ☒ Delegated to local CMHs

II. General Management

PIHP Activity	Retained or delegated?
Leadership and oversight for such activities as: • Access	☐Retained by MSHN

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• Eligibility • Triage and Authorization • Utilization Management	☒ Delegated to local CMHs *Task implemented by CMHSPs with oversight responsibility from PIHP.
Maintain local legal counsel with responsibility to notify PIHP of any and all possible litigation	☐Retained by MSHN ☒ Delegated to local CMHs
Participate in reviews and audits of MSHN as appropriate	☐Retained by MSHN ☒ Delegated to local CMHs *This responsibility will be detailed in MSHN operating agreement.
CMHSP participation in MSHN, Council, Committees and Workgroups, as necessary	☐Retained by MSHN ☒ Delegated to local CMHs *This responsibility will be detailed in MSHN operating agreement.
CMHSP participation in PIHP Consumer Advisory Council, as necessary	☐Retained by MSHN ☒ Delegated to local CMHs *This responsibility will be detailed in MSHN operating agreement.
The PIHP will assure the development and maintenance of an administrative structure to assure compliance with regulations. Also includes: **A.** MSHN will strive to ensure that all consumers served receive quality services in accordance with the mission and values of the MSHN. **B.** MSHN will develop, implement, and monitor the needed policies, procedures and formal activity plans. **C.** MSHN will establish operating practices that meet the requirements	☒Retained by MSHN ☐ Delegated to local CMHs

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of 42CFR 438 Managed Care, the State of MI PIHP contract and related attachments, delineating those functions that will be fulfilled by the PIHP and those functions that will be delegated to MSHN Affiliate CMHSP's (Community Mental Health Service Provider).	
PIHP Legal Support 1) PIHP/Affiliate Medicaid contract XXVII. LIABILITY AND FINANCIAL RISK. C. Each party to this Agreement must seek its own legal representative and bear its own costs including judgments in any litigation which may arise out of its activities to be carried out pursuant to its obligations hereunder. It is specifically understood and agreed that neither party will indemnify the other party in such litigation 2) MDHHS/PIHP Contract The State, its departments, and its agents shall not be responsible for representing or defending the PIHP, PIHP's personnel, or any other employee, agent or subcontractor of the PIHP, named as a defendant in any lawsuit or in connection with any tort claim.	☐Retained by MSHN* ☐ Delegated to local CMHs* *The PIHP and the individual CMHSPs are each liable for their own activities.
Oversight of delegated activities 1) PIHP/Affiliate contract XXX. MONITORING THE AGREEMENT. **A.** The performance of the terms of this Agreement shall be monitored on an ongoing basis by the designated representatives of the Payor and of the Provider. **B.** The Chief Executive Officer of each party hereto shall appoint administrative liaisons to be available to communicate with the liaisons of the other party.	☒Retained by MSHN ☐ Delegated to local CMHs

III. Financial Management

PIHP Activity	Retained or delegated?
Routine accounting and budgeting functions, purchasing and inventory management, engagement of annual financial audit, compliance audit and consulting relationships – as detailed in MSHN procedures and MDHHS PIHP and CMHSP contract.	☐Retained by MSHN ☒ Delegated to local CMHs
Tracking of Medicaid & SUD funding expenditures and revenues – as detailed in MSHN procedure	☐Retained by MSHN ☒ Delegated to local CMHs

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Data compilation and cost determination for rate-setting purposes	☐Retained by MSHN ☒ Delegated to local CMHs
FSR, ~~Administrative Cost Report UNC (Medicaid and Healthy Michigan),~~ and Encounter Quality Initiative (EQI) ~~and Sub-element~~ to PIHP – As detailed in MDHHS PIHP contract	☐Retained by MSHN ☒ Delegated to local CMHs
Billing of all third-party payers (as Medicaid is the payer of last resort) – As detailed in MDHHS PIHP contract When CMH bills Medicare, a Coordination of Benefits Agreement must be in place.	☐Retained by MSHN ☒ Delegated to local CMHs
Establish a budget and financial management system sufficient to monitor revenues and expenditures for the region, monitor changes in the Medicaid population for the PIHP region and the effect on capitated funds received from MDHHS, manage financial reserves to meet unexpected demand, determination of methodology for Medicaid payment to local CMHSP – As detailed in MSHN procedures	☒Retained by MSHN ☐ Delegated to local CMHs
Compile of data cost information for weighted average determination, per service, for the region – As detailed in MSHN procedures	☒Retained by MSHN ☐ Delegated to local CMHs
Report FSR and ~~Medicaid Utilization Net Cost~~Encounter Quality Initiative reporting to MDHHS – as detailed in MDHHS PIHP contract	☒Retained by MSHN ☐ Delegated to local CMHs
Develop a Risk Management Plan for the PIHP, develop a regional reinvestment strategy for allocation of Medicaid savings, develop and submit Risk Management Plan to MDHHS	☒Retained by MSHN ☐ Delegated to local CMHs

IV. Information Systems Management

PIHP Activity	Retained or delegated?

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Develop and maintain an understanding of MDHHS data collection, management, submission, and reporting requirements. MDHHS/PIHP Contract (Includes knowledge of up to date MDHHS documentation and participation in IT Council discussion of changes to reporting requirements)	☐Retained by MSHN ☒Delegated to local CMHs
Collect and accurately report all MDHHS required data elements, including BH-TEDS, regional supplemental data, Performance indicators (MMBPIS), Critical Incidents and other required data on time according to MSHN and MDHHS requirements. (Includes: Documented data extraction and processing methods; Implement and maintain data systems that collect, store, extract, and ~~report data~~report data; Submit timely BH-TEDS data formatted as required.) MDHHS/PIHP Contract	☐ Retained by MSHN ☒Delegated to local CMHs
Communicate immediately and work with MSHN IT staff to resolve BH-Client Registry data difficulties that prevent correct and timely submission of data. ~~and to resolve encounter data difficulties that prevent correct and timely submission of data.~~ MDHHS/PIHP Contract	☐ Retained by MSHN ☒Delegated to local CMHs
Collect and accurately report encounter data on time according to MSHN and MMDHHS requirements. MDHHS/PIHP Contract (Includes: Document data extraction and processing methods to sufficiently explain how Encounter data gets created; Implement and maintain data systems that collect, store, extract, and report Encounter data according to MMDHHS requirements; Validate that Encounter data and reporting formats, values, and logic meet MSHN instructions and requirements prior to submission; Ensure that every consumer with an Encounter reported has a BH-TEDS record ; Comply with HIPAA 837 transaction requirements; Submit Encounter files in a timely manner.)	☐ Retained by MSHN ☒Delegated to local CMHs
Document data extraction and processing methods to sufficiently explain how performance indicator data gets created. MDHHS/PIHP Contract, and BBA.	☐ Retained by MSHN ☒Delegated to local CMHs

Commented [FG101]: Revise to include reference about this being a client registry. Critical to the submission of BH-TEDS and Encounter processes being accepted.

