Fiscal Year 2018~~8~~9 Substance Use Disorder - Treatment
Contractual Agreement

Between

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

And

«PROVIDER»
(as a "Subrecipient" as that term is defined in OMB 2 CFR 200 Subpart A; CFDA #: 93.959~~Circular A-133 §.210~~)

For the purpose of:

Treatment

Payment by:
«CONTRACT_TYPE»

TABLE OF CONTENTS

ACRONYM AND GLOSSARY DEFINITIONS

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

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

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

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

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

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

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

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

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~~**and/or "Case Management"** means facilitating access to services, community and natural supports to ensure~~

~~consumer needs are met.~~

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

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

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

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

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

Co-Occurring Disorders are concurrent substance-related and mental health disorders. Use of the term carries no implication as to which disorder is primary and which secondary, which disorder occurred first, or whether one disorder caused the other.
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~~**"Continuum of Care"** is an integrated network of treatment services and modalities, designed so that an individual's changing needs will be met as that individual moves through the treatment and recovery process.~~

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

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

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

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

"Covered Services" means the medically necessary behavioral health service as amended from time to time in accordance with this Agreement, and which PROVIDER is qualified and responsible for providing to covered consumer, in accordance with MSHN policies and procedures in return for payments by the MSHN under this Agreement and listed on Attachment B.

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

Discharge Summary is the written summary of the client's treatment episode. The elements of a discharge summary include description of the treatment received, its duration, a rating scale of the clinician's perception of investment by the client, a client self-rating score, description of the treatment and non-treatment goals attained while the client was in treatment, and detail those goals not accomplished with a brief statement as to why.

Discharge/Transfer Criteria is when, in the process of treatment, certain problems and priorities indicate a different level of care, a different provider, or discharge from treatment may be necessary. The level of functioning and clinical severity of a client's status in each of the six ASAM dimensions is considered in determining the need for discharge or transfer.

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

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

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

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

Encounter is used for billing purposes related to treatment services, recovery support, and early intervention services to indicate a measure of time spent providing a service with a consumer. A minimum of fifteen (15) minutes must be spent with a consumer in order to use this code.

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

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

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

"Episode of Care" is the period of service between the beginning of a treatment service for a drug or alcohol problem and the termination of services for the prescribed treatment plan. The first event in this episode is an admission and the last event is a discharge. Any change in service and/or provider during a treatment episode should be reported as a discharge, with transfer given as the reason for termination. If the change of service or change in level of care occurs at the same provider under the same LARA license number, then a discharge does not need to be completed until the consumer is completely discharged from all services being provided under that LARA license number. For reporting purposes, "completion of treatment" is defined as completion of all planned treatment for the current treatment episode.

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

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

"**FSR**" means Financial Status Report

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

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

MDHHS refers to the Michigan Department of Health and Human Services (MDHHS).
"**MDHHS**" means the Michigan Department of Health and Humans Services.

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

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

1. Client is experiencing a Substance Use Disorder reflected in a primary, validated, DSM5 or ICD-10 Diagnosis (not including V Codes) that is identified as eligible for services in the MSHN Provider Contract.
2. A reasonable expectation that the client's presenting symptoms, condition, or level of functioning will improve through treatment.

3. The treatment is safe and effective according to nationally accepted standard clinical evidence generally recognized by substance use disorder or mental health professionals.
4. It is the most appropriate and cost-effective level of care that can safely be provided for the client's immediate condition based on The ASAM Criteria, 3rd Edition.

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

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

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

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

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

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

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

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

"**Rate Schedule**" means the schedule of charges for Covered Services attached hereto as Attachment "HCPCS/CPT Service Code Grid – Substance Use Disorder Services" and including any amendments thereto.

Recovery means a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. SAMHSA states Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations.
~~**"Recovery"** means a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. SAMHSA states Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations.~~
REMI stands for the Regional Electronic Medical Information (REMI) system. REMI is the web-based managed care information system used by MSHN implemented on February 1, 2018. REMI replaced CareNet for collection of state and federal data elements, PIHP performance indicators, utilization management (authorization of services), and reimbursement.

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

ROSC refers to Recovery Oriented System of Care which describes a paradigm shift from an acute model of treatment to a care model that views SUD as a chronic illness. A ROSC is a coordinated network of community-based services and supports that is person-centered and builds over a period of months and/or years on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

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

~~**"ROSC"** means Recovery Oriented System of Care.~~

~~"~~**SPF**~~"~~ means Strategic Prevention Framework.

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

- Pre-contemplation: "People are not intending to take action to change behaviors in the foreseeable future, are most likely unaware that their behavior is problematic, and are not considering change at this stage."
- Contemplation: "People have become aware that a problem exists, may be beginning to recognize that their behavior is problematic and that they should be concerned, start to look at the pros and cons of their continued actions, but are typically ambivalent about their use and changing their behavior."
- Preparation: "People understand the negative consequences of continued behavior outweigh any perceived benefits, are intending to take action in the immediate future, may begin specific planning for change, setting goals, and making a commitment to take small steps towards change."
- Action: "People have chosen a strategy for change and are actively pursuing it by making specific, overt, and drastic modifications in their life style (significant challenges for the person), and positive change has occurred."
- Maintenance: "People are working to sustain positive change, prevent relapse, become aware of situations that will trigger negative behavior, and actively avoid those when possible" a stage which can last indefinitely."

~~"~~**Subrecipient**~~"~~ means an entity that expends awards received from a pass-through entity to carry out a project. As defined by Office of Management and Budget (OMB) 2 Code of Federal Regulations (CFR) 200 Subpart A~~OMB Circular A-133~~, a subrecipient relationship exists when funding from a pass-through entity is provided to perform a portion of the scope of work or objectives of the pass-through entity's award agreement with the awarding agency. A pass-through entity is an entity that provides an award to a subrecipient to carry out a project. For purposes of this agreement, "subrecipient" refers to the SUD Treatment Service provider named on this agreement, whereas ~~as~~ "pass-through entity" refers to MSHN. See OMB 2 CFR 200 Subpart A~~OMB Circular A-133~~ for further information.

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

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

Transfer is the movement of the client from one level of service to another or from one provider to another within the continuum of care.

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

Urgent cases are those clients screened for substance use disorder services (i.e. pregnant women) and must be offered treatment within 24 hours.

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

~~**"Transfer"** is the movement of the client from one level of service to another, within the continuum of care.~~

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

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

FY 20189 CONTRACTUAL AGREEMENT

This Agreement is entered into by Mid-State Health Network (hereinafter referred to as "MSHN") and «PROVIDER», as the subrecipient as defined in OMB 2 CFR 200 Subpart A~~Circular A-133~~ (hereinafter referred to as "PROVIDER") and is effective from October 1, 201~~7~~8, through September 30, 201~~8~~9.

