Fiscal Year 20XX Contractual Agreement

BETWEEN

{{NAME OF CMHSP}}

AND

{{NAME OF INPATIENT FACILITY}}

For the purpose of:
Psychiatric Inpatient Services

Contents

CONTRACTUAL PROVISIONS....4

ATTACHMENT A - ACRONYM AND GLOSSARY DEFINITIONS....20

ATTACHMENT B - STATEMENT OF WORK....24

ATTACHMENT C - RECIPIENT RIGHTS POLICIES & ATTESTATION....32

ATTACHMENT D - CMHSP CONTACT INFORMATION....33

ATTACHMENT E - DISCLOSURE OF OWNERSHIP & CONTROLLING INTEREST STATEMENT....34

ATTACHMENT F - REGIONAL TRAINING GRID....42

ATTACHMENT G - DEPARTMENT OF HEALTH AND HUMAN SERVICES RECIPIENT RIGHTS APPEAL PROCESS (C 6.3.2.4)....43

ATTACHMENT H - CONTINUING EDUCATION REQUIREMENTS FOR RECIPIENT RIGHTS STAFF (C 6.3.2.3A)....48

ATTACHMENT I - RR TRAINING STANDARDS FOR CMH AND PROVIDER STAFF TR (C 6.3.2.3B)....49

FY 20XX COMMUNITY PSYCHIATRIC INPATIENT AGREEMENT

THIS AGREEMENT FOR PROVIDER SERVICES (this "Agreement") is made and entered into on this 1st day of October, **XXXX**, by and between {{CMHSP}} whose administrative office address is {{CMHSP ADDRESS}}, and {{PROVIDER NAME}} whose business address is {{PROVIDER ADDRESS}} ("Provider").

Whereas, the CMHSP was established by the Board(s) of Commissioners of the applicable county(ies) pursuant to Act 258 of the Public Acts of 1974, as amended, (the Mental Health Code), MCL 330.1001;

Whereas, under Section 204(b)(1) of the Mental Health Code, MCL 330.1001 *et seq*., Arenac, Bay, Clare, Clinton, Eaton, Gladwin, Gratiot, Hillsdale, Huron, Ingham, Ionia, Isabella, Jackson, Mecosta, Midland, Montcalm, Newaygo, Osceola, Saginaw, Shiawassee, and Tuscola Counties entered into a regional entity arrangement for the purpose of the preparation, submission, and implementation of an Application for Participation ("AFP") to the Michigan Department of Health & Human Services ("MDHHS") for a Medicaid Prepaid Inpatient Health Plan ("PIHP"); and

Whereas, Mid-State Health Network ("MSHN") is designated by the CMHSPs and pursuant to Section 204(b) of the Mental Health Code and MSHN's Bylaws dated June 12, 2013;

Whereas, the MDHHS approved the 2013 Application for Participation and MSHN as the PIHP to contractually manage the Specialty Services Waiver Program(s) and the Supports Waiver Program(s) approved by the federal government and implemented concurrently by the State of Michigan in the designated services area of the Arenac, Bay, Clare, Clinton, Eaton, Gladwin, Gratiot, Hillsdale, Huron, Ingham, Ionia, Isabella, Jackson, Mecosta, Midland, Montcalm, Newaygo, Osceola, Saginaw, Shiawassee, and Tuscola Counties (the "Service Area").The MDHHS entered into, effective January 1, 2014, a MDHHS/PIHP Managed Specialty Supports and Services Contract (referred to as the "MDHHS/PIHP Master Contract for") with MSHN for the provision of Medicaid mental health and substance abuse services and supports; and

Whereas, MSHN entered into, effective January 1, 20XX, a PIHP/CMHSP Medicaid Subcontracting Agreement with the CMHSP whereby the PIHP subcontracts to the CMHSP, as a Specialty Services provider, to provide the Medicaid mental health specialty supports and services to Medicaid eligible within the CMHSP's specific county in said PIHP Medicaid Services Area; and

Whereas, pursuant to Section 116 (2)(b) and 3(e) and Section 228 of the Mental Health Code, the (MDHHS entered into, effective October 1, 20XX, a MDHHS/CMHSP Managed Mental Health Supports and Services Contract for General Funds (referred to as the "MDHHS/CMHSP Master Contract") with the CMHSP of the applicable county; and