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Participate in and complete documentation necessary for information system capabilities assessments, both internal to the PIHP and external (i.e., from MDHHS) (Includes: Timely and correct completion of ~~Mini-~~any ISCAT material requirements and accompanying attachments; Timely and correct completion of documentation and attachments needed by the PIHP for the ISCAT to accurately reflect all workflow processes.) MDHHS/PIHP Contract, and BBA.	☐Retained by MSHN ☒Delegated to local CMHs
Participate in Health Information Exchange processes as defined by MDHHS requirements and to improve care for persons served in the region. This includes acting not only as a receiver, but also a sender of information into the exchange. Develop process for submitting BH-ADTs per the statewide behavioral health ADT specification set. MDHHS/PIHP Contract	☐Retained by MSHN ☒Delegated to local CMHs
Disseminate to the CMHSP's the specifications for encounter, Performance Indicators (MMBPIS), Critical Incidents, data submission, including: • Dates due to MSHN • Method of submission to PIHP • Format of submission to PIHP Annual validation of PIHP PI indicators (1, 2, 3, 4 and 10) conducted at annual site visit. MDHHS/PIHP Contract	☒ Retained by MSHN ☐Delegated to local CMHs
Create and manage data systems that store, extract, process, and submit region-wide 837 encounter and BH-TEDS data according to MMDHHS specifications. MDHHS/PIHP Contract	☒ Retained by MSHN ☐Delegated to local CMHs
Process and submit affiliation 837 encounter and BH-TEDS data. (Includes: Accept and convert CMHSP encounter (837) and BH-TEDS submissions and resubmissions, check them for accuracy and quality, combine them into PIHP files, submit the combined files to MDHHS according to their requirements, and store and track status on all files; Accept, understand, and work with error reports provided by MDHHS on 837 and BH-TEDS data submission to correct and resubmit data as require; Generate and distribute error reports to CMHSPs as needed, and work with CMHSPs to obtain corrected data submissions; Provide consultation to CMHSPs (i.e., provide guidance and requirements for solutions to issues on data quality and submission status). MDHHS/PIHP Contract	☒ Retained by MSHN ☐Delegated to local CMHs

Commented [FG102]: HSAG dropped the requirement for CMHSPs to do mini-ISCATs. They are required to supply supporting documentation for the ISCAT document that MSHN is required to complete. This supporting documentation reflects workflow processes occurring at the CMHSP where it may vary from other CMHSPs.

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Conduct formal assessments of the CMHSP capacity and capability for carrying out the delegated information systems management activities on an ongoing and annual basis. (This includes: Interview staff that perform data systems management activities; Inspect and review the CMHSP's data system(s) and/or documentation, including policies, procedures, and guidelines; Compare a sampling of BH-TEDS and encounter records to system data, and system data to submitted BH-TEDS and encounter data, to validate consumer data is being collected, processed, and reported properly; Create and distribute to the CMHSP the analysis and summary of the findings of the assessment: including: Problems, Solution recommendations or requirements, Request for corrective action plan; Verify that the CMHSP has completed the corrective action, and if not, report to the IS Director and Compliance Committee.)	☒ Retained by MSHN ☐Delegated to local CMHs
The MSHN Corporate Compliance Committee will review all assessment results annually, or as needed to meet obligations of the PIHP. Reference MSHN Policy	☒ Retained by MSHN ☐Delegated to local CMHs
Supports Intensity Scale, in compliance with the MDHHS/PIHP contract.	☐ Retained by MSHN ☒Delegated to local CMHs

~~V. Jail Diversion~~

Commented [KJ103]: Per 11.23.20 E-mail, Jail Diversion removed from PIHP responsibilities

~~PIHP Activity~~	~~Retained or delegated?~~
~~MDHHS/PIHP contract: "The Contractor (PIHP) shall coordinate with the appropriate entities, services designed to divert beneficiaries that qualify for MH/DD specialty services from a possible jail incarceration, when appropriate. Such services should be consistent with the Jail Diversion Practice Guidelines."~~	~~☐ Retained by MSHN~~ ~~☒ Delegated to local CMHs~~
~~The PIHP will collect data reflective of jail diversion activities and outcomes as indicated in the Practice Guideline.~~ ~~PIHP will ensure that the Affiliates are notified of any changes to the MDHHS practice guideline for Jail Diversion.~~	~~☐Retained by MSHN~~ ~~☒ Delegated to local CMHs~~

V~~I~~. Person Centered Planning

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PIHP Activity	Retained or delegated?
MDHHS contract states: "The Michigan Mental Health Code establishes the right for all individuals to have an Individual Plan of Service (IPS) developed through a person-centered planning process (Section 712, added 1996). The Contractor (PIHP) shall implement person-centered planning in accordance with the MDHHS Person-Centered Planning Practice Guideline"	☐Retained by MSHN ☒ Delegated to local CMHs
Development, modification, and monitoring of Affiliation policies and procedures related to PCP. Development, modification, and monitoring of training curriculum and resources to be used Affiliation wide. Development of review tool(s) related to PCP.	☒Retained by MSHN ☐ Delegated to local CMHs

VII. Provider Network

PIHP Activity	Retained or delegated?
Local assessment of need for provider capacity. The CMHSP shall: • Annually evaluate the needed and actual capacity of its provider network and redistribute resources where necessary to ensure timely access and necessary service array to address consumer demands.	☐Retained by MSHN ☒ Delegated to local CMHs *Task implemented by CMHSPs with oversight responsibility from PIHP.
Local Network Development and Management: • Manage procurement of local providers sufficient to fulfill all PIHP delegated activities and to meet identified needs, including recruitment of staff (or contracted) interpreters, translators, and bi-lingual/bi-cultural clinicians • Negotiate contracts between the CMHSP and providers based on a procurement method that meets state and federal standards and in accordance with PIHP policy *Excludes SUD provider network development and management except for CCBHC network management requirements, as applicable	☐Retained by MSHN ☒ Delegated to local CMHs *PIHP will have a common list of approved contractors, but individual CMHSPs are not required to utilize the services of any contractor who has been approved. There may be some central system for

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	reporting on the performance of contractors; the details for this are still under consideration.
Utilization of the standardized Regional Financial Management Services (FMS)~~I~~ Services contract template and site review monitoring tool. Maintenance of standardized Regional ~~FI~~ FMS Services contract template and site review monitoring tool.	☒ Delegated to local CMHs and regionally standardized ☒ Retained by MSHN
Utilization of the standardized Inpatient Psychiatric Services contract template and site review monitoring tool. Maintenance of standardized Regional Inpatient Psychiatric Services contract template and site review monitoring tool.	☒ Delegated to local CMHs and regionally standardized ☒ Retained by MSHN
Coordination and Continuity of Care: • Coordination of care with the QHP's within the CMHSP catchment area • Develop relationships with other Health Care providers and SUD Providers to ensure coordinated services and appropriate referrals. • Develop service coordination agreements with each of the pertinent public and private community-based organizations and providers to address issues that relate to a shared consumer base.	☐Retained by MSHN ☒ Delegated to local CMHs
Monitor and Evaluate providers. The CMHSP shall: • Have an established process for monitoring (at least annually) the performance of each provider relative to the contract. The monitoring process will minimally assess performance and compliance indicators established by the PIHP. *Excludes SUD provider network development and management	☐Retained by MSHN ☒ Delegated to local CMHs
Provider Credentialing: • CMHSP shall credential providers, as appropriate, in accordance with the Credentialing section in this document. • Ensure that network providers residing and providing services in bordering states meet all applicable licensing and certification requirements within their state. c. • Have written policies and procedures, that comply with MSHN policies and procedures, for monitoring its providers and for sanctioning providers who are out of compliance with the MSHN's standards.	☐Retained by MSHN ☒ Delegated to local CMHs *There will be centralized reciprocity using uniform credentialing standards.