I. GENERAL CONTRACT SUMMARY

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

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

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

~~Abstinence-Based (AB) Providers – In the interest of consumer choice, MSHN will contract with Abstinence-Based providers who offer written policies and procedures stating the following:~~

~~i. If a prospective client, at the point of access, expresses his/her preference for an abstinence-based treatment approach, the access worker will obtain a signed "MSHN Informed Consent" form that attests that the client was informed in an objective and non-judgmental way about other treatment options including MAT, and the client is choosing an abstinence-based provider from an informed perspective.~~
~~When a client already on MAT (or considering MAT) is seeking treatment services (counseling, case management, recovery supports, and/or transitional housing) at the point of access to an AB facility, access staff a) will be accepting and non-judgmental towards MAT as a choice, b) will not pressure the client to make a different choice, and c) will work with that client to do a "warm handoff" to another provider who can provide those ancillary services while the client pursues his or her chosen recovery pathway that includes MAT.~~

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

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

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

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

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

Additional Attachments: PROVIDER is required to comply with language in all attachments to this contract as they apply.

Attachment A Statement of Work
Attachment B ~~-~~Cost Reimbursement
Attachment C Performance Indicators
Attachment D Business Associate Agreement
Attachment ~~E –~~ Disclosure of Ownership & Controlling Interest Statement~~HCPCS/CPT Service Code Grid – Substance Use Disorder Services~~
~~Attachment F-~~ Reporting Requirements for MSHN SUD Providers FY 201~~8~~9
Attachment - HCPCS/CPT Service Code Grid – Substance Use Disorder Services (Sent as a separate attachment)

II. TREATMENT SERVICE OBLIGATIONS OF THE PROVIDER

A. General Provisions
~~A.~~

Authorization: MSHN shall not make any payment for PROVIDER services rendered to persons who are not eligible for services; for services to eligible consumers which are, in the opinion of MSHN, determined not to be Medically Necessary; services that constitute optional care; or services that have not been properly authorized by MSHN through its Utilization Management (UM) Department. ~~With the exception of situations as defined in the **MSHN-SUDSP Manual**., PROVIDER shall obtain specific authorization from the UM Department prior to providing Covered Services to an eligible consumer.~~ Each UM Department authorization for Covered Services shall expire upon the earlier of (i) expiration date specified in the authorization and/or **MSHN-SUDSP Manual.** ~~and~~ (ii) termination of this Agreement. Authorization requests shall be based on clinical eligibility and medical necessity as defined in the MSHN-SUDSP MANUAL~~**MSHN-SUDSP Manual.**~~ MSHN obligation to pay any claim shall be subject to MSHN verification of a consumer's status as a Member or financial eligibility at the time the service was rendered. If the consumer did not meet eligibility criteria and is not a Medicaid or Healthy Michigan Plan covered consumer at the time the service was delivered, the PROVIDER may bill the consumer for the service. In no case shall a Medicaid or Healthy Michigan Plan covered consumer be billed for any service or for any portion of a service. The PROVIDER must use ~~CareNet~~REMI's ~~assessment tool~~ brief screening and level of care determination ~~-~~as part of the initial ~~-~~determination of eligibility for services at the beginning of a treatment episode. ~~assessment of eligible consumers entering a treatment episode~~. ~~Please see the **MSHN-SUDSP Manual.** for applicable policies and/or procedures.~~

1.
2. **Access to Service:** MSHN, in partnership with its SUDSP network and Community Mental

Health Service Provider (CMHSP) network, maintains a regional multi-portal 24/7/365 access system for SUD services. ~~MSHN does not maintain a centralized access center~~; PROVIDER shall ensure that all consumers are able to receive services in accordance with the access standards (Attachment P4.1.1 "Access Standards" of PIHP/MDHHS contract) set forth by the Michigan Department of Health and Humans Services (MDHHS) and the MDHHS Office of Recovery Oriented Systems of Care (OROSC) Treatment Policy #7- Access Management System. PROVIDER is also required to utilize the brief screening and Level of Care Determination in REMI to document access and referral activities. Requirements of PROVIDER pertaining to after-hours access include:

i. PROVIDER phone systems link directly to the CMHSP access system during non-business hours or their automated response systems instruct callers to contact the CMHSP access system during non-business hours.

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

~~1.~~

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

3.

~~3.~~4. **Admission Preference:** Persons presenting with Medicaid or Healthy Michigan Plan (HMP) are entitled to medically necessary SUD services. Preference for treatment admission shall be applied in the following order (from highest priority to lowest): (i) pregnant injecting drug users; (ii) pregnant substance abusers; (iii) injecting drug users; (iv) a parent whose child has been removed from the home under the Child Protection Laws of this State or is in danger of being removed from the home under the Child Protection Laws of this State because of the parent's substance use; and (v) all others. Consumers identified in i, ii, iii and iv above are prioritized regardless of county of residence within the MSHN region. In the State of Michigan, an injecting drug user is defined as anyone who has injected a drug within the last thirty (30) days.

~~4.~~ **Interim Services:** Interim services must be provided as defined by the MDHHS Office of Recovery Oriented Systems of Care (OROSC) Treatment Policy #7- Access Management System. ~~Access System Standards.~~

5.

~~5.~~6. **Waiting List:** Outpatient, Residential and ~~Detox~~Withdrawal M~~m~~anagement PROVIDER should notify the UM Department immediately when they have to implement a waiting list and when the waiting list has ended. Persons with Medicaid or HMP eligibility may not be put on a waiting list. If necessary residential and ~~detox~~withdrawal management services are not available to a Medicaid or HMP eligible recipient, other appropriate service options must be made available.

~~6.~~ **Residency ~~Determination~~**: The P~~rovider~~ROVIDER may not limit access to the programs and services funded by this portion of the Agreement only to the residents of the P~~rovider~~'ROVIDERS~~s~~ region, because the funds provided by the Department under this Agreement come from federal and statewide resources. Members of federal and state-identified priority populations must be given access to screening and to assessment and

treatment services, consistent with the requirements of this portion of the Agreement, regardless of their residency. However, for non-priority populations, ~~the PIHP~~MSHN may give its residents priority in obtaining services funded under this portion of the Agreement when the actual demand for services by residents eligible for services under this portion of the Agreement exceeds the capacity of the agencies funded under this portion of the Agreement.~~In order to determine residency, PROVIDER shall request any one of the following documents for verification (the document must include a current or updated regional address):~~

7. **Gambling Disorder Screening, Assessment, and Referral:** Outpatient and Residential providers shall administer the 3-question NODS-CLiP Gambling Disorder screen to consumers upon admission. Results of the NODS-CLiP screen must be documented and made available to MSHN in a format to be provided by MSHN. PROVIDER shall administer the 10-question NODS-SA assessment upon affirmative response to any one of the three questions on the NODS-CLiP. The assessment outcome must be documented and made available to MSHN in a format to be provided by MSHN with either a "rule out" of gambling disorder or a diagnosis of gambling disorder (hereinafter referred to as "GD").

