MSHN

Mid-State Health Network

REQUEST FOR PROPOSAL

For Substance Use Disorder (SUD) Recovery Housing Services

Issued Monday, December 23,2024

Proposals Are Due to MSHN Office No Later Than:

Friday February 7, 2025 at 5:00 p.m.

https://www.midstatehealthnetwork.org/

Contents

REQUEST FOR PROPOSAL

Issued By

Mid-State Health Network

Project Title:	Substance Use Disorder (SUD) Recovery Housing Services
RFP Issue Date:	Monday, December 23, 2024
Intent to Bid Due Date:	Friday, January 17, 2025 (5:00 p.m.)
Questions Due Date:	Monday, January 6, 2025 (5:00 p.m.)
MSHN Responses to Questions:	Monday, January13, 2025
Proposal Due Date:	Friday, February 7, 2025 (5:00 p.m.)
Contact Person:	Kyle Jaskulka, Contract Specialist
MSHN Website:	www.midstatehealthnetwork.org

Section I - GENERAL INFORMATION

I. Introduction

a. Mid-State Health Network, Prepaid Inpatient Health Plan (hereinafter referred to as "MSHN") manages public services for Substance Use Disorder (hereinafter referred to as "SUD") Services, in twenty-one counties designated by the Michigan Department of Health and Human Services as Region 5. The CMHSP Participants include Bay-Arenac Behavioral Health Authority, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network, Tuscola Behavioral Health Systems, Huron County Community Mental Health Authority, The Right Door for Hope, Recovery & Wellness, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, Saginaw County Community Mental Health Authority, and Shiawassee Health & Wellness. MSHN operates within this region to manage public services for SUD services under the provisions of Act 500 of the Michigan Public Acts of 2012, as amended. As such, MSHN's mission is to ensure access to high-quality, locally delivered, effective and accountable public behavioral health and substance use disorder services provided by its participating members. MSHN's mission statement can be found on MSHN's website.

II. Purpose

a. MSHN is committed to operating in a Recovery Oriented System of Care (ROSC). The network of services shall be comprised of a continuum of care for prevention, treatment, recovery, and harm reduction supports. A ROSC is a coordinated network of community-based services and supports that are person-centered, build on the strengths and resiliencies of individuals, families, and communities to improve health, wellness, and quality of life for those with substance use disorders, and are at risk.

b. This Request for Proposal (RFP) provides interested Providers with sufficient information to enable them to prepare and submit proposals for consideration by MSHN to satisfy its need for SUD Recovery Housing Services. MSHN is seeking sealed proposals from interested and qualified Providers that possess the capacity, infrastructure, and organizational competence to deliver to eligible individuals, SUD Recovery Housing Services as provided at an identified location within MSHN's 21 county region, specifically.

c. Recovery housing is defined by Substance Use, Gambling, and Epidemiology (SUGE, MDHHS) as "providing a location where individuals in early recovery from a behavioral health disorder are given time needed to rebuild their lives, while developing the necessary skills to embark on a life of recovery. This temporary arrangement will provide the individual with a safe and secure environment to begin the process of reintegration into society, and to build the necessary recovery capital to return to a more independent and functional life in the community. These residences provide varying degrees of support and structure. Participation is based on individual need and the ability to follow the requirements of the program." Recovery housing is expected to be a safe, structured, and substance free environment.

d. MSHN is specifically seeking new Providers to provide Recovery Housing Services across MSHN's 21 county region and/or a current PIHP Network Provider who is interested in expanding or re-locating to the identified region. MSHN reserves the right to prioritize proposals made for counties that currently have no recovery housing supports in place, such as Arenac, Bay, Clare, Clinton, Gladwin, Gratiot, Hillsdale, Huron, Ionia, Isabella, Jackson, Mecosta, Newaygo, Osceola, Shiawassee, and Tuscola.

e. It is expected that the proposal to provide these services shall follow all applicable State and Federal standards and guidelines, including but not limited to the MDHHS/PIHP Contract, MDHHS Medicaid Provider Manual, MDHHS Treatment Technical Advisory #7: Peer Recovery Support Services, MDHHS Treatment Technical Advisory #11: Recovery Housing, Michigan Continuing Education Requirements for Certified Peer Recovery Coaches, and National Alliance for Recovery Residences Standards.

III. Issuing Office

a. This RFP is issued by MSHN. The issuing office is the sole point of contact for this RFP. Information related to this RFP shall be posted on MSHN's website.

IV. Timeline

EVENT	FIRM DATE
RFP Issue Date	Monday, December 23, 2024
Intent to Bid Deadline	Friday, January 17, 2025(5:00 P.M.)
Question Submission Deadline	Monday, January 6, 2025 (5:00 P.M.)
MSHN Responses to Questions	Monday, January 13, 2025
RFP Submission Deadline	Friday, February 7, 2025 (5:00 P.M.)
Contract Award	On or after March 4, 2025
Contract Start Date	To Be Negotiated

V. Remote/Virtual Presentation

a. Providers who submit a proposal may be required to make a remote/virtual (Zoom or similar meeting platform) presentation of their proposal.

VI. Contract Award

a. It is anticipated that a contract shall be awarded on or after March 4, 2025. Providers who are awarded contracts shall not assign any duties or obligations under the contract without written permission of MSHN.

VII. Amendment

a. In the event it becomes necessary to revise any part of this RFP, information shall be posted on the MSHN website at the web address identified.

VIII. Withdrawal / Modification

a. Providers who submit a proposal may later request a withdrawal or modification in writing prior to the closing date and time specified therein. The written request shall be signed by an authorized representative of the Provider. If a previously submitted proposal is withdrawn before the proposal closing date and time, the Provider may submit another proposal at any time up to the proposal closing date and time. Bids/proposals may not be modified after the fixed closing date and time specified therein.

IX. Late Proposals

a. Late proposals, those submitted after the fixed closing date and time specified therein, shall not be accepted, or reviewed. Proposals submitted after the fixed closing date and time shall not be considered and shall be discarded. MSHN shall not be held responsible for technical difficulty or delivery complications that result in the bidding Provider being unable to meet the timeline

requirements specified herein.

X. Rejection of Proposals

MSHN reserves the right to reject any and/or all proposals received as a result of this RFP, or to negotiate separately with any source whatsoever in any manner necessary to serve the best interests of MSHN. This RFP has been developed for information and planning purposes only. MSHN reserves the right to re-solicit/re-advertise as MSHN deems necessary.