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*Excludes SUD provider network development and management	
Right, to approve, suspend & terminate individual practitioners, providers & sites if it has delegated decision-making.	☒Retained by MSHN ☐ Delegated to local CMHs
Organizational Credentialing: • Credential providers in accordance with MSHN Procedure: Credentialing – Organizational Providers. • Validate and revalidate, at least every two years, that the organizational provider is licensed or certified as necessary to operate in the State, and has not been excluded from Medicaid or Medicare participation. • Ensure the contract between CMHSP and any organizational provider requires provider to credential and recredential their employed and subcontract direct service providers in accordance with CMHSP policy and procedures (which must conform to MSHN and MDHHS credentialing processes). • Ensure those licensed and providing services in bordering states meet applicable licensing and certification requirements of that state. • Mid-cycle primary source verification shall occur at time of license and/or other credential renewal as outlined in MSHN credentialing procedures Notify organization, in writing, of adverse credentialing decisions and ability to appeal. • Complete semi-annual reporting of credentialing activities, as required (refer to reporting requirements). • Ensure new contracts with new providers of services covered by the Federal HCBS Rule (42 CFR Parts 430, 431, 435, 436, 440, 441 and 447) only if the provider has obtained provisional approval status through completion of the HCBS New Provider Survey, demonstrating that the provider does not require heightened scrutiny. Provisional approval allows a new provider or an existing provider with a new setting or service to provide services to HCBS participants for 90 days *Excludes SUD provider network development and management except for CCBHC SUD Network Management requirements, as applicable	☒Retained by MSHN (SUD Network Providers) ☒ Delegated to local CMHs

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• Licensed Independent Practitioner (LIP) Credentialing: CMHSP shall assure that all LIPs, whether employed or contracted by the CMHSP to provide clinical or medical services, will be credentialed; and all clinicians and physicians, whether employed or contracted by the CMHSP, will be privileged for each specific function to be performed
• Credentialing and privileging shall be age and disability specific according to the populations served.
• At minimum, the following credentials shall be verified, by primary source, prior to employment/contract and in accordance with timelines outlined in MSHN credentialing policies and procedures:
  ○ License or certification
  ○ Board Certification or highest level of credentials attained, or completion of any required internships/residency programs, or other postgraduate training
  ○ Documentation of graduation from an accredited school
  ○ NPDB or all of the following:
  ▪ Minimum 5 year history of professional liability claims resulting in judgment or settlement;
  ▪ Disciplinary status with regulatory board or agency; and
  ▪ Medicare/Medicaid sanctions
  ○ AMA or AOA may be used to satisfy requirements of (a.), (b.), and (c.) above if the individual being credentialed is a physician.
• Ensure those licensed and providing services in bordering states meet applicable licensing and certification requirements of that state.
• Notify LIPs, in writing, of adverse credentialing decisions and ability to appeal.
• Mid-cycle primary source verification shall occur at time of license and/or other credential renewal as outlined in MSHN credentialing procedures.
• Maintain copies of all initial and recredentialing applications, attestation statements, evidence of primary source verification, documentation of credentialing decisions, and notification(s) to LIP in the employees' or contractors' credentialing files in accordance with record retention procedures.
• Credentialing shall occur at the time of employment/contract and at least biennially thereafter.
• Demonstrate that processes do not discriminate against: a. A health care professional solely on the basis of license, registration, or certification and b. A healthcare professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.
• Monitor sub-contractors, at least annually, with adherence to
	☒Retained by MSHN (SUD Network Providers)
	
	☒ Delegated to local CMHs

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above. • Complete semi-annual reporting of credentialing activities, as required (refer to reporting requirements) *Excludes SUD provider network development and management	
Credentialing Monitoring and Evaluation • MSHN, through delegated managed care reviews, will audit credentialing policies, procedures, and conduct a file review in accordance with the Monitoring and Evaluation policy and procedures.	☒Retained by MSHN ☐ Delegated to local CMHs
-Secure contract with and manage all CMHSP's and SUD Network Providers.	☒Retained by MSHN ☐ Delegated to local CMHs
Establish PIHP Provider Network Management policies and procedures	☒Retained by MSHN ☐ Delegated to local CMHs
Monitor capacity and demand for services in the PIHP region	☒Retained by MSHN ☐ Delegated to local CMHs
-Establish and delegate a local level -process for soliciting network provider feedback and/or complaints	☐Retained by MSHN ☒ Delegated to local CMHs PIHP retains process for soliciting CMHSP and SUD provider network complaints
Provider shall upload monthly to Payor its current provider network listing.	☐Retained by MSHN ☒ Delegated to local CMHs

VIII. Quality Management

PIHP Activity	Retained or delegated?
Develop/Implement~~Develop, approve, and review~~ a Quality Assessment and Performance Improvement Program consistent with MDHHS/PIHP	☒☐Retained by MSHN

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Medicaid Contract QAPIP Technical requirement • Complete QAPIP Annual Report • Develop QAPIP Annual Plan~~Plan and Annual Report~~	☐~~☒~~ Delegated to local CMHSPs~~s~~
Local functions of quality assurance and management. These activities shall include: • develop and implement a Quality Improvement Program in accordance with the MDHHS/PIHP Medicaid Contract and the MSHN ~~Regional~~ Quality Assessment and Performance Improvement Program~~lan~~. • ensure Best Practice Guidelines are adhered to • ~~ensure a trauma-informed system~~ • ensure that compliance issues are adequately addressed and reported to the PIHP. • MDHHS/PIHP Medicaid Contract QAPIP TR	☐Retained by MSHN ☒ Delegated to local CMHs
Conduct Performance Improvement Projects (PIPs) as required by MDHHS. MDHHS/PIHP Medicaid Contract QAPIP TR	☒~~☐~~Retained by MSHN ☐~~☒~~ Delegated to local CMHs ~~*Conducted by CMHSPs with oversight from PIHP.~~
Establish ~~Each CMHSP shall have~~ a Behavior Treatment Plan Review Committee to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions. MDHHS/PIHP Medicaid Contract QAPIP TR	☐Retained by MSHN ☒ Delegated to local CMHs
~~Develop, approve, and review a Quality Assessment and Performance Improvement Program Annual Plan and Annual Report~~	~~☒Retained by MSHN~~ ~~☐ Delegated to local CMHs~~
Conduct, ~~r~~Review, ~~r~~Report, and complete quality improvement plans~~corrective action~~ in accordance with the following Quality initiatives~~activities~~: • Two Performance Improvement Projects as required by MDHHS. • Michigan Mission Based Performance Indicators (MMBPIS) • Sentinel Events, Critical Incidents, Risk Events and Root Cause Analysis as needed. • Consumer Experience Feedback (e.g., Consumer Surveys, , Self-Assessments, Focus Groups) • Behavior Treatment Data (restrictive and intrusive interventions, physical interventions, and 911 calls for behavioral assistance.) • Organizational Self-Assessment of trauma informed care (min every	☐Retained by MSHN ☒ Delegated to local CMHs ~~*Conducted by CMHSPs with oversight from PIHP.~~

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3 years) • Other performance measures as agreed to through Operations council MDHHS/PIHP Medicaid Contract QAPIP TR; PIHP Trauma Policy	
Disseminate to CMHSP Participants the specifications including due dates to MSHN, methods of submission, and format of submission for the following Quality activities: • Two performance improvement projects as required by MDHHS • Mission Based Performance Indicator System (MMBPIS) • Sentinel Event, Critical Incident, and Risk Event reporting • Consumer Feedback (satisfaction surveys, self-assessments, focus groups etc.) • Behavior Treatment Data • Other performance measures as agreed to through Operations council MDHHS/PIHP Medicaid Contract QAPIP TR	☒Retained by MSHN ☐ Delegated to local CMHs
The PIHP will utilize an Affiliation wide process to provide oversight and guidance ~~as needed~~ through provider monitoring, data aggregation, analysis, and identification of improvement efforts to the CMHSP for the following Quality activities: • Two performance improvement projects as required by MDHHS • MMBPIS • Critical Incident Review System • Behavior Treatment Plan Review • Consumer Experience Feedback • Other performance measures as agreed to through Operations council MDHHS/PIHP Medicaid Contract QAPIP TR	☒ Retained by MSHN ☐ ~~----~~Delegated to local CMHs

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~~IX.~~ **VIII. Self-Determination**

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PIHP Activity	Retained or delegated?
Part II(A) Section 4.7 of the MDHHS contract states: "It is the expectation that PIHPs will assure compliance among their network of service providers with the elements of the Self-Determination Policy and Practice Guideline dated 10/1/12 contract attachment 4.7.1. "	☐Retained by MSHN ☒ Delegated to local CMHs
Development, modification, and monitoring of Affiliation policies and procedures related to SD. Development, modification, and monitoring of training curriculum and	☒Retained by MSHN ☐ Delegated to local CMHs

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resources to be used Affiliation wide. Development of review tool(s) related to SD.	