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

   PROVIDERS will be reimbursed $5.00 for each NODS-CLiP screen administered and $10.00 for NODS-SA assessment administered, regardless of rule out or diagnosis.

~~7.~~
~~8. State Driver's License~~
~~9. State ID Card~~
~~10. Voter Registration Card~~
~~11. Utility bill in the consumer's name~~
~~12. Medicaid County of Eligibility~~
~~13.~~
~~14. If the consumer cannot produce any of these documents, PROVIDER must have the consumer sign an attestation stating the consumer is either homeless or is living in MSHN region temporarily with a plan to move to the region permanently. The attestation can be an added sentence(s) in the case file on a form where the consumer(s) provide signature(s) or it can be a separate document.~~
~~15.~~
~~16. In cases where the consumer has Medicaid, or HMP, the consumer must have their county status update/changed within 30-60 days. In cases where the consumer is eligible for block grant funding, the consumer must provide documentation that action has been taken to establish residency within 30-60 days. Documentation of all relevant paperwork and actions taken by both consumer and/or provider should be maintained in the case file.~~
~~17.~~
~~18. Considerations for exceptions to this policy shall be reviewed on a case-by-case basis.~~

B. Billing Provisions

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

services. Additional information is contained within the MSHN-SUDSP MANUAL~~MSHN-SUDSP MANUAL~~.

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

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

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

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

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

NOTE: If a consumer is receiving residential treatment services, PROVIDER shall not bill MSHN for days the consumer was not in residence during the treatment episode.~~, with the exception that any time in which a consumer is not present during the residential treatment episode, additional approval by appropriate MSHN UM department staff is required.~~ If circumstances require the individual to leave the residential treatment facility for more than 24 hours (ie: brief hospitalization) but the individual is expected to return to the residential facility to resume treatment, the provider should notify the MSHN UM department of the reason for the gap in service.

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

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

6. **Duplicate Coverage**: PROVIDER will collect information concerning duplicate coverage, workers' compensation and personal injury liability at the time of treatment or admission and will provide such information to MSHN. In the event that benefits available through MSHN are determined to be secondary to those of any other health care coverage with respect to Covered Services, PROVIDER shall seek reimbursement pursuant to such other coverage prior to submitting a claim to MSHN. Any secondary payment shall be determined in accordance with applicable terms of MSHN policies and procedures and Medicaid Plan in effect for each consumer, taking into account amounts billed to and that portion paid by the primary payor ~~payor~~. PROVIDER shall cooperate in administering coordination of benefits and other third party reimbursement provisions. PROVIDER agrees to accept the lesser of the primary allowable or MSHN contracted amount as payment in full for a covered service or activity if MSHN is the secondary coverage for any combination of payor~~payor~~s, including other carriers which pay before MSHN in the coordination of benefits order of benefit determination. Reference the MSHN-SUDSP MANUAL~~MSHN-SUDSP MANUAL~~ for applicable policies and/or procedures.

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

8. **Obligations to Continue Care:** In the event of any termination of this Agreement (by reason of insolvency or otherwise), PROVIDER agrees that it shall continue providing services to consumers receiving treatment until implementing and completing an approved transition plan which may include referral to another appropriate service or an orderly discharge. The PROVIDER shall then relinquish all relevant clinical documents, billing information for each

recipient, all medications and personal property of recipients and any equipment purchased with the MSHN funds that has not been fully depreciated. This provision shall not prohibit collection from consumers of appropriate amounts with respect to deductible amounts, co-payments, co-insurance and/or non-cCovered sServices, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, in accordance with the terms of the applicable consumer's Subscriber Agreement. The provisions of this Agreement shall remain in effect until the transition plan has been fully executed.

C. Other Provisions

1. **Quality Assurance:** PROVIDER shall cooperate with MSHN and participate in and comply with all peer review program, utilization review, quality assurance and/or total quality management programs, audit systems, site visits, grievance procedures, satisfaction surveys and other procedures as established from time to time by MSHN, or as required by regulatory or accreditation agencies. PROVIDER shall be bound by and comply with all final determinations rendered by each such peer review or grievance process. PROVIDER acknowledges and agrees that MSHN may also obtain site review findings and reports regarding the Provider from other PIHPs or CMHSPs, and ~~the~~ ~~Payor~~MSHN may utilize such information in the exercise of its rights under this Agreement. MSHN retains the right to seek additional information or take further actions following the Provider site review, including, without limitation, conducting follow up site reviews.

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

PROVIDER acknowledges and agrees MSHN or any representative agent shall have the right to review and inspect records related to credentialing activities maintained by PROVIDER relative to its staff and contracted personnel/agencies. To the extent permitted by law, PROVIDER shall make such records available to MSHN or any representative agent and any governmental agency without charge to MSHN. Further, in regards to and in accordance with MSHN's Credentialing policies/procedures and practices, the PROVIDER hereby acknowledges and agrees that MSHN or its designee may share its credentialing information, site review findings and written report with other PIHPs or CMHSPs, upon request and as determined by MSHN, and any written response from the Provider. Notwithstanding anything to the contrary contained in this Agreement, PROVIDER agrees that MSHN may also obtain credentialing information, site review findings and reports regarding the Provider from other PIHPs or CMHSPs, and MSHN may utilize such information in the exercise of its rights under this Agreement.

P~~P~~ROVIDER shall not assign a consumer to any practitioner who has not fully complied with credentialing process as outlined in the MDHHS Credentialing and Re-credentialing Process (Attachment P7.1.1), the Substance Abuse Disorder Policy Manual – Credentialing and Staff Qualification Requirements, and MSHN Credentialing/Recredentialing policies and procedures.

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

~~PROVIDER acknowledges and agrees MSHN or any representative agent shall have the right to review and inspect records related to credentialing activities maintained by PROVIDER relative to its staff and contracted personnel/agencies. To the extent permitted by law, PROVIDER shall make such records available to MSHN or any representative agent and any governmental agency without charge to MSHN. Reference the MSHN-SUDSP MANUAL for applicable policies and/or procedures. Further, in regards to and in accordance with MSHN's Credentialing policies/procedures and practices, the PROVIDER hereby acknowledges and agrees that MSHN or its designee may share its credentialing information, site review findings and written report with other PIHPs or CMHSPs, upon request and as determined by MSHN, and any written response from the Provider. Notwithstanding anything to the contrary contained in this Agreement, PROVIDER agrees that MSHN may also obtain credentialing information, site review findings and reports regarding the Provider from other PIHPs or CMHSPs, and MSHN may utilize such information in the exercise of its rights under this Agreement.~~

~~3.~~2. ~~**Medicaid**~~ **Fair Hearing**: Medicaid consumers who request or receive ~~alternative~~ services that are paid for with Medicaid funds per Michigan's approved use of Section (a)(1)(A) of the Social Security Act ~~do not~~ have the right to a ~~Medicaid~~ Fair Hearing. They also have the right to a local ~~dispute~~ appeal ~~resolution~~ process~~es~~ when ~~alternative~~ services are denied, reduced, suspended or terminated.