Whereas, the CMHSP, at its discretion, has the right to direct-operate and/or contract for supports and services with persons who meet the supports/services eligibility criteria in the Service Area of the applicable county; and

Whereas, the CMHSP is, from time to time, in need of psychiatric inpatient supports/services, under a contractual arrangement, from a qualified, licensed facility for an eligible person who meets the supports/services eligibility criteria; and

Whereas, Provider has been presented to the CMHSP as being in the business of providing such psychiatric inpatient supports/services and as being licensed, qualified and willing to provide psychiatric inpatient services as required by the CMHSP under the terms and conditions set forth herein; and

Whereas, Provider desires to render certain services and supports more specifically set forth and pursuant to the terms and conditions of this Agreement in the Statement of Work**,** attached as Attachment A to this agreement and made a part hereof the (collectively, the "Services").

Now, therefore, in consideration of the above and in consideration of the mutual covenants contained, it is agreed by the CMHSP and Provider as follows:

CONTRACTUAL PROVISIONS

1. Authority

This Agreement is entered into pursuant to the authority granted to the CMHSP pursuant to the Mental Health Code. This Agreement is in accordance with the rules, regulations, and standards (referred to as the "MDHHS Administrative Rules") of the MDHHS adopted and promulgated in accordance with the Mental Health Code.

This Agreement is in accordance with the requirements of the Balanced Budget Act of 1997 the ("BBA"), as amended, and the BBA final rules, regulations, and standards, and with the requirements of the applicable state and federal programs. This Agreement is in accordance with the standards as contained in the aforementioned ("AFP") as they pertain to the provisions of specialty Services to Medicaid eligible, and the plans of correction and subsequent plans of correction submitted by the PIHP and approved by the MDHHS, and any stated conditions, as reflected in the MDHHS approval of the AFP, unless prohibited by federal or state law.

The Mental Health Code, the MDHHS rules, the MDHHS/CMHSP Master Contract, and the MDHHS/PIHP Master Contract, the PIHP/CMHSP Medicaid Subcontracting Agreement, and applicable State and federal laws shall govern the expenditure of funds and provisions of Services hereunder including in any area not specifically covered by this Agreement.

2. Term and Termination

2.1 Term: The initial term of this Agreement shall be for fiscal year 20XX (FYXX) and shall begin on _____ and shall expire on _____, unless earlier terminated as set forth herein. Following expiration of the initial term, this Agreement shall automatically renew for up to two successive twelve (12) month periods under the same terms and conditions as herein contained effective October 1st of each year. Provider shall have the opportunity to review the initial agreed upon rate with the CMHSP on an annual basis, but agrees that if any change to the rate is not agreed to and fully executed before September 30 of each year, the rate then currently in effect shall remain unchanged.

2.2 Termination without Cause: Any party to this agreement may terminate this Agreement at any time without cause by providing sixty (60) days prior written notice to Provider or CMHSP, as applicable.

2.3 Termination with Cause: In the event Provider breaches any of the terms of this contract (and if the CMHSP deems such a breach to be a material breach), the CMHSP may terminate this contract immediately and without prior notice.

2.4 Continuity of Care upon Termination of Agreement: Provider shall continue to render the Services consistent with the terms and conditions of this Agreement during any notice period and shall complete all Consumer documentation prior to the effective date of termination. Provider will assure Consumer treatment and care continues regardless of the reason for termination of this Agreement. Provider duties and responsibilities for patient care and treatment shall survive termination or expiration of this Agreement, regardless of cause.

3. Funding

This Agreement is contingent upon receipt by the CMHSP of sufficient federal, state and local funds, upon the terms and conditions of such funding as appropriated, authorized and amended, upon continuation of such funding, and collections of Consumer fees and third-party reimbursements, as applicable. In the event that circumstances occur that are not reasonably foreseeable, or are beyond the control of the CMHSP, that reduces or otherwise interferes with its ability to provide or maintain specified Services or operational procedures for its Service Area, the CMHSP shall provide immediate notice to Provider if it would result in any reduction of the funding upon which this Agreement is contingent. The CMHSP shall not refer patients to Provider, without concurrence of Provider, for treatment hereunder if any such reduction in funding would not enable the CMHSP to meet its financial obligations hereunder for payments to Provider for such Services, as applicable.