~~X.~~IX. **Utilization Management**

PIHP Activity	Retained or delegated?
Prospective approval or denial of requested service: • Full review with new UM Work Plan • Initial assessment for and authorization of psychiatric inpatient services • Initial assessment for and authorization of psychiatric partial hospitalization services • Initial and ongoing authorization of services to individuals receiving community-based services- Grievance and Appeals, Second Opinion management, coordination and notification- Communication with consumers regarding UM decisions, including adequate and advance notice, right to second opinion and grievance and appeal	☐Retained by MSHN ☒ Delegated to local CMHs *This topic has been marked as an implementation issue requiring the development of a specific policy or procedure at the MSHN level.
Local-level Concurrent and Retrospective Reviews of affiliate Authorization and Utilization Management decisions/activities to internally monitor authorization decisions and congruencies regarding level of need with level of service, consistent with PIHP policy, standards and protocols.	☐Retained by MSHN ☒ Delegated to local CMHs
Persons who are enrolled on a habilitation supports waiver must be certified as current enrollees and be re-certified annually. A copy of the certification form must be in the individual's file and signed by the local CMHSP representative.	*This will be a **local responsibility** that is **prompted centrally by MSHN**. It will be a central

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	responsibility to manage the resource of waiver slots and provide oversight.
Development, adoption and dissemination of Practice Guidelines (PGs), Medical Necessity Criteria, and other Standards to be used by the Provider Network. 42 CFR: 438.236: Practice Guidelines	☒Retained by MSHN ☐ Delegated to local CMHs
Development, modification and monitoring of related PIHP UM Policy, Procedures and Annual Plan as part of the Affiliation QI Plan.	☒Retained by MSHN ☐ Delegated to local CMHs
Review and Analysis of the Provider Networks quarterly utilization activity and reporting of services. Annual review of each Provider and the PIHP's overall Utilization Activities.	☒Retained by MSHN ☐ Delegated to local CMHs
Use nationally-recognized criteria (MCG Behavioral Health Medical Necessity Guidelines) based on sound clinical evidence to ensure a consistent benefit across the region, needs identification instruments, and the person-centered planning process to make utilization management (UM) decisions for behavioral health services as well as for agreed upon thresholds comparable to all Michigan Pre-Paid Inpatient Health Plans (PIHPs).	☐Retained by MSHN ☒ Delegated to local CMHs
Review of CMHSP policies and procedures and quarterly UM analysis of data toward compliance with all aspects of consistent application of medical necessity criteria for acute care services.	☒Retained by MSHN ☐ Delegated to local CMHs

~~XI.~~X. **Integrated Health**

PIHP Activity	Retained or delegated?
Participate in PIHP/MHP Joint Performance Metrics and Measures as outlined in the MDHHS/PIHP contract.	☐Retained by MSHN ☒ Delegated to local CMHs
Implementation of Joint Care Management Processes: Facilitate monthly care coordination meetings and joint care management plans in CareConnect 360 for members with identified high risk factors who are receiving services from a Medicaid Health Plan and PIHP/CMHSP.	☒Retained by MSHN ☐ Delegated to local CMHs

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Data validation activities as required by MDHHS.	
Provide local level coordination among all providers (behavioral health and physical health) for persons being served; provide status updates to MSHN as requested to support care coordination activities between funders of services (PIHP and MHP)	☐Retained by MSHN ☒ Delegated to local CMHs
Coordination and Continuity of Care: Implement procedure to coordinate the services that the CMHSP furnishes to the consumer with the services that the consumer receives from other entities.	☐Retained by MSHN ☒ Delegated to local CMHs

~~XII.~~XI. **1915(i) State Plan Amendment, Children's Waiver and Serious and Emotional Disturbance Waiver**

1915(i) State Plan Amendment	Retained or delegated?
The PIHP shall ensure independent and unbiased examination of all persons who meet the eligibility criteria for the 1915(i) and submit to MDHHS reviewed and approved assessments and evaluations.	☒ Retained by MSHN Review and submission to MDHHS for approval ☒ Delegated to local CMHs CMHSP local responsibility to determine eligibility.
The PIHP shall ensure that the determination of continuing eligibility is completed and reviewed for and submitted to the Michigan Department of Health and Human Services (MDHHS).	☒ Retained by MSHN Review and submission to MDHHS for approval ☒ Delegated to local CMHs Formal review of the individual plan of service no less than annually
The PIHP shall oversee and assure that services are provided in amount, scope, and duration as specified in the approved plan.	☐Retained by MSHN ☒ Delegated to local CMHs
Children's Waiver	Retained or delegated?

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Commented [TL105]: This has been delayed due to the pandemic per MDHHS. I anticipate it will be implemented and so, I think can keep the retained box checked.

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The PIHP shall identify children who meet the eligibility criteria for the Children's Waiver Program and submit to MDHHS prescreens for those children.	☐ Retained by MSHN Review and submission to MDHHS for approval ☒ Delegated to local CMHs CMHSP local responsibility to determine eligibility.
The PIHP shall carry out administrative and operational functions delegated by MDHHS to the PIHP as specified in the CMS approved C-waiver application. These delegated functions include: level of care determination; review of participant service plans; prior authorization of waiver services; utilization management; qualified provider enrollment; quality assurance and quality improvement activities.	☐ Retained by MSHN ☒ Delegated to local CMHs with oversight and monitoring by PIHP
The PIHP shall review and approve the appropriate Category of Care/Intensity of Care and the amount of publicly funded hourly care for each Children's Waiver Program recipient per the Medicaid Provider Manual.	☒ Retained by MSHN Review and submission to MDHHS for approval ☐ Delegated to local CMHs
The PIHP shall oversee and assure that services are provided in amount, scope, and duration as specified in the approved plan. The PIHP shall assure via oversight that CWP services will not be provided for CWP enrolled beneficiaries who reside in an institutional setting, including a Psychiatric Hospital, CCI, or are incarcerated for an entire month.	☐Retained by MSHN ☒ Delegated to local CMHs
Serious Emotional Disturbance Waiver	Retained or delegated?
PIHP shall assess eligibility for the SEDW and submit applications to the MDHHS for those children the PIHP determines are eligible.	☒ Retained by MSHN Review and submission to MDHHS for approval ☒ Delegated to local CMHs CMHSP local responsibility to determine eligibility.
The PIHP shall carry out administrative and operational functions delegated by MDHHS to the PIHP as specified in the CMS approved C-waiver application. These delegated functions include: level of care determination; review of participant service plans; prior authorization of waiver services; utilization management; qualified provider enrollment; quality assurance and quality improvement activities.	☐Retained by MSHN ☒ Delegated to local CMHs with oversight and monitoring by PIHP

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The PIHP shall oversee and assure that services are provided in amount, scope, and duration as specified in the approved plan. PIHPs must assure sufficient service capacity to meet the needs of SEDW recipients. The PIHP shall assure via oversight that SEDW services will not be provided for SEDW enrolled beneficiaries who reside in an institutional setting, including a Psychiatric Hospital, CCI, or are incarcerated for an entire month.	☐Retained by MSHN ☒ Delegated to local CMHs with oversight and monitoring by PIHP
Ensure that local agreements with County local MDHHS offices are developed that outline roles and responsibilities regarding the MDHHS SEDW Child Welfare Project. Participate in required SEDW Child Welfare Project State/Local technical assistance meetings and trainings.	☐Retained by MSHN ☒ Delegated to local CMHs
Local MDHHS workers, PIHP SEDW Coordinator, CMHSP SEDW Leads and Wraparound Supervisors identify a specific referral process for children identified as potentially eligible for the SEDW. Participate in required SEDW Child Welfare Project State/Local technical assistance meetings and trainings. Collect and report to MDHHS all data as requested by MDHHS.	☒ Retained by MSHN Aggregation and Reporting to MDHHS ☒ Delegated to local CMHs Collection and reporting to the PIHP *PIHP Lead to participate in referral process, meetings and trainings. *CMHSP Leads to participate in referral process, meetings and trainings.