Section II - TERMS AND CONDITIONS

I. Incurring Costs

a. MSHN is not liable for any cost incurred by Providers prior to the issuance of a contract.

II. Proposal Disclosure

a. All information in the Provider's proposal is subject to the provisions of Public Act 442 of 1976, known as the Freedom of Information Act.

III. Funding Period

a. It is anticipated that any resulting offered contract shall begin on a date to be identified following the RFP Award process and shall be valid through September 30, 2025, contingent upon availability of funding from MDHHS. It is anticipated that contracts may be renewed annually (each fiscal year ending September 30) based on funding availability, Provider performance and MSHN satisfaction with Provider services.

IV. Conflict of Interest

a. Providers shall affirm that no principal, representative, agent or other person acting on behalf of or legally capable of acting on its behalf, is currently an employee of MSHN; nor is he/she privy to insider information which would tend to give, or give the appearance of tending to give, an unfair advantage to the Provider, which may constitute a conflict of interest.

b. Within the proposal response, all Providers shall disclose any known direct or indirect financial interests (including but not limited to ownership, investment, or any other form of remuneration) that may exist between the Provider, his/her potential subcontractors and MSHN.

c. Providers shall complete a Disclosure of Ownership, Controlling Interest, and Criminal Conviction (detail outlined in Required Narrative / Documents section of this RFP and *Attachment D*).

d. Provider shall complete and sign Certificate of Compliance with PA517 form (identified as *Attachment E* in this RFP).

e. Provider will be subject to the federal and State conflict of interest statutes and regulations that apply to the Contractor under a contract with MSHN, including Section 1902(a)(4)(C) and (D) of the Social Security Act: 41 U.S.C. Chapter 21 (formerly Section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. §423): 18rovidersS.C. §207)): 18 U.S.C. §208: 42 CFR §438.58: 45 CFR Part 92: 45 CFR Part 74: 1978 PA 566: and MCL 330.1222; 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. Provider assures, in addition to compliance with P.L. 103-227, any services or activity funded in whole or in part through MSHN 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.

g. 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, 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.

Provider will be subject to the federal Anti-Kickback and Stark Law restrictions (42 U.S.C. §1395 and 42 U.S.C. §1320)

V. Relationship of the Parties/Independent Contractor

a. The relationship between MSHN and any selected Provider is that of the Provider being an independent contractor for MSHN. No agent, employee, or servant of the Provider shall be deemed an employee, agent, or servant of MSHN for any reason. The Provider shall be solely and entirely responsible for its acts and the acts of its agents, employees, and servants during the performance of a contract resulting from this RFP.

VI. No Waiver of Default

a. The failure of MSHN to insist upon strict adherence to any term of a contract resulting from this RFP shall not be considered a waiver or deprive MSHN of the right thereafter to insist upon strict adherence to that term, or any other term, of the contract.

VII. Disclaimer

a. All the information contained within this RFP and its attachments reflect the best and most accurate information available to MSHN at the time of RFP preparation. No inaccuracies in such information shall constitute a basis for legal recovery of damages, either real or punitive.
b. All proposals submitted pursuant to this RFP become the sole property of MSHN.

Section III - MINIMUM QUALIFICATIONS

Provider Requirements: Interested Providers shall meet the following minimum requirements to be considered for funding and attest to the following:

a. Have the necessary systems in the areas of administration and clerical support for the program. This includes the necessary computer equipment, compatible software and Internet connections to be able to electronically request authorization for services and submit data and billing; a valid, active and maintained email account that can receive and submit communications is also required.

b. Have an established financial system in operation which meets generally accepted accounting principles and systems (i.e., maintains fiscal solvency).

c. Hold a current certification through Michigan Association of Recovery Residences (MARR) at a level III or higher. Note: If the Provider does not have a current certification and is planning to become certified, the Provider shall provide information pertinent to pending MARR application(s). A level III recovery house has administrative oversight and provides more structure than levels I and II and has at least one paid staff person. A level IV recovery house is highly structured and employs administrative and credentialed clinical staff. All MARR certifications are site specific and any changes in location or services must be approved by MSHN prior to services being rendered at that location.

    i. If bidder has received a MARR certification approval, attach a copy of the completed enrollment application and letter from MARR indicating approval.

d. Have the capacity to obtain and retain program staff who meet the minimum qualifications/credentialing requirements. Recovery housing staff should minimally have a peer recovery coach certification in place from the State of Michigan training or CCAR and maintain their certification to meet Michigan's standards (ie. Michigan Continuing Education Requirements for Certified Peer Recovery Coaches. (see MDHHS Medicaid Provider Manual, and MDHHS Provider Qualifications Chart, MARR level III or IV).

e. Demonstrate an ability to understand, relate to, and operate within an ethnic, racial, age, LGBTQ+IA, and economically diversified population. In addition, have the capacity to provide services in settings accessible and acceptable to individuals and communities intended to be served.

f. Provider will be accepting of supporting people's individualized pathways of recovery and the continuum of approaches that includes, such as Medication for Opioid Use Disorder (MOUD), etc.

g. The Provider will demonstrate ongoing coordination and collaboration of individuals in services care with SUD treatment providers, as needed. This will most often be SUD outpatient levels of care, and the recovery housing provider is required to ensure that person is engaged in SUD treatment to be receiving MSHN funding for recovery housing.

h. The provider will demonstrate the ability to support documentation requirements, minimally including the following:

    i. Basic demographic information
    ii. Releases of information are required in client file for the following: primary care physician, outpatient provider, MSHN, emergency contact
    iii. Primary Care Physician information needs to minimally include the physician's name, practice name, address, and telephone number to meet MDHHS standards.
    iv. Evidence of enrollment with an outpatient provider
    v. Application
    vi. Screening: This includes an agency screening as well as the Brief Screening completed in REMI
    vii. Signed client acknowledgement of discussion and receipt of recovery housing rules and expectations
    viii. Recovery Plan developed with the client and recovery coach and included in the client's file at the Recovery House. Recovery/Service Plans must include the following components:
        1. Individualized Plans of Service developed in partnership with the client as evidenced by the client's words
        2. Goals & objectives are written using specific, measurable, attainable, realistic & time limited elements.
    ix. Evidence of regular care coordination with service providers
    x. Evidence of regular attendance with a formal outpatient provider 84
    xi. Evidence of regular drug screening, if necessary (this service is not billable to MSHN)
    xii. Evidence of weekly house meetings
    xiii. Recovery coaching progress notes if recovery coaching is provided on location
    xiv. Block Grant Income Eligibility & Fee Determination form

i. The provider will demonstrate the ability to support all recovery housing standards as articulated in the MSHN SUD Provider Manual for FY25. This includes the following:
    i. Screening
    ii. Application for Admission
    iii. Admission Policy
    iv. Health & Safety
    v. House Rules & Meetings
    vi. MAT Inclusion
    vii. Reporting Criteria
    viii. Training for Recovery Housing Staff
    ix. Warm Transfer

j. Agree to comply with Federal Confidentiality, Privacy and Security Regulations, and State Confidentiality laws. This includes compliance with Title 42 (Public Health) of the Code of Federal Regulations (CFRs).