4. Relationship of the Parties

In performing its responsibilities under this Agreement, it is expressly understood and agreed that Provider's relationship to the CMHSP is that of an independent contractor. This Agreement shall not be construed to establish any principal/agent relationship between the CMHSP and Provider.

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

4.2 It is expressly understood and agreed that Provider's staff psychiatrists, employees, servants, agents, and subcontractors providing Services pursuant to this Agreement shall not in any way be deemed to be or hold themselves out as the psychiatrists, employees, or agents of the CMHSP. Provider's staff psychiatrists, employees, agents, and subcontractors shall not be entitled to any fringe benefits from the CMHSP, such as, but not limited to, health and accident insurance, life insurance, longevity, economic increases, or paid vacation and sick leave.

4.3 Provider shall be responsible for paying all salaries, wages, or other compensation due to its staff psychiatrists, employees, agents and subcontractors performing Services under this Agreement, and for the withholding and payment of all applicable taxes, including, but not limited to, income and social security taxes, to the proper federal, state and local governments. Provider shall carry worker's compensation coverage and unemployment insurance coverage for its staff psychiatrists and other employees and agents as required by law and shall require the same of its subcontractors and shall provide the CMHSP with proof of said coverage. Provider will be solely and entirely responsible for its acts and the acts of its agents, employees, , and sub-contractors.

5. Relationships with Other Contractors of the CMHSP

The relationship of Provider, pursuant to this Agreement, with other contractors of the CMHSP shall be that of independent contractor. Provider, in performing its duties and responsibilities under this Agreement, shall fully cooperate with the other contractors of the CMHSP Provider.

6. Subcontracting

6.1 If Provider delegates or subcontracts any Services to be provided under this Agreement, the payment-authorizing CMHSP retains the right to review, approve and monitor any subcontracts or any subcontractor's compliance with this Agreement and all applicable laws and regulations.

6.2 Provider may subcontract for the provision of any of the Services specified in this Agreement including contracts for administrative and financial management, and data processing. Provider shall be held solely and fully responsible to execute all provisions of this contract, whether or not said provisions are directly pursued by Provider, or pursued by Provider through a subcontract vendor. Provider shall ensure that all subcontract arrangements clearly specify the type of Services being purchased. Subcontracts shall ensure that the CMHSP and the MDHHS are not parties to the contract and therefore not a party to any employer/employee relationship with the subcontractor of Provider. Subcontracts entered into by Provider shall address such provisions as Provider deems necessary for the development of the Service delivery system, and shall include standard terms and conditions as the MDHHS may develop.

7. Assignment

Provider shall not assign this Agreement without the express written consent of the CMHSP.

8. Business Records, Maintenance of Records & Audits

8.1 Financial Review: In accordance with 2 CFR Subpart F, Provider shall submit, upon request of the CMHSP, financial statements and related reports and schedules that accurately reflect the financial position of Provider. Provider must submit, upon request of the CMHSP, its financial statements and supporting reports and schedules as presented to its governance authority. The CMHSP reserves the right to require Provider to secure an independent financial audit.

8.2 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.

8.3 Access to Books and Records: The CMHSP, the MDHHS and the State of Michigan or their designated representatives shall be allowed to review, copy and/or audit all financial records, licensure, accreditation and certification reports and to review and/or audit all clinical Services records of Provider pertaining to performance of this Agreement, to the full extent permitted by applicable federal and state law. Refusal to allow the CMHSP, the MDHHS or the State of Michigan or their designated representative(s) access to said records for the above-stated purposes shall constitute a material breach of this Agreement for which the CMHSP may exercise any of its remedies available at law or in equity, including, but not limited to, the immediate termination of this Agreement. Clinical records and financial records and supporting documentation must be retained by Provider and be available for audit purposes as required by state law.

8.4 Access to Books and Records by Federal Authorities: If the Secretary of the U.S. Department of Health and Human Services, the Comptroller General of the United States or their duly authorized representatives (referred to as the "Requesting Parties") request access to books, documents, and records of Provider as outlined in Provider Manual and in accordance with Section 952 of the Omnibus Reconciliation Act of 1980 [42 USC 1395x(v)(1)(I)] and the regulations adopted pursuant thereto, Provider agrees to provide such access to the extent required. Furthermore, Provider agrees that any contract between it and any other organization to which it is to a significant extent associated or affiliated with, owns or is owned by or has control of or is controlled by (referred to as "Related Organization"), and which performs Services on behalf of it or the other party hereto will contain a clause requiring the Related Organization to similarly make its books, documents, and records available to the Requesting Parties.