Commented [TL108]: Checked the retained box due to this. PIHP is signing off on the CMH determination that without the waiver, the child would otherwise be in an institution.

~~XIII.~~XII. **Compliance**

Compliance	Retained or delegated?

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Develop, ~~and~~ approve and implement MSHN's Corporate Compliance Plan and complete an effectiveness report on an annual basis	**X** Retained by MSHN ___Delegated to local CMHs
Adopt MSHN Compliance Plan or develop a Compliance Plan that is in compliance with MSHN Compliance Plan	Retained by MSHN _X__Delegated to local CMHs
MSHN Corporate Compliance Committee: • Review audit and monitoring results • Develop data mining activities and review results • Provide feedback related to compliance related activities • Provide feedback for MSHN Corporate Compliance Plan • Review and provide feedback for the annual Compliance Plan effectiveness report • Provide feedback on development of new Compliance related policies and procedures and complete annual review of current Compliance related policies and procedures	**X** Retained by MSHN ___Delegated to local CMHs
Participation in Regional Compliance Committee • Advising the MSHN Director of Customer Service, Compliance and Quality Improvement on matters related to compliance • Assist in the review of, and compliance with, contractual requirements related to program integrity and 42 CFR 438.608 • Assist in developing reporting procedures consistent with federal requirements • Assist in developing data reports consistent with contractual requirements • Assisting with the review, implementation, operation, and distribution of the MSHN Compliance Plan • Reviewing and updating, as necessary, MSHN policies and procedures related to compliance • Evaluating the effectiveness of the Compliance Plan • Determining the appropriate strategy/approach to promote compliance and detect potential violations and areas of risk as well as areas of focus • Recommending and monitoring the development of internal systems and controls to carry out the Compliance Plan and supporting policies as part of daily operations. • Reviewing compliance related audit results and corrective action plans, making recommendations when appropriate. • Assisting in development and implementation of compliance related trainings.	Retained by MSHN _X__Delegated to local CMHs
Implementation of Compliance Monitoring activities outlined within the MSHN Corporate Compliance Plan and MSHN Compliance Procedures to comply with applicable laws, regulations and program requirements.	___ Retained by MSHN X Delegated to local CMHs

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	*Conducted by CMHSPs with oversight from PIHP.
Submission of quarterly Office of Inspector General activity report to the PIHP	Retained by MSHN _X__Delegated to local CMHs
Submission of quarterly Office of Inspector General activity report to the Office of Inspector General by the PIHP	**X** Retained by MSHN ___Delegated to local CMHs
Completion of local level compliance related investigations reported directly to the CMHSP, at the direction of the PIHP or as a result of an Office of Inspector General referral	Retained by MSHN _X_Delegated to local CMHs
Completion of PIHP level compliance related investigations reported directly to the PIHP or as a result of an Office of Inspector General referral	X Retained by MSHN __Delegated to local CMHs

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EXHIBIT B

MEDICAID FUNDING EXHIBIT

EXHIBIT WILL BE SENT OUT AS A SEPARATE ATTACHMENT

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EXHIBIT C
DISCLOSURE OF OWNERSHIP & CONTROLLING INTEREST STATEMENT

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

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

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

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

Provider/Provider Entity Information

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

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

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

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Section I: Individual Provider Ownership Information

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

See instructions for more information and examples

If yes, list the name, primary address, date of birth (DOB), and Social Security Number (SSN) for each person having an Ownership Interest in the Individual Provider of 5% or greater. List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having an Ownership Interest of 5% or greater. (42 CFR §455.104(b)(1)(i)).

Attach additional sheets as necessary - ☐ Yes ☐ No

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

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

Section II: Ownership in Other Providers & Entities

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

If yes, list the name and the SSN or TIN of the other provider or entity in which the *Owner identified in Section I* also has an Ownership or Controlling Interest (42 CFR §455.104(b)(3)). Attach additional sheets as necessary - ☐Yes ☐ No

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

Section III: Subcontractor Ownership

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

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

If yes, list the following information for each person or entity with an Ownership or Controlling Interest in any Subcontractor in which you *also have* Direct or Indirect Ownership Interest of 5% or more (42 CFR §455.104(b)(1)(iii)). Attach additional sheets as necessary - ☐Yes ☐ No

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

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Section IV: Familial Relationships of All Owners

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

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

Name of Owner 1	Name of Owner 2	Relationship

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

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

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

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

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

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

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

7. Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity ever been **terminated** from participation in Medicaid, Medicare, CHIP or a Title XX program? ☐Yes ☐ *No-Skip to #8* ☐ *N/A-Skip to #8*

If yes, list those person and the requirement information below. (42 CFR §455.106(1)(2) and 455.416). Attach additional sheets as necessary - ☐Yes ☐ No

Name:	**DOB:**
Address:	**SSN (indiv.) or TIN (entity):**
City, State, Zip:	**Terminated from Medicare?** ☐Yes ☐ No
Reason for Termination:	**Date of Termination:**
State that originated Termination:	**Date of Reinstatement:**

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

Section VI: Business Transaction Information

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

8. **Business Transactions – Subcontractors:** Has the Provider Entity had any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) month period? ☐Yes ☐ *No-Skip to #9* ☐ *N/A-Skip to #9* **If yes,** list the information for Subcontractors with whom the Provider Entity has had business transactions totaling more than $25,000 during the previous 12 month period ending on the date of this request (42 CFR §455.105(b)(1)) Attaching additional sheets as necessary - ☐Yes ☐ No	
Name of Subcontractor:	**Subcontractor's SSN or TIN:**
Subcontractor Address:	**City, State, Zip:**
Subcontractors Owner (SO):	**SO's SSN or TIN:**
SO's Address:	**City, State, Zip:**
9. **Significant Business Transactions – Wholly Owned Suppliers:** Has the Provider Entity had any Significant Business Transactions with a Wholly Owned Supplier exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period? ☐Yes ☐ *No-Skip to #10* ☐ *N/A-Skip to #10* **If yes,** list the information for any Wholly Owned Supplier with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past 5-year period (43 CFR §455.105(b)(2)). Attach additional sheets as necessary - ☐Yes ☐ No *See Glossary for definition.*	
Name of Supplier:	**Suppliers SSN or TIN:**
Suppliers Address:	**City, State, Zip:**
10. **Significant Business Transactions – Subcontractors:** Has the Provider Entity had any Significant Business Transactions with a Subcontractor totaling more than $25,000 in the past five (5) year period? ☐Yes ☐ *No-Skip to #11* ☐ *N/A-Skip to #11* **If yes,** list the information for Subcontractors with whom the Provider Entity had any Significant Business Transactions exceeding the $25,000 during the past 5-year period (42 CFR §455.105(b)(2)). Attach additional sheets as necessary - ☐Yes ☐ No	
Name of Subcontractor:	**Subcontractor's SSN or TIN:**
Subcontractor Address:	**City, State, Zip:**
Subcontractors Owner (SO):	**SO's SSN or TIN:**
SO's Address:	**City, State, Zip:**

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

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Section VII: Management and Control

11. **Managing Employees:** Does the Provider Entity have any Managing Employees?
☐Yes ☐ *No-Skip to #12* ☐ *N/A-Skip to #12*
If yes, list all Managing Employees that exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operations of Provider Entity (general manager, business manager, administrator or director), including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104(b)(4). Attach additional sheets as necessary - ☐Yes ☐ No

Name	DOB mm/dd/yyyy	Complete Address	SSN	Title

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

Name	DOB mm/dd/yyyy	Complete Address	SSN

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

Signature_____ Title_____

Print Name_____ Date_____

_____ _____ _____
Phone Number Fax Number Email Address

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Disclosure Instructions

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

Section I: Provider Entity Ownership Information

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

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

Section II: Ownership in Other Providers & Entities

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

Section III: Subcontractor Ownership

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

Section IV: Familial Relationships of All Owners

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

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

List your own criminal convictions, sanctions, exclusions, debarments, and termination, *and* for any person who has an ownership or controlling interest, or is an agent or managing employee of your entity. List all offenses related to each person's or entity's involvement in any program under Medicare, Medicaid, CHIP, or the Title XX services since the inception of these programs. Review all of the databases necessary to verify this information:

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

Section VI: Business Transaction Information

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

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

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

Section VII: Management & Control

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

Glossary

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

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

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

Determination of ownership or control percentages:

a) *Indirect ownership interest*. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to 4 percent indirect ownership interest in the disclosing entity and need not be reported.