Section IV - PROPOSAL SUBMISSION

I. Economy of Preparation

a. Proposals shall be prepared simply, economically, and according to the format delineated elsewhere in this RFP. The Provider is expected to provide a straight-forward, concise description of the Provider's ability to meet the requirements of the RFP. Fancy bindings, colored displays, promotional materials, etc., are not desired. Emphasis shall be on the completeness and clarity of content.

II. Provider Responsibilities

a. Utilization of technology to obtain needed RFP documents and inform MSHN of questions.
b. Carefully review the entire RFP prior to submitting a response. The Provider, by submitting a response, attests to its full understanding of all details and specifications related to this RFP.
c. Be responsive in a manner that utilizes the order specified on the Provider Checklist (*Attachment A*) to aid proper consideration of each section of the proposal.
d. Use concise, persuasive language (see Economy of Preparation above). Clearly identify any best or evidence-based practice to be utilized.
e. Ensure all related required documents/narratives are addressed for each proposed service.
f. Providers are encouraged to be creative in the development of their proposed delivery of services. Collaboration with community partners is encouraged and shall be described where appropriate.
g. Submission of documents in a timely manner via delivery mechanisms as indicated in the RFP.
h. By submission of a proposal, the selected Provider attests it shall meet current MSHN Board Procedure and Policy requirements for the duration of the contract. This information can be found on the MSHN website.
i. By submission of a proposal, the selected Provider attests that it shall adhere to the specifications for services herein. Service descriptions shall be made part of Provider contracts and monitored accordingly.
j. Successful Providers shall agree to accept and serve all individuals referred by MSHN or its agent under the contract.

III. Proposal Submission

a. Proposal and all required attachments shall be provided electronically to MSHN no later than 5:00 p.m. on Friday, February 7, 2025 to be considered. Proposal content shall be organized in a manner that directly corresponds with the RFP (e.g., use of same headings as within RFP). Electronic submissions **MUST** be organized in a manner that corresponds with the RFP and RFP submission. Electronic documents shall be labeled by RFP section, subpart and document name (e.g., VI_I_Provider Profile).
b. Proposals shall be accepted until 5:00 p.m. on Friday, February 7, 2025. Proposals must be received by the specified closing date and time to be reviewed. Proposals submitted after the closing date and time shall not be considered and shall be declared invalid.
c. An official authorized to bind the Provider to its provisions shall sign the proposal submission (see *Provider Cover Sheet – Attachment B*).
d. All proposals shall identify a primary point of contact for the provider.
e. All Proposals shall be delivered electronically by e-mail at the following address:

Attention: Kyle.Jaskulka@midstatehealthnetwork.org

The following title shall appear on the subject line of the e-mail message for proper delivery:

CONFIDENTIAL RESPONSE – SUD Recovery Housing Services RFP

Section V - NOTIFICATION OF INTENT TO BID / PROVIDER QUESTIONS

I. Notification of Intent to Bid Requested

a. The bidding Provider is requested to inform MSHN of their intent to bid for the services outlined in this RFP. The Provider shall inform MSHN of their intent to bid no later than 5:00 p.m. on Friday, January 17, 2025 via email to Kyle Jaskulka at Kyle.Jaskulka@midstatehealthnetwork.org. The email shall be clearly labeled with subject line "RECOVERY HOUSING SERVICES RFP INTENT TO BID." The content of the email shall contain the name and address of the Provider as well as the services they intend to bid for.

II. Provider Questions

a. Provider questions can be submitted Attn. Kyle Jaskulka (by email only to Kyle.Jaskulka@midstatehealthnetwork.org with the subject line "SUD RECOVERY HOUSING RFP QUESTIONS") until 5:00 p.m. on Monday, January 6, 2025. All responses to questions shall be disseminated by MSHN on Monday, January 13, 2025 to all parties that have submitted, as of that date, an Intent to Bid notice, as described. RFP related specific questions shall not be accepted for response in any format other than described in this paragraph. Questions and responses shall also be posted to the MSHN website.

Section VI – BIDDER REQUIRED NARRATIVE/DOCUMENTS

Documentation Requirements

Interested Providers shall meet and provide documentation for the following to be considered. Provider narrative shall include the Provider name on each page. Responses shall be double spaced, Arial font size 11. Failure to include complete responses for each of the applicable sections shall result in a loss of points. For any of the following, if the required narrative and/or document is not available (such as for a recently licensed entity), Provider may indicate "not applicable" and provide an explanation.

I. **Provider Profile (50 points)**: Provider shall provide a narrative description and any supporting documentation to address the following:
   a. Provider Cover Sheet (see *Attachment B*).
   b. History of Provider organization and explanation of the purpose or mission of the Provider and how it relates to the RFP.
   c. Business status: Proof of Business Entity: Documentation and proof of business entity as recognized by the Internal Revenue Service (IRS).
   d. Describe the rationale for the Provider pursuing this opportunity.
   e. Describe future plans/issues facing the Provider.
   f. List experiences with developing and sustaining collaborative relationships with other agencies and/or where mergers have occurred.
   g. Describe the Provider's experience in this or related field.
   h. MARR certification letter,
   i. MSHN Provider Application (see *Attachment C*).
   j. Disclosure of Ownership, Controlling Interest, and Criminal Convictions (see *Attachment D*). All sections within the Attestation must be completed regardless of status of the organization (e.g., Non-Profit, Government, Corporation). This includes full addresses, dates of birth and social security numbers for all identified management staff and/or Board Members as outlined in PIHP Policy and the Code of Federal Regulations.