9. Conflict of Interest

Provider affirms that no principal, representative, agent or another acting on behalf of or legally capable of acting on behalf of Provider is currently an employee of the MDHHS or any of its constituent institutions, an employee or board member of the CMHSP, nor is any such person related to Provider currently using or privy to such information regarding the CMHSP which may constitute a conflict of interest. Breach of this covenant may be regarded as a material breach of the Agreement and a cause for termination.

10. Non-Discrimination

10.1 In performing its duties and responsibilities under this Agreement, Provider shall comply with all applicable federal and state laws, rules and regulations prohibiting discrimination. Provider shall not discriminate against any employee or applicant for employment with respect to hire, tenure, terms, conditions, or privileges of employment or a matter directly or indirectly related to employment because of race, color, religion, national origin, age, sex, height, weight, or marital status pursuant to the Elliott Larsen Civil Rights Act of 1976 PA 453, as amended (MCL 37.2202 *et seq.*).

Provider shall comply with the provisions of the Michigan Persons With Disabilities Civil Rights Act of 1976 PA 220 ("PWDRA"), as amended (MCL 37.1101 *et seq*). Provider shall comply with the Americans with Disabilities Act of 1990 ("ADA"), P.L. 101-336, 104 Stat 327 (42 USC 12101 *et seq.*), as amended, and regulations promulgated thereunder.

Provider shall comply with the Title VI of the Civil Rights Act of 1964 (42 USC 2000d *et seq.*) and Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency, Section 504 of the Federal Rehabilitation Act of 1973, as amended (Public Law 93-112, 87 Stat. 394), Title IX of the Education Amendment of 1972, as amended (20 USC 1681-1683 and 1685-1686) and the regulations of the U.S. Department of Health and Human Services issued thereunder (45 CFR, Part 80, 84, 86 and 91). 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, sex, color, religion, ethnicity, or 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, Affordable Care Act ("ACA") Section 1557. Any breach of this section may be regarded as a material breach of this contract. Provider shall comply with the Age Discrimination Act of 1975 (42 USC 6101 *et seq*). Provider shall not refuse to treat, and shall not discriminate in the treatment of, any Consumer or referral under this Agreement based on the individual's source of payment for Services, or on the basis of age, height, weight, marital status, arrest record, race, creed, disability, color, national origin or ancestry, religion, gender, political affiliation or beliefs. Provider agrees to assure accommodation of physical and communication limitations for Consumers served under this Agreement. Provider must assure that Consumers are permitted to choose his/her health care professional to the extent appropriate and reasonable.

11. Disclosure of Ownership and Control

Provider will comply with all federal regulations by disclosing to the CMHSP's CEO information about individuals with ownership or control interests in Provider, if any, by completing and executing **Attachment E: Disclosure of Ownership and Control**, attached and incorporated hereto, and returning same with an executed copy of this Agreement. The federal 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's obligations under this Agreement with the CMHSP, 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 whenever a change in entity ownership or control takes place.

12. Indemnification & Hold Harmless

Provider shall, at its own expense, protect, defend, indemnify and hold harmless the CMHSP, and its elected and appointed officers, employees and agents from all claims, damages, costs, law suits and expenses, including, but not limited to, all costs from administrative proceedings, court costs and attorney fees that they may incur as a result of any acts, omissions or negligence of Provider or any of its officers, employees, agents or subcontractors which may arise out of this Agreement. Provider's indemnification responsibilities under this section shall include any damages, costs and expenses which are in excess of the sum paid out on behalf of or reimbursed to the CMHSP, its officers, employees and agents by the insurance coverage obtained and/or maintained by Provider pursuant to the requirements of this Agreement.

13. Insurance

The PROVIDER, or any of their subcontractors, shall not commence work under this contract until they have obtained the insurance required under this paragraph, and shall keep such insurance in force during the entire life of the contract.

13.1.1. All coverage shall be with insurance companies licensed and admitted to do business in the State of Michigan with a minimum “A-“rating by Best’s Insurance Rating Service. The requirements below should not be interpreted to limit the liability of the PROVIDER.