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

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

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

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

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

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

a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
b) Any Medicare intermediary or carrier; and

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c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

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

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

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

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

Subcontractor: means;

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

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

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

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EXHIBIT D
BUSINESS ASSOCIATE AGREEMENT

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

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

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

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

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

1. Definitions.

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

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

(i) For purposes of this definition, compromises the security or privacy of the protected health information means poses a significant risk of financial, reputational, or other harm to the individual.

(ii) A use or disclosure of protected health information that does not include the identifiers listed at 45 CFR 164.514(e)(2), date of birth, and

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zip code does not compromise the security or privacy of the protected health information.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Rights and Obligations of Business Associate.

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

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

c. Safeguards. Business Associate shall use appropriate and reasonable safeguards to prevent use or disclosure of PHI other than as provided for by this Addendum. To the extent applicable, Business Associate shall comply with the Security Rule's administrative, technical and safeguard requirements. In addition, to the extent applicable, Business Associate shall implement Administrative Safeguards, Physical Safeguards, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI

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that it creates, receives, maintains, or transmits on behalf of Covered Entity and shall maintain and implement reasonable policies and procedures that prevent, detect, contain and correct security violations of ePHI. Risk analysis is a requirement in § 164.308(a)(1)(ii)(A). Conducting a risk analysis is the first step in identifying and implementing safeguards that comply with and carry out the standards and implementation specifications in the Security Rule. Business Associate shall attest to conducting an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the Business Associate. Business Associate shall make its policies, procedures and documentation required by the Security Rule relating to the Safeguards available to the Secretary for the purpose of determining Covered Entity's compliance with the Security Rule.

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

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

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

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

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

i. Documentation and Accounting of Disclosures. To the extent applicable,

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

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

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

3. Obligations of Covered Entity.

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

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

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

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

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

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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 subcontractor, to whom it provides PHI agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

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

4. Term and Termination.

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

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

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

d. Effect of Termination.

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

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

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

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

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

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

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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.

MID-STATE HEALTH NETWORK

By: Date: ~~9.2.20~~

Its: Chief Executive Officer

«NAME_OF_ORGANIZATION»~~**BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY**~~

By: Date:

Its: Chief Executive Officer

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EXHIBIT E
MSHN Minimum CMHSP Training Requirements

NOTE: FY2~~1~~24 Training Grid Will be included in formal draft sent out for signatures following MSHN BOD Approval

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EXHIBIT F

Commented [KJ113]: DPNM/Dep. Dir./CEO

MEDICAID SUBCONTRACT CERTIFICATION FORM

On behalf of «Name of Organization»~~BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY~~, the undersigned certifies that:

1. The CMHSP has adopted policies and procedures that are in substantial compliance with those specified and required by:
   a. the PIHP – CMHSP Medicaid Sub-contract
   b. the 2013 Application for Participation (AFP) for Specialty Prepaid Inpatient Health Plans
   c. the most current contract between the CMHSP and Michigan Department of Health and Human Services

2. With regard to the 2013 Application for Participation the CMSHP further certifies that in accordance with the AFP, it is in full compliance with AFP 5.3.1.5 - A regional plan to establish partnerships with local housing agencies and housing providers. The goal of these collaborations should be to develop interagency strategies that increase affordable, community-based, integrated housing options for people with disabilities that meet their preferences and needs.

3. The CMHSP shall ensure its participation in the development of School-to-Community transition services as defined in the PIHP Medicaid Managed Specialty Supports & Services contract (Attachment P7.10.4.1; School to Community Transition Planning).

4. The CMHSP shall ensure they are within the established guidelines and requirements for completing Supports Intensity Scale (SIS) Assessments as specified by the MDHHS and the target completion date relative to the end date of the appropriate three-year cycle (FY18 is the start of a new three-year cycle).

5. The CMHSP shall utilize MDHHS-required standardized assessment tools, including the Level Of Care Utilization System (LOCUS), Supports Intensity Scale (SIS), Child and Adolescent Functional Assessment Scale (CAFAS)/Preschool and Early Childhood Functional Assessment Scale (PECFAS) as described in the MDHHS/PIHP Contract effective October 1.

5. The CMHSP will, upon request, furnish documentation evidencing accreditation by one of the following accrediting bodies as requested (check one):
   ☐ CARF ☐ Joint Commission ☐ URAC ☐ COA ☐ Other:_____
   Status of accreditation (check one): ☐Full-accreditation expiring_____
   ☐Other: _____

6. The CMHSP will work with the PIHP to develop and implement processes related to out-of-compliance, heightened scrutiny, and provisional status providers to ensure compliance and participation with the state's transition plan for the Home and Community Based Setting requirements, as described in the MDHHS PIHP ~~FY2021~~ Contract ~~Part I Section 18.1.13~~ (HCBS Rule Transition Implementation).

Commented [KJ114]: J. Obermesik 8.20.21: p. 79 – #6 should the date 2021 should be changed to 2022? If yes, any way to rephrase to not have to change the date annually?

Commented [KJ115R114]: 8.23.21: Re-phrased to indicate non-FY reference

7. The CMHSP agrees to support the PIHP in pursuing, achieving and maintaining compliance with the following MDHHS expectations: The PIHP shall manage its responsibilities in a manner that promotes maximum value, efficiency and effectiveness consistent with state and federal statute and applicable waiver standards. These values include limiting managed care administrative duplication thereby reducing avoidable costs while maximizing the medical loss ratio. The PIHP shall actively manage behavioral health services throughout its service area using standardized methods and measures for determination of need and appropriate delivery of service. The PIHP shall ensure that cost variances in services are supported by quantifiable measures of need to ensure accountability,

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value and efficiency. The PIHP shall minimize duplication of contracts and reviews for providers contracting with multiple CMHSPs in a region.

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

The person signing this Certification is duly authorized to sign on behalf of «Name_of_Organization»~~BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY~~.