~~4.~~3. **Covered Services:** PROVIDER represents and warrants to MSHN that Covered Services shall be provided to all consumers in an appropriate, timely, and cost effective manner. Further, PROVIDER represents and warrants to MSHN that PROVIDER shall furnish such services according to applicable medical, mental health and substance use disorder practices, national standards and applicable laws and regulations.

~~5.~~4. **Covered Consumers**: PROVIDER reserves the right to provide professional services to consumers other than covered consumers, however, they will not solicit, request, or require any covered consumer, as a condition of receiving medical services, to dis-enroll from the Plan or MSHN and become a private consumer of PROVIDER or enroll in any fee-for-service health benefit plan or other health benefit plan in which PROVIDER participates.

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

5.

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

8. **Health and Safety:** Covered consumers shall be subject to immediate transfer to another participating PROVIDER and this Agreement shall be subject to immediate termination, in

the event that MSHN determines that a covered consumer's health or safety is in immediate jeopardy.

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

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

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

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

11.

~~12.~~ **Financial Review:** The PROVIDER must submit, no later than six (6) months following the close of the provider's fiscal year, an independent financial audit conducted by a Certified Public Accounting (CPA) firm. ~~Reference the MSHN SUDSP Manual. for applicable policies and/or procedures.~~

12.

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

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

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

operate and/or to provide Medicaid programs and supports/services within the State of Michigan.

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

- A health care professional solely on the basis of license, registration or certification;
- A health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.

1. **16. ASAM LOC Requirements ~~for SUD Contractors~~:** MSHN shall enter into agreements for SUD treatment providers who have completed the MDHHS Level of Care Designation Questionnaire and received a formal designation for the LOC that is being offered. MSHN shall enter into a contract for ~~these two~~those services only after the provider has received a state designation. The LOC designation must be renewed, every two years.~~SUD treatment with organizations that provide services based on the American Society of Addiction Medicine (ASAM) Level of Care (LOC) only.~~ This requirement is for community grant and all Medicaid/Healthy Michigan Plan funded services.

   The provision of SUD treatment services must be based on the ASAM LOC criteria. To ensure compliance with and fidelity to ASAM, MSHN shall ensure that policies and practices of annually reviewing their provider network include the following:
   - On-site review of the program, policies, practices and clinical records.
   - A reporting process back to MDHHS on the compliance with the purported LOC for each provider, including any corrective action that may have been taken and documentation that indicates all LOCs are available in the region.
   - Ensuring review documentation is available for MDHHS during biannual PIHP site visits for comparison with MDHHS provider reviews.

~~2. MSHN must ensure that to the extent licensing allows, all of the following LOCs are available for adult and adolescent populations:~~

~~Level of Care~~	~~ASAM Title~~
~~0.5~~	~~Early Intervention~~
~~1~~	~~Outpatient Services~~
~~2.1~~	~~Intensive Outpatient Services~~
~~2.5~~	~~Partial Hospitalization Services~~
~~3.1~~	~~Clinically Managed Low Intensity Residential Services~~
~~3.3*~~	~~Clinically Managed Population Specific High Intensity Residential Services~~
~~3.5~~	~~Clinically Managed High Intensity Residential Services~~
~~3.7~~	~~Medically Monitored Intensive Inpatient Services~~
~~OTP Level 1**~~	~~Opioid Treatment Program~~

1-WM	Ambulatory Withdrawal Management without Extended On-Site Monitoring
2-WM	Ambulatory Withdrawal Management with Extended On-Site Monitoring
3.2-WM	Clinically Managed Residential Withdrawal Management
3.7-WM	Medically Monitored Inpatient Withdrawal Management

* Not designated for adolescent populations **Adolescent treatment per federal guidelines

It is further required that all SUD treatment providers complete the MDHHS Level of Care Designation Questionnaire and receive a formal designation for the LOC that is being offered. MSHN shall enter into a contract for these two services only after the provider has received a state designation. The LOC designation must be renewed, every two years.

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

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

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

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

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

20. **Compliance with the MDHHS/PIHP Contract:**
It is expressly understood and agreed by the parties hereto that this Agreement is subject to the terms and conditions of the MDHHS/PIHP Contract. The Provider shall comply with any applicable terms or conditions of such contract. The MDHHS Contract is incorporated by reference to this Contract, and by such incorporation, is made part of this Contract. Amendments to the MDHHS Contract are also terms of this Contract. The provisions of this Agreement shall be applicable unless a conflict exists between this Agreement and the provisions of the MDHHS/PIHP Contract. In the event that any provision of this Agreement is in conflict with the terms and conditions of the MDHHS/PIHP Contract, the provisions of said MDHHS/PIHP Contract shall prevail. However, a conflict shall not be deemed to exist where this Agreement:

(1.) contains non-conflicting additional provisions and additional terms and conditions not set forth in the MDHHS Contracts;
(2.) restates provisions of the MDHHS/PIHP Contract to afford the PayorMSHN 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 PayorMSHN in the MDHHS/PIHP Contract.

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

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

22. **Program Compliance:** PROVIDER shall implement and maintain a compliance and program integrity plan that is designed to guard against fraud and abuse in accordance with federal and state law, including but not limited to 42 CFR 438.608 and as included in the MDHHS/PIHP Master Agreement.
    a. The Compliance Plan must include, at a minimum, all of the following elements:
        1) Written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards, including but not limited to the False Claims Act (31 USC 3729-3733, the elimination of fraud and abuse in Medicaid provisions of the Deficit Reduction Act of 2005; and the Michigan Medicaid False Claims Act (PA 72 of 1977, as amended by PA 337 of 2005) and the Michigan Whistleblowers Protection Act (PA 469 of 1980).
        2) Clearly defined practices that provide for prevention, detection, investigation and remediation of any compliance related matters.
        3) The designation of a compliance officer and a compliance committee that are accountable to senior management;
        4) Effective training and education for the compliance officer and the organization's employees;
        5) Effective lines of communication between the compliance officer and the organization's employees;
        6) Enforcement of standards through well publicized disciplinary guidelines;
        7) Provision for internal monitoring and reporting;
        8) Provision for prompt response to detected offenses, and for development of corrective action initiatives.
        9) Submission to MSHN of quarterly reports detailing program integrity activities. Program Integrity activities include but are not limited to:
            – Tips/grievances received
            – Data mining and analysis of paid claims, including audits performed based on the results
            – Audits performed
            – Overpayments collected
            – Identification and investigation of fraud, waste and abuse (as these terms are defined in Section 33.0 Program Integrity of the MDHHS/PIHP Master Agreement)
            – Corrective action plans implemented
            – Provider dis-enrollments
        ~~8)~~ – Contract terminations
    b. Upon request, PROVIDER will furnish a copy of the compliance plan to MSHN.
    c. PROVIDER agrees to report immediately to the MSHN Compliance Officer any suspicion or knowledge of fraud or abuse, including if possible, the nature of the complaint, the name of the individuals or entity involved in the suspected fraud and abuse, including name, address, phone number, Medicaid identification number and/or any other

identifying information. The PROVIDER agrees not to investigate or resolve the alleged fraud and/or abuse and agrees to fully cooperate with any investigation by MSHN, its payers and/or the MDHHS or Office of the Attorney General and with any subsequent legal action that may arise from such investigation.