13.1.2. All deductibles and self-insured retention (SIR’s) are the responsibility of the PROVIDER.

13.1.3. The PROVIDER shall maintain certificates of insurance from all PAYOR-approved subcontractors and ensure adequate coverage is provided throughout the term of the subcontractor’s agreement. All coverage for subcontractors shall be subject to the minimum requirements identified below.

13.1.4. PROVIDER, at its sole expense, must maintain the insurance coverage identified below. All required insurance must protect the PAYOR from claims that arise out of, are alleged to arise out of, or otherwise result from PROVIDER's or subcontractor's performance. PROVIDER shall obtain and maintain the following types of insurance policies with limits set forth below:

Required Limits	Additional Requirements
Commercial General Liability Insurance	

Minimum Limits: $1,000,000 Each Occurrence $1,000,000 Personal & Advertising Injury $2,000,000 General Aggregate $2,000,000 Products/Completed Operations	
Automobile Liability Insurance	
If a motor vehicle is used in relation to the Contractor's performance, the Contractor must have vehicle liability insurance on the motor vehicle for bodily injury and property damage as required by law.	
Workers' Compensation Insurance	
Minimum Limits: Coverage according to applicable lawsgoverning work activities	Waiver of subrogation, except where waiver is prohibited by law.
Privacy and Security Liability (Cyber Liability) Insurance	
Minimum Limits: $1,000,000 Each Occurrence $1,000,000 Annual Aggregate	PROVIDER must have their policy cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability.
Professional Liability (Errors and Omissions) Insurance	
Minimum Limits: $1,000,000 Each Occurrence $3,000,000 Annual Aggregate	

13.1.4.1. **Additional Insured:** Commercial General Liability and Automobile Liability, as described above, shall include an endorsement stating the following shall be additional insured: PAYOR, together with all elected and appointed officials, all employees and volunteers, all boards, commissions, and/or authorities and board members, including employees and volunteers thereof. It is understood and agreed by naming the PAYOR as additional insured, coverage afforded is considered to be primary and any other insurance PAYOR may have in effect shall be considered secondary and/or excess, unless specifically waived in writing by PAYOR.

13.1.4.2. **Cancellation Notice:** All insurances policies as described above shall include an endorsement stating the following: “It is understood and agreed that Thirty (30) days (Ten (10) days for non-payment of premium) advance written Notice of Cancellation, Non-Renewal, Reduction and/or Material Change shall be sent to the PAYOR.

13.1.4.3. **Proof of Insurance:** The PROVIDER shall provide PAYOR, at the time that the contracts are returned for execution, a Certificate of Insurance as well as the required endorsements. In lieu of required endorsements, if applicable, a copy of the policy sections where coverage is provided for additional insured and cancellation notice is acceptable. Copies or certified copies of all policies mentioned above shall be furnished, if so requested.

13.1.4.4. **Continuation of Coverage:** If any of the above coverages expires during the term of this agreement, the PROVIDER shall deliver renewal certificates and/or endorsements to the PAYOR at least ten (10) days prior to the expiration date.

13.1.4.5. The duty to maintain the insurance coverage specified in this Section shall survive the expiration or termination of this Agreement and shall be enforceable, regardless of the reason for termination of this Agreement, against PROVIDER.

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

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

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

14. Compliance with the Law; Applicable Law and Venue

14.1 This Agreement shall be construed according to the laws of the state of Michigan as to the interpretation, construction and performance.

14.2 The CMHSP and Provider agree that the venue for the bringing of any legal or equitable action under this Agreement shall be established in accordance with the statutes of the state of Michigan and/or Michigan Court Rules. In the event that any action is brought under this Agreement in federal court, the venue for such action shall be the Federal Judicial District of Michigan, Eastern District.

14.3 Provider, its officers, employees, servants, and agents shall perform all their respective duties and obligations under this Agreement in compliance with all applicable federal, state, and local laws, ordinances, rules and regulations.