II. **Organization/Management:** Provider shall provide a narrative description and any supporting documentation to address the following:
   a. **General (5 points):**
      i. Provide a current, dated, program specific Organizational Chart which includes administrative structure.
   b. **Personnel Management (10 points):**
      i. Provide assurances that bidder meets MSHN Minimum Training Requirements.
      ii. Description of process and frequency for training staff and evaluating staff performance.
   c. **Financial Management (25 points):**
      i. Financial Audit: The Provider shall attach a copy of its Audited Financial Statements for the previous two (2) years of operation. This shall include auditor notes and comments as well as any Management Letters.
      ii. Explain if there are any pending or unresolved issues that relate to the last two (2) years of fiscal audits **and/or** if the Provider has made a plan of correction addressing those areas. Include corrective action steps taken. Note: Provider may indicate "not applicable" if the Provider does not have any unresolved issues **and/or** has not had identified areas which would require corrective action steps.

iii. Providers will be reimbursed for services based on MSHN's regional SUD Service Rate schedule.
iv. If requesting startup funds to assist with costs related to starting a new program, the Provider shall submit a sustainability plan to ensure the ability to maintain operations.

d. Information Systems (20 points):
   i. Description of information system (including data entry process, data disaster recovery and adherence to the Health Insurance Portability and Accountability Act (HIPAA) standards).
   ii. Description of system for monitoring and processing authorizations and claims of services being provided.
   iii. Description of capacity to support the Recovery Capital Assessment with individuals in services as an MDHHS/MARR requirement of recovery housing providers.
   iv. Description of capacity to complete a HIPAA Risk Assessment and Security Management Plan.

e. Quality Management (10 points):
   i. Description of Quality Improvement Plan (this shall include information on how reports are utilized and methods used to measure outcomes and utilization).
   ii. If a new provider, explain how a Quality improvement Plan and/or MSHN's Quality Assessment Performance Improvement Plan will be followed and/or used.
   iii. Include the most recent Quality Improvement Plan.
   iv. Include the most recent Customer Satisfaction Survey.
   v. Description of how the provider will monitor the following performance outcomes for individuals supported in services:
      1. Percentage of clients with housing at discharge
         a. Scope: This includes all people served as indicated by Behavioral Health Treatment Episode Data Set (BH-TEDS) living arrangement status at admission and then at discharge.
      2. Percentage of clients with employment at discharge
         a. Scope: This includes all people served as indicated by Behavioral Health Treatment Episode Data Set (BH-TEDS) employment status at admission and then at discharge.

f. Community Involvement (15 points):
   i. Description of how Provider utilizes participation from individuals served in policy development, program planning and routine decision making.
   ii. Description of process to utilize community resources from existing entities in program planning.

g. Corporate Compliance (5 points):
   i. Description of Corporate Compliance Plan process and include a copy of the most recent Plan if applicable. Note: The Federal Medicaid Integrity Program (MIP) requires entities receiving more than five million dollars ($5 million) in Medicaid funds to have a Corporate Compliance Plan. Note: Provider may indicate "not applicable" if the Provider does not have its own Compliance Plan.

h. Recipient Rights (10 points):
   i. Description of procedures relating to the Recipient Rights process.
   ii. Provide the following information for the previous two (2) years:

1. Number of Recipient Rights complaints
2. Number of substantiated complaints by category
3. Description of what corrective actions were taken to address the substantiated Rights violations

III. MARR Certification (5 points): The Provider shall attach evidence of current MARR Certification and/or any applicable application.

IV. Insurance (30 points): The Provider shall attach evidence of current:

a. Worker's Compensation insurance coverage in accordance with applicable and required law governing work activities; Waiver of subrogation, except where waiver is prohibited by law.
b. Professional Liability insurance coverage (errors and omissions) in a sum of not less than $1,000,000 per claim and $3,000,000 in annual aggregate.
c. Commercial General Liability insurance coverage with broad form endorsement or equivalent, if not in the policy proper, $1,000,000 each occurrence; $1,000,000 Personal & Advertising Injury; $2,000,000 Products/Completed Operations; $2,000,000 General Aggregate.
d. Automobile Liability insurance coverage including all owned, non-owned, and hired vehicles. If a motor vehicle is used in relation to the Contractor's performance, the Contractor must have vehicle liability insurance on the motor vehicle for bodily injury and property damage as required by law. Note: Provider may indicate "not applicable" if the Provider shall not be transporting individuals.
e. Privacy & Security Liability (Cyber Liability) insurance coverage Policy must cover information security, privacy liability, privacy notification costs, regulatory defense & penalties, and website media content liability with limits not less than $1,000,000 each occurrence and $1,000,000 annual aggregate.

V. Implementation Planning (25 points): Provider shall submit an implementation plan which shall be put into place if awarded a contract for services including:

f. Program plan for supporting Evidence-Based Practices (EBP's) within the recovery residence. Description should include what EBPs will be utilized, the format for services (i.e., Individual and/or group), and coordination of care to support ongoing engagement in services.
g. Estimated timeframe for hiring, onboarding, and training new program staff (if applicable) to meet the minimum staffing requirements for SUD Recovery Housing related services as outlined in the Mid-State Health Network Provider Manual and MARR Certification requirements.
h. Describe who in your organization shall be responsible for reporting to MSHN.
i. Describe the Provider's plan for addressing program service capacity regarding PIHP referrals.
j. Procurement of any organization or staff required license and/or certification.
k. Timeframe in which the Provider plans to assume contractual obligations.

VI. References (10 points): Provider shall submit two (2) letters of reference/support from various community agencies and/or professional individuals with whom the Provider has collaborated within the last five years.

Section VII - RECOVERY HOUSING REQUIRED NARRATIVE / DOCUMENTS

I. Recovery Housing Services Overview

It is MSHN's expectation that SUD recovery housing will be rooted in evidence-based practices, will offer individualized and recovery-oriented care, and will identify and address what led to the SUD recovery housing admission (i.e., precipitating factors). SUD treatment services will occur at the appropriate intensity, duration, and scope as determined by the individual's clinical need for that service as dictated by the American Society of Addiction Medicine (ASAM) standards as assessment by the SUD outpatient provider, but no less than one time per month.

II. Substance Use Disorder (SUD) – Recovery Housing Services

Across Region 5's twenty-one counties, MSHN supports active and vibrant recovery communities of which recovery housing is a critical component. Drawing on MDHHS's Substance Use, Gambling and Epidemiology (SUGE)'s Treatment Technical Advisory #11, the National Alliance of Recovery Residences (NARR) guidelines, and clinical best practices, MSHN has established the following expectations of recovery houses which are part of MSHN's SUD provider network.