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

III. General Provisions for MSHN

A. Payment Timelines:

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

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

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

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

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

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

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

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

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

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

C. Accessibility: PROVIDER shall ensure that all consumers are able to receive services in accordance to the access standards (Attachment P4.1.1 "Access Standards" of PIHP/MDHHS contract) set forth by the Michigan Department of Health and Humans Services (MDHHS). PROVIDER also ensures services are delivered in a manner that takes into consideration the consumer's ethnicity, cultural differences, language proficiency, communication abilities, and physical limitations. PROVIDER is responsible for procuring any necessary supports or accommodations that are required by the consumer. ~~in order to ensure they can meaningfully participate in their own treatment, such as but not limited to language interpretation services or other assistive communication devices.~~ PROVIDER shall maintain adequate facilities and sufficient personnel to provide consumers with timely access to Covered Services. PROVIDER agrees to notify MSHN of any material additions, reductions or elimination of services as soon as possible. ~~Reference the MSHN-SUDSP Manual for applicable policies and/or procedures.~~

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

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

E.

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

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

Manual for applicable policies and/or procedures.

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

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

H.

PROVIDER is responsible for assisting any non-insured or under-insured consumer with Medicaid/HMP eligibility application within 30-days of admission (or within 30-days of loss of coverage). Block grant eligibility shall be determined at the time of admission to services. Financial information needed to determine ongoing ability to pay (financial responsibility) must be reviewed annually or at a change in an individual's financial status, whichever occurs sooner. on a month-to-month basis, on-going monthly verification of coverage must be documented in the consumer's file.

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

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

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

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

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

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

V. Medicaid Responsibilities of MSHN

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

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

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

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

VI. CONTRACTUAL PROVISIONS

A. General Responsibilities of the PROVIDER

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

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

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

3. **Notification of Modification**: The Director of the PROVIDER agency shall ensure at least 60 days notification to the MSHN, in writing, of any action by its governing board or any other funding source, which would require or result in significant modification in the provision of services or funding or compliance with the terms and conditions of this contract, its attachments and referenced documents., ~~including the MSHN-SUDSP Manual.~~

4. **Notices to MSHN:** PROVIDER shall notify MSHN within ten (10) business days of any of the following events: (i) of any civil, criminal, or other action brought against it for any reason or any finding of any licensing/regulatory body or accrediting body, the results of which suspend, revokes, or in any way limits PROVIDER authority to render Covered Services: (ii) of any actual or threatened loss, suspension, restriction or revocation of PROVIDER license or ability to fulfill its obligations under this agreement; (iii) of any

malpractice action filed against PROVIDER; (iv) of any charge or finding or ethical or professional misconduct by PROVIDER; (v) of any loss of PROVIDER professional liability insurance or any material change in PROVIDER liability insurance; (vi) of any material change in information provided to MSHN in the accompanying PROVIDER Network Application or in the Credentialing Information concerning any PROVIDER; (vii) any other event which limits PROVIDER ability to discharge its responsibilities under this Agreement professionally, promptly and with due care and skill or (viii) PROVIDER is excluded from participation with the Federal procurement programs or any healthcare program (including the Medicare and Medicaid Programs).

NOTIFICATION OF PROVIDER NETWORK CHANGES
The PROVIDER shall notify MSHN 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 MSHN determines to negatively affect recipient access to covered services may be grounds for sanctions (42 CFR 438.207(c)(3)).
~~4.~~

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

6. DDCAT & TIC: All SUD Treatment Providers under contract with MSHN shall complete the DDCAT (Dual Diagnosis Capability in Addiction Treatment) Assessment and the Trauma Informed Organizational Survey. Both documents shall be uploaded to Box, with supporting documentation for all items on the DDCAT uploaded to Box and labeled appropriately. All contracted SUD Treatment service providers shall set goals for improvement in both categories annually. All contracted SUD Providers are expected to meet criteria for dual diagnosis capability (co-occurring capability).

~~6.~~7. ~~All SUD Treatment Providers under contract with MSHN shall complete the DDCAT (Dual Diagnosis Capability in Addiction Treatment) Survey and the Trauma Informed Organizational Survey. Both documents and all required supporting documentation shall be uploaded to box. All contracted SUD Treatment service providers shall set goals for improvement when appropriate, and MSHN will review these goalsse tools annually to continue to set goals for improvement when appropriate.~~

B. Assurances of PROVIDER

1. **Compliance with Applicable Laws:** PROVIDER will comply with applicable Federal and State laws, guidelines, rules and regulations in carrying out the terms of this Agreement. In addition, all expenses must meet Office of Management and Budget (OMB) Circular 2 CFR 200 Subpart A~~E Cost Principles~~. PROVIDER will also comply with all applicable general administrative requirements such as grant/Agreement principles, and audit requirements, in carrying out the terms of this Agreement.

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

section may be regarded as a material breach of this contract.

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

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

3. **Debarment and Suspension:** By signing this agreement, assurance is hereby given to MSHN that PROVIDER will comply with Federal regulation 45 CFR Part 76 and certifies to the best of its knowledge and belief that it and its subcontractors:

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

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

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

1) Has not within a three-year period preceding this agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction, violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property.

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

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

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

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

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

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

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

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

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

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

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

~~j.~~i. **Notice requirements:** PROVIDER must notify MSHN CEO immediately if search

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

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

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

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

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

~~o.~~n. **Acceptance of Claims:**

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

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

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

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

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

5.

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

C. Block Grant Requirements

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

1. Pay for inpatient hospital services except under conditions specified in federal law
2. Make cash payments to intended recipients of services
3. Purchase or improve land, purchase, construct, or permanently improve and building or any other facility, or purchase major medical equipment

4. Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of funds
5. Provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs
6. Enforce state laws regarding the sale of tobacco products to individuals under the age of 18
7. Pay the salary of an individual as a rate in excess of Level I of the Federal Executive Schedule, or approximately $199,700

D. Termination

~~7.~~8. **By Either Party Without Cause**: This Agreement may be terminated by either party without regard to breach or other cause, and without liability by reason of such termination, upon sixty (60) days prior written notice to the other party.