_____ _____
Executive Director Date

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EXHIBIT G

Commented [KJ116]: ALL - PLEASE UPDATE AS NECESSARY (Dates; e-mails; report name)
Verify and update dates as needed

FINANCIAL AND NON-FINANCIAL REPORT DUE DATES FOR FY221		
FINANCIAL REPORTS		
REPORT NAME	**DUE TO MSHN**	**SUBMIT TO**
MID-YEAR STATUS REPORT OCTOBER 1 - MARCH 31	5/17/2021~~2021~~2022	leslie.thomas@midstatehealthnetwork.org & amy.keinath@midstatehealthnetwork.org
PROJECTION FINANCIAL STATUS REPORT BUNDLE OCTOBER 1 - SEPTEMBER 30	8/1/2021~~2021~~2022	leslie.thomas@midstatehealthnetwork.org & amy.keinath@midstatehealthnetwork.org
MEDICAID YEAR END ACCRUAL SCHEDULE OCTOBER 1 - SEPTEMBER 30	9/24/2021~~2021~~2022	leslie.thomas@midstatehealthnetwork.org & amy.keinath@midstatehealthnetwork.org
INTERIM FINANCIAL STATUS REPORT BUNDLE OCTOBER 1 - SEPTEMBER 30	10/27/2021~~2021~~2022	leslie.thomas@midstatehealthnetwork.org & amy.keinath@midstatehealthnetwork.org
FINAL FINANCIAL STATUS REPORT BUNDLE OCTOBER 1 - SEPTEMBER 30	2/14/2023~~2022~~2023	leslie.thomas@midstatehealthnetwork.org & amy.keinath@midstatehealthnetwork.org
ENCOUNTER QUALITY INITIATIVE REPORT		leslie.thomas@midstatehealthnetwork.org & amy.keinath@midstatehealthnetwork.org
OCTOBER 1 – JANUARY 31	5/16/2021~~2021~~2022	
OCTOBER 1- MAY 31	9/16/2021~~2021~~2022	
OCTOBER 1 – SEPTEMBER 30	2/14/2023~~2022~~2023	
~~**ADMINISTRATIVE COST REPORT**~~ ~~OCTOBER 1 TO SEPTEMBER 30~~	~~2/15/2022~~	~~leslie.thomas@midstatehealthnetwork.org & amy.keinath@midstatehealthnetwork.org~~
ANNUAL AUDIT REPORT, MANAGEMENT LETTER, AND CMHSP RESPONSE TO THE MANAGEMENT LETTER, COMPLIANCE EXAM AND PLAN OF CORRECTION.	30 days after receipt but no later than 6/30/2023~~2022~~2023	leslie.thomas@midstatehealthnetwork.org & amy.keinath@midstatehealthnetwork.org
EXHIBIT H OCTOBER 1 – SEPTEMBER 20	2/14/2023	leslie.thomas@midstatehealthnetwork.org & amy.keinath@midstatehealthnetwork.org
NON-FINANCIAL REPORTS		

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COPYRIGHT NOTIFICATION FOR APPROVAL BY MSHN	30 DAYS PRIOR TO REGISTERING COPYRIGHT	amanda.ittner@midstatehealthnetwork.org
ANNUAL LITIGATION REPORT	10/31/20210	kim.zimmerman@midstatehealthnetwork.org
24/7/365 ACCESS	Submitted with FSR	Leslie.Thomas@midstatehealthnetwork.org
CRITICAL INCIDENTS	Submitted within the required time frames based on event type.m30 -60 days following the end of the month in which the event occurred. eveeeeeonthly (data is due by the last Friday of the month)	REMI Webservice Affiliate Submission Contact: sandy.gettel@midstatehealthnetwork.org
Sentinel Event Reporting	Quarterly	Box Submission Contact: sandy.gettel@midstatehealthnetwork.c
OCTOBER 1 – DECEMBER 31	3/31/20221	sandy.gettel@midstatehealthnetwork.org
JANUARY 1 – MARCH 30	6/30/2022	sandy.gettel@midstatehealthnetwork.org
APRIL 1 – JUNE 30	9/30/2022	sandy.gettel@midstatehealthnetwork.org
JULY 1 - SEPTEMBER 30	12/31/2022	sandy.gettel@midstatehealthnetwork.org
ADMINISTRATIVE PERSONNEL CHANGES IN SENIOR MGM (CEO, MEDICAL DIRECTOR)	NOTIFY MSHN WITHIN 7 DAYS OF CHANGE	amanda.ittner@midstatehealthnetwork.org
NOTICE OF PROGRAM CLOSING	PRIOR TO 60 DAYS OF CLOSING	amanda.ittner@midstatehealthnetwork.org
BEHAVIOR TREATMENT REVIEW	Quarterly	**Box Submission** Contact:Contact: sandy.gettel@midstatehealthnetwork.org
OCTOBER 1 – DECEMBER 31	1/31/2022	
JANUARY 1 – MARCH 30	4/30/2022	
APRIL 1 – JUNE 30	7/31/2022	
JULY 1 - SEPTEMBER 30	10/31/20212	

Commented [KJ117]: Added per 3.10.21 DPNM e-mail

Commented [CT118]: Kyle – please have Sandy update

Commented [SG119R118]: There are no changes related to the CMHSPs for sentinel event reporting.

Commented [SG120R118]: Done

Commented [KJ121]: J. Obermesik 8.20.21: p. 82 – The dates under Sentinel Event Reporting need to be updated?

Commented [SG122R121]: Done

Commented [DD123]: Should their be a contact here?

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PROGRAM INTEGRITY ACTIVITY REPORTS (due quarterly)		kim.zimmerman@midstatehealthnetwork.org
OCTOBER 1 – DECEMBER 31	1/15/2022~~1~~	
JANUARY 1 – MARCH 30	4/15/2022~~1~~	
APRIL 1 – JUNE 30	7/15/2022~~1~~	
JULY 1 - SEPTEMBER 30	10/15/2022~~1~~	
MEDICAID FAIR HEARINGS		dan.dedloff@midstatehealthnetwork.org
APRIL 1 - SEPTEMBER 30	12/31/2021~~0~~	
OCTOBER 1 - MARCH 31	7/31/2022~~1~~	
RECIPIENT RIGHTS REPORT		dan.dedloff@midstatehealthnetwork.org
APRIL 1 - SEPTEMBER 30	12/15/2021~~0~~	
OCTOBER 1 - MARCH 31	6/15/2022~~1~~	
~~APPEALS/GRIEVANCES/SECOND OPINION~~MDHHS MEMBER GRIEVANCES REPORTING		**Box Submission** Contact: dan.dedloff@midstatehealthnetwork.org
~~JULY 1 - SEPTEMBER 30~~FY21 Q4	~~12/31/2020~~11/1/2021	
~~OCTOBER 1 – DECEMBER 31~~FY22 Q1	~~3/31/2021~~2/1/2022	
~~JANUARY 1 – MARCH 30~~FY22 Q2	~~6/30/2021~~5/2/2022	
~~APRIL 1 – JUNE 30~~FY22 Q3	~~9/30/2021~~8/1/2022	
MDHHS MEMBER APPEALS REPORTING		**Box Submission** Contact: dan.dedloff@midstatehealthnetwork.org
FY21 Q4	11/1/2021	
FY22 Q1	2/1/2022	
FY22 Q2	5/2/2022	
FY22 Q3	8/1/2022	
MDHHS SERVICE AUTHORIZATION REPORTING		**Box Submission** Contact: Skye.Pletcher@midstatehealthnetwork.org
FY21 Q4	11/1/2021	
FY22 Q1	2/1/2022	
FY22 Q2	5/2/2022	
FY22 Q3	8/1/2022	

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CONSUMER SATISFACTION RAW DATA	86/05630/20224	**Box Submission** Contact: dan.dedloff@midstatehealthnetwork.org sandy.gettel@midstatehealthnetwork.org
MISSION BASED PERFORMANCE INDICATOR SYSTEM	Quarterly	REMI Webservice Affiliate Submission Contact: sandy.gettel@midstatehealthnetwork.org
OCTOBER 1 - DECEMBER 31	3/15/20224	
JANUARY 1 - MARCH 31	6/15/20224	
APRIL 1 - JUNE 30	9/15/20224	
JULY 1 - SEPTEMBER 30	12/15/20242	
PROVIDER CREDENTIALING ACTIVITY REPORT	Semi-Annually	**Box Submission** https://mshn.app.box.com/folder/140716047 Contact: TBD
Q1, Q2, Q3 Activities	8/1/2022	
Q1, Q2, Q3, Q4 Activities	11/1/2022	

Commented [SG124]: These dates were modified through QIC since the review of the draft contract. Can this be noted to ensure there is an awareness.