Individuals residing in recovery housing must be actively engaged in formal outpatient treatment with a credentialed outpatient provider. It is the expectation that an assessment by a credentialed SUD treatment provider be completed PRIOR to admission. Information including the name and date, if known, of the provider who completed the assessment should be documented on the recovery housing Screening and Intake form. In the instance a person has successfully completed a SUD residential episode, and has met the criteria for recovery housing, but is not connected to an outpatient provider, the recovery housing provider will have 14 days to connect the person to an outpatient provider. (See SAMHSA "Recovery Housing Best Practices" for additional information).

a. *Recovery Housing* - Provider must be capable of providing services to beneficiaries in a MARR certified facility. Provider must have the capacity to follow evidence-based practices, requirements and guidelines for MARR level III and IV.

    i. Provider must demonstrate they meet the requirements to provide Recovery Housing Services as outlined in Treatment Policy #11 (http://www.michigan.gov/documents/mdhhs/TA_T_11_Recovery_Housing_532174_7.pdf)
    ii. Provider must demonstrate the ability to screen, assess, and refer people appropriately based on individual needs.
    iii. Provider must document the coordination of care process that takes place to ensure individual is engaging in outpatient treatment services beginning at the admission process and monthly throughout stay in the recovery house.
    iv. Provider must demonstrate an understanding of evidence-based practices, privacy practices, medical necessity, trauma informed care, cultural competency, and services appropriate for this setting.
    v. Provider must have an ongoing process to adapt to changes in state and federal requirements for this level of care.
    vi. Provider must have documented policies and procedures in place to meet all current requirements.
    vii. Provider must have an established schedule that includes the required covered

services including basic care, interactive education, life skills/self-care, and milieu/environment. Schedule must be inclusive of a full week of options, including on nights and weekends.

viii. Provider must demonstrate appropriate staffing and peer availability all 7 days of the week.

Services in recovery housing must be delivered according to an individualized recovery plan based on a comprehensive needs assessment. The plan must be developed within the required timeframe for the service being provided and signed by the beneficiary. The recovery plan must contain:

i. S.M.A.R.T. (Specific, Measurable, Attainable, Reasonable, and Time-bound) goals and objectives, derived from the assessment, with appropriately identified amount, scope, and duration for each.
ii. Identification of the activities designed to assist the beneficiary to attain his/her goals and objectives.
iii. Discharge plan that articulates the need for aftercare/follow-up services.

III. Staffing Requirements

Narrative Description Requirements

I. **Recovery Services Program Overview (40 points):** Provider shall address the following:
   a. Philosophy of the Provider in the administration of SUD Recovery Housing related services.
   b. Recovery approaches identifying any evidence based or best practices interventions. If services are new to the agency, then describe evidence-based practices that will be utilized and why, with research data, to support decision(s).
   c. Indicate method and frequency of evaluating progress.
   d. Strategies used to engage residents in services, increase retention in recovery housing, and reduce barriers to services.
   e. Strategies to improve coordination between recovery housing and SUD treatment levels of care.
   f. Describe how the Provider supports screening, assessing, and connecting the person with their recovery housing resource.
   g. Describe the discharge process for individuals receiving services and coordination with other providers involved in the individuals' care.
   h. Provide an overview of the policies/procedures used by the agency to support recovery housing services.
   i. Provide an overview of the weekly recovery housing schedule inclusive of supports Monday through Sunday, weekly. (Note: Can also be submitted as an attachment).

II. Staffing Requirements (MARR III or IV Certified) (5 Points)
   a. Please provide a detailed staffing plan which addresses how the staffing requirements will be met. Staffing plan should include:
      i. Description of staffing positions including credentials/licensure/qualification for each (if applicable)
      ii. Number of full-time employees (FTE) for each position

iii. For each position, please identify if the bidder already has existing staff or if the position will need to be filled if the contract is awarded.
iv. Evidence the bidder meets the staffing ratios and requirements set forth by MARR for level 3 or 4, and the Treatment Technical Advisory #11.
v. Provide a brief overview of the current training requirements of recovery housing staff.

Section VIII - PRE-CONTRACT REVIEW

I. Delegated Functions

a. Managed care administrative functions that shall be performed by MSHN are specifically defined within the Code of Federal Regulations (CFRs). MSHN has overall responsibility to manage these functions. Prior to delegating specific managed care functions to any recovery housing services Provider, MSHN shall conduct a Pre-Contract Assessment to determine the Provider's capacity to carry out those specific functions.

b. Prior to contract start date, the Provider shall comply or have an implementation plan in place to comply with standards and requirements as identified in the Pre-Contract Evaluation Review Standards. The required information shall be reviewed only if the Provider is awarded a contract. At that time, additional clarification and/or documents may be requested of the Provider by MSHN as part of the Pre-Contract Evaluation.

Section IX - RATES

I. Cost Documentation

Providers will be reimbursed for services based on MSHN's regional SUD Service Rate schedule.

Section X - SUBMISSION EVALUATION

I. Evaluation Process

a. Award recommendations are contingent upon evaluation of the responses submitted.

b. A Review Committee for the RFP shall be formed by MSHN who shall evaluate each proposal.

c. Any additional proposal evaluation shall be completed by MSHN staff and recommendations shall be made to the MSHN Board based on overall evaluation results, service need and network capacity. It is the objective of MSHN to acquire needed services and supports at fair and economical prices, with appropriate attention to quality of care and maintenance of existing – care relationships and service networks currently utilized. The following is an overview of the criteria which MSHN shall utilize when evaluating proposals:

   i. All minimum requirements identified within the RFP have been met;
   ii. Suitability of the Proposal
   iii. Proposal aligns with MSHN's mission;
   iv. Proposed solution meets the needs and criteria set forth in the RFP;
   v. Qualifications necessary to undertake service project. Attain and retain qualified staff to deliver services throughout the time frame needed;
   vi. Proposal provides evidence of Providers competency and capacity to perform the functions defined within the RFP;
   vii. Expertise in delivery of appropriate clinical solutions. Successful delivery of similar services;
   viii. Evaluation and review of compliance, quality and customer service reviews within MSHN and/or other PIHPs (existing providers only).
   ix. Identified budget consistent with program objectives and demonstrates alignment with quality of service.

d. The MSHN Board shall make the final decision.