~~8.~~9. **By Either Party for Breach:** This Agreement may be terminated on thirty (30) days prior written notice upon the failure of either party to carry out the terms and conditions of this Agreement, provided the alleged defaulting party is given notice of the alleged breach and fails to cure the default within the thirty (30) day period.

~~9.~~10. **By MSHN**: This Agreement may be terminated immediately without further liability on the part of MSHN, if PROVIDER or an official of PROVIDER or an owner is convicted of any activity in the above-referenced sections of this Agreement during the term of this Agreement or any extension thereof. This agreement may be terminated immediately by MSHN without further liability in the event of unavailability, reduction or loss of funding whatever the cause.

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

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

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

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

All liability to third parties, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities such as the provision of policy and

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

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

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

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

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

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

E. Continuation of Contractual Agreement

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

F. Liability Insurance

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

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

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

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

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

G. Resolution of Disputes

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

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

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

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

H. Special Conditions

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

   Medicaid/HMP: Sub-acute ~~detox~~withdrawal management~~ification~~ and residential treatment services may be provided to eligible consumers who reside in the PIHP region and request the services. Sub-acute ~~detox~~withdrawal management~~ification~~ may be authorized for up to three (3) days or more, if clinically appropriate. Residential services may be authorized for up to twenty-one (21) days or more if clinically appropriate.

2. **Accepted Proposal Applicability:** The proposal submitted by PROVIDER and accepted by MSHN describing the services and programs to be delivered under this agreement are contractual

obligations of the PROVIDER. The accepted proposal is incorporated into this agreement by reference and is a part hereof. Any expansions to the original proposal shall be submitted to MSHN for review and approval prior to implementation.

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

   MSHN-contracted SUD treatment providers are expected to adopt a MAT-inclusive treatment philosophy in which 1) the provider demonstrates willingness to serve all eligible treatment-seeking individuals, including those who are using MAT as part of their individual recovery plan at any stage of treatment or level of care, and without precondition or pressure to adopt an accelerated tapering schedule and/or a mandated period of abstinence, 2) the provider develops policies that prohibit disparaging, delegitimizing, and/or stigmatizing of MAT either with individual clients or in the public domain.
   Abstinence-Based (AB) Providers – In the interest of consumer choice, MSHN will contract with Abstinence-Based providers who offer written policies and procedures stating the following:
   i. If a prospective client, at the point of access, expresses his/her preference for an abstinence-based treatment approach, the access worker will obtain a signed "MSHN Informed Consent" form that attests that the client was informed in an objective and non-judgmental way about other treatment options including MAT, and the client is choosing an abstinence-based provider from an informed perspective. The informed consent must be initialed by the client to signify receipt and review of MSHN's Informational Grid on Recovery Pathways for Opioid Use Disorder (OUD).
   ii. When a client already on MAT (or considering MAT) is seeking treatment services (counseling, case management, recovery supports, and/or transitional housing) at the point of access to an AB facility, access staff a) will be accepting and non-judgmental towards MAT as a choice, b) will not pressure the client to make a different choice, and c) will work with that client to do a "warm handoff" to another provider who can provide those ancillary services while the client pursues his or her chosen recovery pathway that includes MAT.
   iii. Providers' policies will include language that prohibits delegitimizing, and/or stigmatizing of MAT (e.g. using either oral or written language that frames MAT as "substituting one addiction for another") either verbally with individual clients, in written materials for clients or for public consumption, or in the public domain.

I. Contract Remedies and Sanctions

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

a. Discussion with the PROVIDER to identify potential barriers to effective performance and to identify and implement mutually agreeable solutions to performance problems.
b. Require a plan of correction and specified status reports that become a contract performance expectation;
c. Pattern of non-compliance or lack of implementation of the correction action plan.
d. Prior to withholding payment as noted below, the MSHN will give sixty (60) day's notice to allow for a period of correction, except for occurrences of required reports not being submitted as indicated on Attachment "Reporting Requirements for MSHN SUD Providers FY 201~~8~~9."
e. The withholding of payment, in the event that the above noted items have not been successful, t~~T~~he withholding of payment shall be in accordance with MSHN Compliance:

Contract Compliance Procedure ~~.~~ and/or (as applicable) the Quality: Delinquency Procedure for SUD Providers. Measures may include:

i. For sanctions related to required reporting compliance issues, as indicated on Attachment "Reporting Requirements for MSHN SUD Providers FY2019," other reporting requests with due date(s), and/or requested information with due date(s), MSHN may delay scheduled payment to the PROVIDER if not submitted on time as indicated on Attachment "Reporting Requirements for MSHN SUD Providers FY 2019", other reporting requests with due date(s), and/or requested information with due date(s), until such time as compliance is achieved. (NOTE: MSHN may apply this sanction in a subsequent payment cycle should the required reports, as indicated on Attachment "Reporting Requirements for MSHN SUD Providers FY 2019," other reporting requests with due date(s), and/or requested information with due date(s), not be submitted as required).

~~i.~~ii. ~~For sanctions related to required reporting compliance issues, as indicated on Attachment "Reporting Requirements for MSHN SUD Providers FY 2018," MSHN may delay or withhold up to a maximum 25% of the scheduled total payment to the PROVIDER if required report(s) are not submitted on time as indicated on Attachment "Reporting Requirements for MSHN SUD Providers FY 2018" until such time as compliance is achieved. (NOTE: MSHN may apply this sanction in a subsequent payment cycle should the required reports, as indicated on Attachment "Reporting Requirements for MSHN SUD Providers FY 2018," not be submitted as required).~~

~~ii.~~iii. For sanctions related to all other contract non-compliance issues, MSHN may delay ~~up to 25% of~~ the scheduled payment to the PROVIDER until after compliance is achieved. MSHN may add time to the delay on subsequent uses of this provision. (NOTE: MSHN may apply this sanction in a subsequent payment cycle and will give prior written notice to the PROVIDER)

f. Reduction in the PROVIDER authorization/budget in the amount directly related to the MSHN loss of funds due to non-compliance.
g. Recoupment of monies from disbursement;
h. Revocation or suspension of identified applicable delegated functions and/or authorizations until such time as the non-compliance issue(s) have been corrected;
i. Contract termination in instances of material breach, or where the identified steps above have not resolved the deficiency.

J. Special Certification

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

«PROVIDER»

By: _____

Its:

Printed Name:_____

Date:_____

MSHN

By: _____

Its: Chief Executive Officer

Printed Name:_Joseph Sedlock_____

Date: _____

Witness

By:_____

Its:_____

Printed Name:_____

Date:_____

Witness

By: _____

Its: MSHN Contract Manager

Printed Name:_Kyle Jaskulka_____

Date:_____

ATTACHMENT A: STATEMENT OF WORK

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

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

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

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

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

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

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

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

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

be submitted. PROVIDER must notify MSHN once the staff member has achieved

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

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

6. **Communicable Diseases:** **P.A. 368 requires that health professionals comply with specified reporting requirements for communicable diseases and other health indicators.** PROVIDER is required to ensure the confidentiality of identified HIV-positive consumers, and must have procedures and/or policies to ensure protection of the consumer's HIV status. PROVIDER must assure that all ~~prevention and~~ treatment staff attend communicable diseases trainings ~~as specified in the MSHN-SUDSP Manual~~. The Level One training can be found online. PROVIDER must assure all consumers entering residential treatment will be tested for TB upon admission and the test result is known within five (5) days of admission. High-risk TB consumers should be treated using Universal Precaution Practices until test results are known. Consumers who exhibit symptoms of active TB need to be given a surgical mask to wear and placed in respiratory isolation immediately. If respiratory isolation is not available, consumer should be moved to another location until test results are known.