14.4 The parties hereto acknowledge and agree that the following statutes, rules, regulations and procedures govern the provision of Services rendered hereunder and the relationship between the parties:

a) The MDHHS/PIHP Master Contract, and the MDHHS/CMHSP Master Contract;

b) Michigan Mental Health Code and its rules and regulations, as amended;

c) Michigan Public Health Code and its rules and regulations, as amended;

d) MDHHS Medicaid Provider Manual, as amended;

e) Policies and procedures of the CMHSP with respect to Provider networks, and the provision and payment of Services contemplated by this Agreement; and

f) The Anti-Lobbying Act, 18 USC §1913, the Lobbying Disclosure Act of 1995, 2 USC 1601 *et seq*. Further, Provider shall require that the language of this assurance be included in the award documents of all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

g) Pursuant to MCL 423.321 *et seq*., the State shall not award a contract or subcontract to an employer or any subcontractor, manufacturer or supplier of the employer, whose name appears in the current register compiled by the Michigan Department of Licensing and Regulatory Affairs. The State or the CMHSP may void any contract if, subsequent to award of the contract, the name of Provider as an employer, or the name of the subcontractor, manufacturer or supplier of Provider appears in the register.

h) Any other applicable state and federal laws governing the parties hereto.

15. Compliance with the MDHHS/CMHSP Master Contract for General Funds and the MDHHS/PIHP Master Contract

It is expressly understood and agreed by Provider that this Agreement is subject to the terms and conditions of the MDHHS/CMHSP Master Contract and the MDHHS/PIHP Master Contract. In the event that any provision of this Agreement is in conflict with the terms and conditions of a Master Contract, the provisions of the Master Contract shall prevail. However, a conflict shall not be deemed to exist where this Agreement:

a) Contains additional provisions and additional terms and conditions not set forth in the Master Contracts;

b) Restates provisions of a Master Contract to afford the CMHSP or the PIHP the same or substantially the same rights and privileges as MDHHS; or,

c) Requires Provider to perform duties and Services in less time than required of the CMHSP or the PIHP in a Master Contract.

16. Debarment and Suspension and Exclusion

Provider represents and warrants that Provider and its personnel will comply with the Federal Acquisition Regulations (45 CFR 76) and that Provider and its personnel:

a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or excluded from covered transactions by any federal department, government programs, PIHP or CMHSP;

b) have not within a three (3) year period preceding this Agreement been convicted of or had a civil judgment rendered against it for commission of fraud or 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, briber, falsification or destruction of records, making false statements, or receiving stolen property;

c) are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state or local) with commission of any of the offenses enumerated in this Section; and convicted of any crime relating to any Government Programs.

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

17. Licenses, Accreditation, Certifications, Credentialing and Privileging Requirements

17.1 Provider shall obtain and maintain all requisite approvals, federal and state licensures, professional staff licenses and accreditation for its inpatient psychiatric unit. Further, Provider shall comply with the standards of external accrediting agencies, such as The Joint Commission Accreditation of Healthcare Organizations ("JCAHO"), The Commission on Accreditation of Rehabilitation Facilities ("CARF") or Counsel on Accreditation ("COA"). Provider shall submit to the CMHSP copies of license renewal on an annual basis as well as accreditation renewal certificates.

17.2 Provider shall ensure there are systems in place to assure that its staff meet appropriate licensure and competency standards including systems for the primary verification of professional credentials.

17.3 The MDHHS requires the CMHSP to ensure that contracted providers perform criminal background checks on their employees. These criminal background checks are a requirement of this Agreement. Provider must have, and follow, a policy on hiring of persons with criminal backgrounds that is consistent with applicable licensing and/or certification rules.

17.4 Provider shall provide evidence of accreditation by a nationally recognized accreditation body, or must show evidence of a scheduled survey to be completed during the contract year. If Provider is not accredited, it must submit a plan for seeking accreditation within 90 days of the Agreement start date. If Provider fails to receive accreditation due to unsatisfactory survey results, Provider shall submit a plan of correction to the CMHSP within 60 days.

17.5 If Provider employs or contracts with licensed health care professionals, it is required to have a written system (policy and procedure) in place for credentialing and re-credentialing of these individuals. Refer to the CMHSP Provider Manual for more specific information about required credentialing and re-credentialing expectation.

17.6 Provider shall re-apply to the CMHSP every two (2) years to continue in the CMHSP's Provider Network.

18. Staffing and Training Requirements

18.1 Provider, pursuant to this Agreement, shall ensure that:

a) Active treatment is provided by Provider's staff to each Medicaid covered and non-Medicaid Consumer hereunder at the medically necessary level of care;

b) Services hereunder are to be provided by Provider's staff in a manner that demonstrates cultural competency; and

c) Provider shall maintain staffing consistency and programming continuity in the provision of Services to Consumer(s).