Section XI - ATTACHMENTS

ATTACHMENT A: PROVIDER CHECKLIST

ATTACHMENT B: PROVIDER COVER SHEET

ATTACHMENT C: MSHN PROVIDER NETWORK APPLICATION

ATTACHMENT D: DISCLOSURE OF OWNERSHIP, CONTROLLING INTEREST, CRIMINAL CONVICTION

ATTACHMENT E: CERTIFICATE OF COMPLIANCE WITH PA517 OF 2012 FORM

Michigan Association of Recovery Residences, Inc. (MARR)

NOTE:

All Attachments are listed separately from the RFP main document on MSHN's website at https://midstatehealthnetwork.org/stakeholders-resources/about-us/news

ATTACHMENT A - PROVIDER CHECKLIST

SECTION VI REQUIRED NARRATIVE / DOCUMENTS				
SUB-SECTION	INFORMATION	REQUIRED	OPTIONAL	NOTES
VI(I) PROVIDER PROFILE	Provider Cover Sheet (Att. B)	x		
	Narrative Description (5 items)	x		
	Proof of Business Entity	x		
	MSHN Provider Network Application (Att. C)	x		
	Disclosure of Ownership, Controlling Interest, and Criminal Convictions (Att. D)	x		
	MARR Certification	x		
VI(II) ORGANIZATION MANAGEMENT	GENERAL			
	Narrative Description (1 item)	x		
	Organizational Chart	x		
	PERSONNEL MANAGEMENT			
	Narrative Descriptions (2 items)	x		
	FINANCIAL MANAGEMENT			
	Narrative Description (2 items)	x		
	Audited Financial Statements (include Auditor Notes & Management Letters)	x		
	INFORMATION SYSTEMS			
	Narrative Description (3 items)	x		
	QUALITY MANAGEMENT			
	Narrative Description (1 item)	x		
	Quality Improvement Plan	x		
	Customer Satisfaction Survey	x		
	COMMUNITY INVOLVEMENT			
	Narrative Descriptions (3 items)	x		
	CORPORATE COMPLIANCE			
	Narrative Description (1 item)	x		
	Corporate Compliance Plan		X - *Only for Providers receiving more than five (5) million dollars in Medicaid Funds (all sources)*	
	RECIPIENT RIGHTS			
	Narrative Descriptions (2 items)	x		
VI(III) RECOVERY CERTIFICATION	MARR Certification	x		
VI(IV) INSURANCE	Worker's Compensation Insurance Coverage	x		
	Professional Liability Insurance Coverage	x		
	Commercial General Liability Insurance Coverage	x		
	Automobile Liability Insurance Coverage		X - *Only if Provider will be transporting individuals*	
	Privacy & Security Liability Insurance Coverage (Cyber Liability)	x		

VI(V) IMPLEMENTATION PLANNING	Narrative Description (5 items)	x		
VI(VI) REFERENCES	Letters of Reference (2)	x		
SECTION VII TREATMENT SERVICES				
SUB-SECTION	**INFORMATION**	**REQUIRED**	**OPTIONAL**	**NOTES**
VII(I) Recovery Housing PROGRAM OVERVIEW	**Recovery Housing PROGRAM OVERVIEW**			
	Narrative Description (8 items)	x		
	STAFFING REQUIREMENTS			
	Narrative Description (1 item)	x		
SECTION VIII Precontract Evaluation				
SUB-SECTION	**INFORMATION**	**REQUIRED**	**OPTIONAL**	**NOTES**
VIII (I) Pre-Contract Review	Pre-Contract Evaluation	x		

Section IV (Proposal Submission):

One (1) electronic copy (via email) of the proposal shall be submitted by the end of business day (5:00 P.M.) on Friday, February 7, 2025 and labeled by RFP section, subpart and document name. All Proposals shall be delivered electronically by e-mail at the following address: kyle.jaskulka@midstatehealthnetwork.org

The following title shall appear on the subject line of the e-mail message for proper delivery:
CONFIDENTIAL RESPONSE – SUD Recovery Housing RFP

Section V (Notification of Intent to Bid):

The Provider is requested to inform MSHN of their intent to bid by the end of business day (5:00 P.M.) on Friday, January 17, 2025 via an email to kyle.jaskulka@midstatehealthnetwork.org. The email shall be clearly labeled with subject line "SUD Recovery Housing RFP INTENT TO BID."

The Provider is requested to submit questions to MSHN by the end of business day (5:00 p.m.) on Monday, January 16, 2025 via an email to kyle.jaskulka@midstatehealthnetwork.org. The email shall be clearly labeled with subject line "SUD Recovery Housing RFP QUESTIONS."

ATTACHMENT B - PROVIDER COVER SHEET

Legal Business Name: _____

DBA (if applicable): _____

Federal Tax ID Number: _____

Address: _____

Executive Director: _____

Chief Financial Officer: _____

Chief Operations Officer _____

Recipient Rights Advisor: _____

SIGNED STATEMENT OF AUTHORITY

I _____ AM THE _____
Name of Official Title of Official

OF _____
Name of Bidding Organization

I AM AUTHORIZED TO MAKE THE FOLLOWING PROPOSAL ON BEHALF OF THE ORGANIZATION NAMED ABOVE.

I HEREBY CERTIFY: The bidding organization understands and will comply with the specific assurances and certifications contained in this proposal, and further; that the bidding organization understands and will comply with the rules, regulations and policies of the Michigan Department of Health and Human Services (MDHHS). All responses to this Request for Proposal (RFP) concerning the respondent organization, its operation and proposed program are true and accurate. The bidding organization understands that this proposal is an application for funding and does not ensure subsequent funding. If selected for funding, the bidding organization will be bound by the information contained herein as well as the terms and conditions of the resultant contract.

_____
Signature Date

MSHN
Mid-State Health Network

Application for Credentialing
Organizational Providers

Agency Contact Information	
Agency Name:	Website:
Chief Administrator Contact/Title: Phone #:	email:
Finance Contact: Phone #:	email:
Site Review/Quality Contact: Phone #:	email:
Check Appropriate Status: ☐ Sole Prop. ☐ Partnership ☐ Corp. ☐ LLC ☐ Non-Profit ☐ Other: ☐ Governmental entity (i.e., government, governmental subdivision or agency, or public corporation)	
Federally Qualified Health Center: ☐ Yes ☐ No	

Program Information - *attach additional sheets if necessary for multiple sites*			
Facility/Program #1 Name:		MARR Certification #:	
Address #1:	City:	Zip:	County:
Primary Contact/Title: Phone:		email: Fax:	
Same Day Service? ☐ Yes ☐ No		Accepting new enrollees? ☐ Yes ☐ No	
24 hr on-call? ☐ Yes ☐ No		ADA Accessible? ☐ Yes ☐ No	
Please specify all ADA accessible/compliant accommodations:			
Please specify all fluent communicable languages, including sign language:			
MARR Certification (Recovery Housing Providers): ☐ Level III ☐ Level IV			