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

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

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

10. **Care Coordination:** ~~A set of activities designed to ensure needed, appropriate and cost effective care for beneficiaries. As a component of overall care management, care coordination activities focus on ensuring timely information, communication, and collaboration across a care team and between Responsible Plans~~. Required expectations~~Major priorities~~ for care coordination in the context of a care management plan shall include, but not be limited to:

    a. Outreach and contacts/communication to support patient engagement,
    b. Conducting screening, record review and documentation as part of Evaluation and Assessment,
    c. Tracking and facilitating follow up on referrals and post discharge,
    d. Care Planning,
    e. Managing transitions of care activities to support continuity of care,
    f. Address social supports and making linkages to services addressing housing,

food, etc., and
g. Monitoring, Reporting and Documentation.

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

12.

~~10.~~13. **Consumer Satisfaction Surveys:** Treatment PROVIDER is required to participate in a Consumer Satisfaction Survey process ~~, as outlined in the MSHN-SUDSP Manual,~~ for all consumers funded by MSHN. MSHN will compile and publish survey results.

11. **Data Reporting Requirements:** PROVIDER must comply with data reporting requirements contained in the MSHN-SUDSP Manual and in this contract. The PROVIDER is responsible for submitting timely reports to ~~the~~ ~~PAYOR~~MSHN, and as may from time to time be required ~~by the PAYOR~~, to comply~~complying~~ with all reporting requirements as specified in the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s), the Healthy Michigan Program, the Flint 1115 Waiver and Substance Use Disorder Community Grant Programs Master Agreement between MSHN and MDHHS.~~Part II, Section 7.7.1 of the contract and the finance reporting requirements specified in Part II, Section 8.7. Additional requirements are identified in Attachment P 8.9.1 (Performance Objectives). (Reference Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver ProgramFY16 – Part II(B) Section 25.4; Attachment(s) P.7.7.1.1.; PII B.A. Substance Abuse Disorder Policy Manual; See SUD Services Policy Manual/Section I Data Requirements: Substance Abuse Encounter Reporting HCPCS and Revenue Codes Chart; Part II(B) Section).~~

~~10.~~11. **Cooperation with External Medicaid Evaluation:** PROVIDER is expected to cooperate with MSHN efforts in external evaluation of Medicaid services. PROVIDER will assure compliance with submission of necessary data and facilitate access to consumer's files and other records as required.

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

~~13.~~12. **Media Campaign:** PROVIDER shall not finance any media campaign using block grant funding without prior approval. Advertising about the availability of services within MSHN region is not considered a media campaign.

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

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

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

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

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

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

Regulations:

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

Attachment A, cont'd

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

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

20. **Discharge dates**: PROVIDER agrees to ensure that the actual last date of documented service in the chart is the date entered into all discharge records in ~~Carenet~~REMI. ~~Additional discharge information can be found in the MSHN-SUDSP Manual.~~

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

21. **Peer Recovery/Recovery Support Services**: The focus of Peer Recovery/Recovery Support services

are shifted from professional-assisted to peer-assisted in a less formal community setting. These services are provided primarily by individuals in recovery in order to help prevent relapse and to promote recovery.

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

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

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

Fetal Alcohol Spectrum Disorders (FASD): Treatment PROVIDER that serve women should have policies and procedures in place to (i) prescreen for potential FASD of all dependent children (ii) prescreen for potential FASD for all children with whom PROVIDER has contact, (iii) screen when appropriate and (iv) include FASD prevention into treatment regimen. PROVIDER must make FASD screening evaluations, when appropriate. MDHHS BSAAS Treatment Policy 11 requirements must be met in full. Charts should document individual FASD-related screens, referrals and services. It is recommended men be considered for these services as well, when appropriate.

23. **ROSC Participation:** MSHN will continue leading the journey of transformational system change to build a better, more Recovery Oriented Systems of Care (ROSC) in the region. This systems change will be inclusive and a long-term process that will entail changes not only for PROVIDER s of services and supports but for all parts of the system including fiscal, policy, regulatory and administrative strategies. MSHN wants to ensure that this process represents a broad range of stakeholder viewpoints.

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

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

local/county levels.

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

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

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

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

- Ensure Recipient Rights protections are provided to consumers, as defined by LARA, in accordance to the PROVIDER's LARA licensing requirements.
- Ensure there is a designated function for "Customer Services."
- Ensure Customer Services shall have staff to sufficiently meet the needs of the consumers engaged in services.
- Upon request, Customer Services staff shall assist beneficiaries with filing grievances and appeals, accessing local dispute resolution processes, and coordinate, as appropriate, with the Recipient Rights Advisor.
- The PROVIDER shall sufficiently displayed and provide to consumers how to contact Customer Services via phone and/or mail.
- Telephone calls to the Customer Services shall be answered by a live voice during business hours. Telephone menus are not acceptable.
- The hours Customer Services operates and the process for accessing information from Customer Services outside those hours shall be publicized.
- PROVIDERS must maintain Appeal and Grievance records with (at minimum) the following information and the recordkeeping must be accurately maintained in a manner accessible to MSHN and available upon request:
    - A general description of the reason for the appeal or grievance.
    - The date received.
    - The date of each review or, if applicable, review meeting.
    - Resolution at each level of the appeal or grievance if applicable.
    - Date of resolution at each level, if applicable.
    - Name of the covered person for whom the appeal or grievance was filed.

ATTACHMENT B: COST REIMBURSEMENT

FY 2018 FUNDING ALLOCATION SUMMARY
«PROVIDER»

Cost-Reimbursement

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

PROGRAM(S)	$$ AMOUNT
«CR_SERVICES»	$«TOTAL_FUNDING».00

TOTAL COST REIMBURSEMENT ALLOCATION
$«TOTAL_FUNDING».00

ATTACHMENT B.1: FEE FOR SERVICE
FY2018 Fee-For-Service Programs

Fee-For-Service

If applicable, programs identified under this section will be reimbursed based on the rate fee schedule listed in Attachment HCPCS/CPT Service Code Grid – Substance Use Disorder Services.