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EXHIBIT H

Commented [KJ125]: UM/DPNM/Dep. Dir./CEO

TECHNICAL REQUIREMENT

CMHSP RESPONSIBILITIES FOR 24/7/365 ACCESS FOR INDIVIDUALS WITH PRIMARY SUBSTANCE USE DISORDERS

This technical requirement is an attachment to the contract by and between Mid-State Health Network (MSHN) and its affiliated Community Mental Health Services Programs (CMHSP's) beginning in Fiscal Year 2016.

MSHN is responsible for ensuring continual access for individuals with behavioral health needs, including individuals whose primary concern is related to a substance use issue or disorder. CMHSP's have traditionally provided these services to individuals in need of mental health or developmental disability supports. The Substance Use Disorder (SUD) Treatment System has traditionally provided business hours access to the SUD service array. Effective October 1, 2015, the CMHSP access system will be *another* portal of entry for individuals with a primary SUD concern.

MSHN and its CMHSP participants intend that all persons who interact with the Access Systems in the region be screened, as clinically appropriate, for (serious) mental health issues, intellectual disabilities, severe emotional disturbances and/or substance use disorders and that the Access System arrange for services that meet all of the needs of the individuals who come into contact with it.

In its contract with the Michigan Department of Health and Human Services, MSHN is required to operate a regional 24-hour access system for all target populations. Our goal for the regional access system for SUD is not a "single point of entry" system; rather a multi-portal access system – a "no wrong door" approach, now expanded to include 24/7/365 access for individuals with a primary SUD concern.

MSHN has designated CMHSP participants as an entity through which 24/7/365 access for individuals with a substance use concern or disorder will occur, and this document is intended to delineate, without prescribing local implementation options, the associated performance requirements. It is important to note the CMHSP's role includes initial/provisional screening using ASAM (American Society of Addiction Medicine) criteria, referral and follow-up, but does not include seeking or providing authorizations for care. It is the receiving service provider's role to fully assess the individual, provide required interim/ongoing services to members of priority populations, develop plans of service, deliver care and request and manage authorizations for that care.

MSHN has provided financial resources to assist the CMHSP's with infrastructure and service delivery costs associated with carrying out the responsibilities identified in this Technical Requirement, including, but not necessarily limited to:

1) Access, Emergency Services and Referral System Infrastructure and Services.
    a. Collaboration with and participation in local coalitions to determine local community needs, promote health, provide early intervention services and to engage with the community in the prevention of behavioral health problems, including substance use and abuse conditions. (Note: SUD- specific prevention activities require a license

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issued by the State of Michigan. MSHN purchases licensed prevention activities for communities under a specific prevention provider services contract).

2) Customer Services and Recipient Rights costs associated with these expanded responsibilities.
3) Administrative costs resulting from the implementation of these responsibilities.

ACCESS SYSTEM PERFORMANCE REQUIREMENTS[1]:

Priority Populations: There are presently five sub-populations of individuals experiencing a substance use disorder that are priority for admission. Special requirements exist for these priority populations and it is incumbent upon the CMHSP access system and the receiving provider to work together to meet the service priority expectations detailed in the attached Access Management System Policy (page 8).

- Pregnant Injecting Drug User
- Pregnant
- Injecting Drug User
- Parent(s) at Risk of Losing Their Child(ren) Due to Substance Use
- Individual Under Supervision of MDOC and Referred by MDOC or Individual Being Released Directly from an MDOC Without Supervision and Referred by MDOC
- All Others

All Encounters Include:

- Identification of individual as a member of priority population
- ASAM level of care matches the circumstances of the individual at the time of the interaction
- Strengths-based, warm, welcoming, promoting engagement
- Gather demographic information and document in appropriate system
- Document in appropriate system
- Identify provider preferences & facilitate consumer choice

1) Provide to all eligible individuals a welcoming access experience, demonstrating recognition of the strength of the individual asking for help, empathy, and providing an opportunity for the person presenting to describe the situation, problems, functioning difficulties and other aspects of their need for service while exhibiting excellent customer service skills and non-judgmental assistance.
2) Provide individuals who approach the access system, on a 24/7/365 basis, the opportunity to receive timely and appropriate crisis intervention services.
3) Provide individuals who approach the access system, on a 24/7/365 basis, the opportunity to learn about and understand the available service options and how to access them.
4) Provide a professional screening to the individual approaching the access system and make an initial/provisional eligibility and level of care determination;
5) Provide a short-term plan for supporting the individual and linking them directly (warm handoff) to services and/or supports for which they have been screened to be eligible. A "warm handoff" is intended to mean:

[1] Adapted from PIHP and CMHSP Access System Standards, February 2014

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a) Making a direct connection by the CMHSP access system with the SUD service provider that the individual chooses, if possible while the individual requesting service is still on the telephone (or present, in the case of walk-ins); AND
b) Documenting the presenting problem and service need impressions, in the form of an SUD screening AND an indication to the person requesting services that the receiving SUD provider will call them to follow-up on the next business day.
c) Referring individuals screened as appropriate for care to the appropriate care provider; make direct linkages whenever possible.
d) Facilitating the admission of individuals seeking SUD services and take steps necessary to protect and promote the health and safety of all individuals coming into contact with the access system. In particular, individuals needing facilitation and admission to withdrawal management (detoxification) services will be expedited.

6) Document, in REMI, the required demographics and other data essential to decision making and reporting; clinical/functional information obtained in the service/screening process, to ensure the receiving provider has complete information to act upon in picking up services to the individual referred.
7) Follow-up with the program, or if necessary, the individuals who make contact with the access system within two business days to ensure service needs have been met and to re-engage if the referral connections have not been made.
8) Provide initial support and response to customer complaints, including rights complaints and grievances. (CMHSP customer service and/or recipient rights staff are responsible for receiving, providing an initial response to, and documenting complaints and/or grievances from persons served through the access system. The overwhelming majority of concerns should be responded to and resolved at the point of contact with the complainant. Those that cannot be effectively resolved should be documented and forwarded to the designated Recipient Rights Advisor (if the CMHSP is a licensed program) or the Regional Rights Advisor for review, investigation, and resolution. Local CMHSP Customer Service or Recipient Rights personnel may be asked to participate in this process).

COMMUNITY COLLABORATION AND IMPLEMENTATION REQUIREMENTS

1) Establish, enhance, or expand relationships between the CMHSP and the SUD provider system within the service area of the CMHSP so that:
   a. SUD service provider phone systems either link directly to the CMHSP access system during non-business hours or their automated response systems instruct callers to contact the CMHSP access system during non-business hours.
   b. The CMHSP and SUD service providers establish a written after-hours protocol for handling referrals during non-business hours.
   c. Local first responder systems (i.e., police, sheriff, jail, emergency medical, etc.), hospitals and other potential referral sources are informed of the availability of after-hours availability of access services for individuals in need of substance use-related supports and services.

2) Engage in community coalitions and other substance use disorder prevention collaboratives by:

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a. Identifying and assigning responsibility for one or more CMHSP-employed individuals to perform this function;
b. Identify opportunities where existing mental health prevention efforts can be expanded to integrate and/or support primary SUD prevention;
c. With MSHN support general community education and awareness related to behavioral health prevention, access and treatment including outreach (Note that a regional goal is to increase the number of persons served, with emphasis on SUD and persons with HMP).

MSHN will conduct performance monitoring in conjunction with its normal delegated managed care site review activities.

Reporting template (CMHSP RESPONSIBILTY FOR 24/7/365 ACCESS FOR INDIVIDUALS WITH PRIMARY SUD – EXHIBIT H) sent as a separate attachment with this agreement.

Commented [KJ126]: Added per 3.10.21 DPNM e-mail

Commented [CT127R126]: Thanks~

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