Facility #2 Name:		MARR Certification #:	
Address #2:	City:	Zip:	County:
Primary Contact/Title: Phone:		email: Fax:	
Same Day Service? ☐ Yes ☐ No		Accepting new enrollees? ☐ Yes ☐ No	
24 hr on-call? ☐ Yes ☐ No		ADA Accessible? ☐ Yes ☐ No	
Please specify all ADA accessible/compliant accommodations:			
Please specify all fluent communicable languages, including sign language:			
MARR Certification (Recovery Housing Providers): ☐ Level I ☐ Level II ☐ Level III ☐ Level IV			

Facility #3 Name:		MARR Certification #:	
Address #3:	City:	Zip:	County:
Primary Contact/Title: Phone:		email: Fax:	
Same Day Service? ☐ Yes ☐ No		Accepting new enrollees? ☐ Yes ☐ No	
24 hr on-call? ☐ Yes ☐ No		ADA Accessible? ☐ Yes ☐ No	

MSHN
Mid-State Health Network

Application for Credentialing
Organizational Providers

Please specify all ADA accessible/compliant accommodations:
Please specify all fluent communicable languages, including sign language:
MARR Certification (Recovery Housing Providers): ☐ Level I ☐ Level II ☐ Level III ☐ Level IV

Billing Information	
EIN:	NPI#:
Medicaid #:	Medicare #:
Indicate all insurance companies and/or managed care plans you currently have provider agreements with:	

Current Professional Liability Insurance Information - *attach copy of cover sheet (1 million/3 million minimum)*	
Insurance Carrier:	Policy #:
Address:	Coverage Amount:
City: State: Zip:	Expiration Date:

Privileges, Licensure, and Malpractice History	
Has the agency had any of the following **denied, revoked, suspended, reduced, limited, or placed on probation or have voluntarily relinquished** any of the following in anticipation of these actions, or are any of these actions now pending? I*f you answer yes to any of the following, attach full explanation.*	
1. MARR Certification to Operate in the State of Michigan	☐ Yes ☐ No
2.	☐ Yes ☐ No
3. Professional Liability Insurance	☐ Yes ☐ No
4. Malpractice suits settled resulting in a judgment against you in the past five (5) year, or currently pending?	☐ Yes ☐ No
5. Are any malpractice judgements pending?	☐ Yes ☐ No
6. Within the past ten (10) years, has your organization ever been convicted of, or plead guilty to, a criminal offense?	☐ Yes ☐ No
7. Are there any medical incidents for which you have been contacted by an attorney regarding potential malpractice liability (settlement request, writ of summons, etc.)?	☐ Yes ☐ No
8. Have your organization had any Medicaid, Medicare, Block Grant, or other governmental or third-party payor sanctions?	☐ Yes ☐ No
9. Have your organization ever been excluded from the Medicaid or Medicare program? If yes, specify date: Date of Reinstatement:	☐ Yes ☐ No
10. Have civil and monetary penalties been levied against your organization by Medicare or Medicaid programs?	☐ Yes ☐ No
11. You must provide, at minimum, the prior 5 year's history of any professional liability claims resulting in a judgement or settlement. ***Complete Attachment B -Professional Liability Action Detail***	☐ Attached ☐ N/A

Non-Discrimination/Diversity Assurances
MSHN is committed to identifying and encouraging the participation of minority-owned, women-owned, and handicapper-owned businesses within its provider network. Please check all that apply (optional):
☐ Minority-owned ☐ Women-owned ☐ Handicapper-owned

Policy & Practices *attach copies of policies and procedures*		Pg. #
1. Does the organization have policy/practice for access to services? (Including timeliness of response to referral, availability of services, access to services, emergency services, etc.)	☐ Yes ☐ No	
2. Does the organization have a recertification policy/practice?	☐ Yes ☐ No	
3. Does the organization conduct criminal background checks at time of hire and periodically during employment?	☐ Yes ☐ No	
4. Does the organization assess staff competency on an ongoing basis through performance evaluation?	☐ Yes ☐ No	
5. Does the organization have a policy/practice regarding ongoing professional development? (Including orientation and ongoing training)	☐ Yes ☐ No	
6. Does the organization assess the cultural backgrounds of persons served and provide training to staff on any identified cultural issues?	☐ Yes ☐ No	
7. Does the organization's policy on recovery planning describe individualized supports ?	☐ Yes ☐ No	
8. Does the organization's policy on recovery planning include consumer involvement in the development of the plan of service?	☐ Yes ☐ No	
9. Does the organization have a policy/practice regarding serving persons with Limited English Proficiency?	☐ Yes ☐ No	
10. Does the organization have a continuous quality improvement (CQI) policy/practice?	☐ Yes ☐ No	
11. Does the organization have a process to assess customer satisfaction?	☐ Yes ☐ No	
12. Does the organization have policy/procedure describing case records, record review, security, and case record access?	☐ Yes ☐ No	
13. Does the organization have a corporate compliance policy?	☐ Yes ☐ No	
14. Does the organization have a safety management plan that includes: General Safety, Security, Hazardous Materials, Emergency Preparedness, Fire, Infection Control, etc.	☐ Yes ☐ No	

Consent and Release of Liability

Upon the signing of this application, I represent that all of the information now or hereafter given by me in support of this application is true, correct and complete to the best of my knowledge and belief. I agree to promptly notify MSHN if there are any material changes in the information provided, whether prior to or after acceptance as a MSHN participating provider. I hereby authorize the release of any information from any source including but not limited to information from individuals, peers, customers, companies, institutions, agencies, data banks or references who may have information bearing on my moral and ethical qualifications and competence to carry out the privileges I have requested, and I authorize them to release such information as you require, including my prior disciplinary records, for purposes of verifying information obtained in the attached application or any re-application information without any obligation to give me written notice of such disclosure. I agree to hold MSHN and the informant harmless from any liability to me and/or my organization for providing such information.

I hereby further authorize MSHN to release any and all information related in any way to agency professional practice to any person, entity or governmental agency which: (a) provides MSHN with an authorization signed by an agency designee; or (b) has a legal right to know under any state or Federal law. I agree to hold MSHN harmless from any liability for providing any such information as specified herein.

I release all parties from all liability from any damages, causes of action, including, but not limited to, slander and libel, that may result from furnishing any information to you. I agree that any false information in support of this application may result in action up to and including cancellation of any or all contracts subject to contract provisions regardless of when discovered by MSHN. I release MSHN, the MSHN Credentialing Committee, individually and collectively, from any and all liability from any damages and/or causes of action associated with the MSHN credentialing and privileging process.