«FFS_SERVICES»

ATTACHMENT C: PERFORMANCE MEASURES~~INDICATORS~~

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

MEASURE

1) Consumers must be discharged from the ~~CareNet~~REMI system within 60 days of actual discharge (Outpatient PROVIDER's only) ~~or~~
REVIEWED: Quarterly

~~1)~~2) Consumers must be discharged from REMI system within 5 days of actual discharge (Residential/~~Detox~~Withdrawal M~~m~~anagement~~ification~~ PROVIDER's only)
REVIEWED: Quarterly

~~2)~~3) Consumers continuing in treatment in MSHN network must be discharged as a "transfer" in the ~~Carenet~~REMI system (Residential and ~~detox~~W~~w~~ithdrawal M~~m~~anagement PROVIDER's only)
REVIEWED: Monthly

~~3)~~4) PROVIDER must comply with ~~Medicaid~~ Michigan's Mission-Based Performance Indicator System (MMBPIS)~~s~~ (All Medicaid PROVIDER's)
REVIEWED: Quarterly

~~4)~~5) PROVIDER must submit all reports listed in this contract ~~and within the MSHN-SUDSP Manual~~ (and others as requested) in the timeframes identified. ~~-~~The PROVIDER is responsible for submitting timely reports to ~~the PAYOR~~MSHN, as may from time to time be required by ~~the PAYOR~~MSHN, complying with all reporting requirements as specified in Part II, Section 7.7.1 of the contract and the finance reporting requirements specified in Part II, Section 8.7. Additional requirements are identified in Attachment P 8.9.1 (Performance Objectives). (Reference Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver ProgramFY16 – Part II(B) Section 25.4; Attachment(s) P.7.7.1.1.; PII B.A. Substance Abuse Disorder Policy Manual; See SUD Services Policy Manual/Section I Data Requirements: Substance Abuse Encounter Reporting HCPCS and Revenue Codes Chart; Part II(B) Section). (All PROVIDER's)
REVIEWED: Quarterly

~~5)~~6) PROVIDER must maintain a consumer satisfaction process that demonstrates progress towards continual improvement and must adhere to MSHN's consumer satisfaction policy (All PROVIDER's)
REVIEWED: Annually

~~6)~~7) Discharges coded as "left against staff advice" (ASA) should not be greater than 15% of all discharges recorded in ~~CareNet~~REMI (All PROVIDER's)
REVIEWED: Quarterly

ATTACHMENT D:

HIPAA/HITECH BUSINESS ASSOCIATE AGREEMENT

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

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

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

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

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

1. Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Rights and Obligations of Business Associate.

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

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

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

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

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

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

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

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

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

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

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

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

3. Obligations of Covered Entity.

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

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

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

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

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

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

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

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

4. Term and Termination.

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

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

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

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

d. Effect of Termination.

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

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

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

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

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

ATTACHMENT E: DISCLOSURE OF OWNERSHIP & CONTROLLING INTEREST STATEMENT

Mid-State Health Network (MSHN) is required to collect disclosure of ownership, controlling interests, and management information from providers that are credentialed or otherwise enrolled to participate in the Medicaid program and/or the Pre-paid Inpatient Health Plan (PIHP). This 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 Concurrent 1915(b)(c) Wavier Program. Failure to submit the requests information may result in a refusal of participation in MSHN or denial of a claim.

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

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

Provider/Provider Entity Information

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

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

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

Section I: Individual Provider Ownership Information

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

See instructions for more information and examples

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

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

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

Section II: Ownership in Other Providers & Entities

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

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

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

Section III: Subcontractor Ownership

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

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

If yes, list the following information for each person or entity with an Ownership or Controlling Interest in any Subcontractor in which you *also have* Direct or Indirect Ownership Interest of 5% or more (42 CFR §455.104(b)(1)(iii)). Attach additional sheets as necessary - ☐ Yes ☐ No		
Legal Name of Subcontractor:		
Name of Subcontractors *Other Owner*:		*Other Owner's*:
Other Owner's Address:		City, State, Zip:
Other Owner's TIN:	*Other Owner's* SSN:	% Interest:

Section IV: Familial Relationships of All Owners

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

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

Name of Owner 1	Name of Owner 2	Relationship

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

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

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

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

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

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

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

7. Have you or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Individual Provider practice ever been sanctioned, excluded, or debarred from Medicaid, Medicare, CHIP or Title XX program? ☐ Yes ☐ *No-Skip to #7* ☐ *N/A-Skip to #7* **If yes,** list those persons and the required information below. (42 CFR §455.106(1)(2) and 455.436). Attach additional sheets as necessary - ☐ Yes ☐ No	
Name:	DOB:
Address:	SSN (indiv.) or TIN (entity):
City, State, Zip:	List all States where currently excluded:
Reason for Sanction, Exclusion, or Debarment:	
Date(s) of Sanctions, Exclusions, or Debarments:	Date of Reinstatement:

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

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

Section VI: Business Transaction Information

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

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

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

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

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

Section VII: Management and Control

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

Name	DOB mm/dd/yyyy	Complete Address	SSN	Title

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

Name	DOB mm/dd/yyyy	Complete Address	SSN

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

Signature _____ Title _____

Print Name _____ Date _____

Phone Number _____ Fax Number _____ Email Address _____

Disclosure Instructions

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

Section I: Provider Entity Ownership Information

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

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

Section II: Ownership in Other Providers & Entities

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

Section III: Subcontractor Ownership

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

Section IV: Familial Relationships of All Owners

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

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

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

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

Section VI: Business Transaction Information

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

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.

4.

Glossary

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

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

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

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

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

Determination of ownership or control percentages:

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

Exclusions:

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

1. The provider has been convicted of a relevant crime described under 42 USC 1320a-7(a)-7(b).

2. The provider's failure to comply with the enrollment requirements of the Social Welfare Act, Public Act 280 of 1939 (MCL 400.111b -111e) and the provider screening and enrollment requirements pursuant to 42 CFR 455.416. The basis for termination or denial of enrollment under this section includes, but is not limited to the provider's:
   - Failure to submit timely and accurate information;
   - Failure to cooperate with MDHHS screening methods;
   - Failure to submit sets of fingerprints as required within 30 days of a CMS or MDHHS request;
   - Failure to permit access to provider locations for site visits;
   - Falsification of information provided on the enrollment application;
   - Inability to verify a provider applicant's identity; or
   - Failure to comply with Medicaid policies regarding submission of claims and billing Medicaid beneficiaries.

3. The provider is excluded from participation in Medicare, Medicaid or any other Federal health care programs.

4. The provider is convicted of violating the Medicaid False Claims Act, the Health Care False Claims Act, or a substantially similar statute, or a similar statute by another state or the federal government.

5. The provider has a federal or state felony conviction within the preceding 10 years, including, but not limited to:

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

6. The provider has a federal or state misdemeanor conviction within the preceding 10 years, including, but not limited to:

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

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

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

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

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

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

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

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

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

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

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

Subcontractor: means;

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.