I hereby signify my willingness to appear for interviews with MSHN. I fully consent to the inspection of any and all records and documents pertinent to agency application for appointment and/or privileges. I understand and agree that if MSHN determines that this application contains any significant misstatements, misrepresentations, or omissions, MSHN's acceptance of this application for participation and any subsequent participating provider agreement which MSHN enters into with me will be voidable at MSHN's sole discretion.

I understand and agree that: (a) I have the burden of producing all information required or requested by MSHN in connection with this application; (b) MSHN is under no obligation to complete the processing of this application until all information requested is provided; (c) MSHN has the sole discretion to determine whether or not my organization will be accepted as a participating provider; and (d) in the event that MSHN decides not to accept my organization as a participating provider, I may initiate administrative appeal procedures as defined in the MSHN provider appeal policy.

I understand and agree that the certifications, authorizations and other provisions contained herein shall remain in force for so long as this application is pending and, if accepted for participation, for so long as my organizations' provider agreement with MSHN remains in force.

Applicant Signature:_____ Date:_____

Print Name:_____

Organization:_____

Application Checklist

The following items are required to be completed and/or submitted:

Yes	NA	
☐	☐	All applicable items on the application are complete and legible
☐	☐	Signed and dated Consent and Release of Liability (pg. 4)
☐	☐	Written explanations attached for any privilege, licensure, or malpractice history questions answered "Yes"
☐	☐	Copy of current Malpractice and Professional Liability Policy
☐	☐	Completed and Signed Federal W-9 Form
☐	☐	Attachment B – Provider Coversheet
☐	☐	Attachment D – Disclosure of Ownership & Controlling Interest Statement
☐	☐	Attachment E – Certificate of Compliance Form
☐	☐	REMI Multiple User Request Form
☐	☐	Copy of most recent program audit conducted by home PIHP (if applicable)
☐	☐	Copy of MARR Certification Letter (Recovery Residences only)

ATTACHMENT D - DISCLOSURE OF OWNERSHIP & CONTROLLING INTEREST STATEMENT

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

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

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

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

Provider/Provider Entity Information

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

Please choose appropriate category: ☐ Provider Entity ☐ Licensed Independent Practitioner ☐ Managing Employee ☐ HCBS Provider ☐ Other: Group Affiliation? ☐ 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. Have you or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Individual Provider practice ever been sanctioned, excluded, or debarred from Medicaid, Medicare, CHIP or Title XX program? ☐ Yes ☐ *No-Skip to #7* ☐ *N/A-Skip to #7*

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

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

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

If yes, list those persons 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)

8. **Business Transactions – Subcontractors:** Has the Provider Entity had any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) month period? ☐Yes ☐ *No-Skip to #9* ☐ *N/A-Skip to #9*

If yes, list the information for Subcontractors with whom the Provider Entity has had business transactions totaling more than $25,000 during the previous 12 month period ending on the date of this request (42 CFR §455.105(b)(1)) Attaching additional sheets as necessary - ☐Yes ☐ No

Name of Subcontractor:	**Subcontractor's SSN or TIN:**
Subcontractor Address:	**City, State, Zip:**
Subcontractors Owner (SO):	**SO's SSN or TIN:**
SO's Address:	**City, State, Zip:**

9. **Significant Business Transactions – Wholly Owned Suppliers:** Has the Provider Entity had any Significant Business Transactions with a Wholly Owned Supplier exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period? ☐Yes ☐ *No-Skip to #10* ☐ *N/A-Skip to #10*

If yes, list the information for any Wholly Owned Supplier with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past 5-year period (43 CFR §455.105(b)(2)). Attach additional sheets as necessary - ☐Yes ☐ No *See Glossary for definition.*

Name of Supplier:	**Suppliers SSN or TIN:**
Suppliers Address:	**City, State, Zip:**

10. **Significant Business Transactions – Subcontractors:** Has the Provider Entity had any Significant Business Transactions with a Subcontractor totaling more than $25,000 in the past five (5) year period? ☐Yes ☐ *No-Skip to #11* ☐ *N/A-Skip to #11*

If yes, list the information for Subcontractors with whom the Provider Entity had any Significant Business Transactions exceeding the $25,000 during the past 5-year period (42 CFR §455.105(b)(2)). Attach additional sheets as necessary - ☐Yes ☐ No

Name of Subcontractor:	**Subcontractor's SSN or TIN:**
Subcontractor Address:	**City, State, Zip:**
Subcontractors Owner (SO):	**SO's SSN or TIN:**
SO's Address:	**City, State, Zip:**

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

Section VII: Management and Control

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

Name	DOB mm/dd/yyyy	Complete Address	SSN	Title

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

Name	DOB mm/dd/yyyy	Complete Address	SSN

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

Signature_____ Title_____

Print Name_____ Date_____

_____ _____ _____

Phone Number Fax Number Email Address

Disclosure Instructions

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

Section I: Provider Entity Ownership Information

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

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

Section II: Ownership in Other Providers & Entities

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

Section III: Subcontractor Ownership

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

Section IV: Familial Relationships of All Owners

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

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

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

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

Section VI: Business Transaction Information

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

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

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

Section VII: Management & Control

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

Glossary

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

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

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

Determination of ownership or control percentages:

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

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

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

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

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

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

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

ATTACHMENT E - CERTIFICATE OF COMPLIANCE WITH PUBLIC ACT 517 OF 2012

I certify that neither _____ (Company), nor any of its successors, parent companies, subsidiaries, or companies under common control, are an "Iran Linked Business" engaged in investment activities of $20,000,000.00 or more with the energy sector of Iran, within the meaning of Michigan Public Act 517 of 2012. In the event it is awarded a Contract as a result of this Request for Proposals, Company will not become an "Iran Linked Business" during the course of performing the work under the Contract.

NOTE: IF A PERSON OR ENTITY FALSELY CERTIFIES THAT IT IS NOT AN IRAN LINKED BUSINESS AS DEFINED BY PUBLIC ACT 517 OF 2012, IT WILL BE RESPONSIBLE FOR CIVIL PENALTIES OF NOT MORE THAN $250,000.00 OR TWO TIMES THE AMOUNT OF THE CONTRACT FOR WHICH THE FALSE CERTIFICATION WAS MADE, WHICHEVER IS GREATER, PLUS COSTS AND REASONABLE ATTORNEY FEES INCURRED, AS MORE FULLY SET FORTH IN SECTION 5 OF ACT NO. 517, PUBLIC ACTS OF 2012.

_____
(Name of Company)

By: _____ Title: _____

Date: _____