18.2 Provider's staff, when performing Services under this Agreement, shall comply with:

a) All applicable provisions and requirements for Services in the Mental Health Code, any MDHHS rules, Medicaid regulations, and the MDHHS/PIHP Master Contract and the MDHHS/CMHSP Master Contract; and,

b) All applicable policies, guidelines, and standards established by Provider.

18.3 Orientation of and ongoing training and education of Provider's staff shall follow minimum training requirements as listed in the attached MSHN Training Grid see Attachment F.

18.4 Provider shall mandate continuing education to Provider's staff as needed or when necessitated by changes in Provider's programs or as stated in recipient rights requirements, including but not limited to the requirements identified by the MDHHS in the MDHHS/CMHSP Master Contract.

19. Rights of Recipient

19.1 Recipients will be protected from rights violations while they are receiving services under the Agreement. PROVIDER agrees to assume responsibility for the administration, quality of care, treatment services, and protective services for all Recipients, admitted for care. The term “protective services” as used in this paragraph means reporting and referral services required by the PROVIDER under the adult abuse reporting requirements pursuant to Michigan’s Social Welfare Act, being Michigan Compiled Law 400.11 *et seq.* , or the Child Protection Law, Act 238 of the Public Acts of 1975, as amended, being Michigan Compiled Law 722.621 *et seq*.

19.1 The PAYOR and the PROVIDER shall strictly comply with all Recipient Rights provisions of the Mental Health Code and the MDHHS Rules. The PROVIDER shall provide a Recipient Rights protection system for PAYOR recipients admitted into its inpatient unit pursuant to this agreement to comply with the following:

19.1.1. The PROVIDER's Recipient Rights protection system will comply with Chapters 7 and 7A of the Mental Health Code, including completing complaints, investigations, and remedial action in accordance with mandated timeframes.

19.1.2. Complaints, investigations, reports, and remediation will comply with the requirements of Chapter 7 and 7A of the Mental Health Code 1722 (2), required disciplinary action.

19.1.3. Complainants, recipients, staff of the office of recipient rights, and any staff acting on behalf of a recipient will be protected from harassment or retaliation resulting from recipient rights activities and appropriate disciplinary action will be taken if there is evidence of harassment or retaliation. The PROVIDER shall assure that appropriate disciplinary action is taken if such harassment or retaliation occurs.

19.1.4. PROVIDER agrees to implement appropriate remedial or disciplinary action for substantiated allegations of rights violations and submit a written description of the remedial or disciplinary action to PAYOR's Recipient Rights office within five (5) business days of receipt of the Investigative Report.

19.2 Site Visits:

19.2.1. The PAYOR may elect to conduct site visits to the PROVIDER to ensure rights of PAYOR recipients are protected.

19.2.2. The PROVIDER agrees to cooperate with and participate in said site visits and make available to the reviewers any information requested regarding the Recipient Rights system of the PROVIDER and any Rights information concerning any PAYOR recipient of PROVIDER services, either current or past.

19.2.3. PROVIDER will ensure unimpeded access for PAYOR, at any time, and at least annually for the purpose of assessments, to review the PROVIDERs records regarding Recipient Rights requirements such as staff training logs, to complete site visits for monitoring of rights protection, and to ensure compliance with MDHHS' policies and procedures outlined in their compliance standards and training requirements.

19.2.4. The PROVIDER shall inform, in writing, the PAYOR'S CEO of any notice to, inquiry from, or investigation by any federal, state, or local human services, fiscal, regulatory, investigatory, prosecutory, judicial, or law enforcement agency or protection and/or advocacy organization regarding the rights, safety, or care of a Recipientserved under this Agreement. The PROVIDER also shall inform, in writing, the PAYOR'S CEO immediately of any subsequent findings, recommendations, and results of such notices, inquiries, or investigations.

19.3 The PROVIDER shall provide a Recipient Rights protection system for PAYOR recipients admitted into its inpatient unit pursuant to and as applicable under this agreement to comply with the following:

19.3.1. Recipients will be protected from rights violations while they are receiving services under the Agreement.

19.4 The PROVIDER agrees to monitor the safety and welfare of recipients while they are under its service supervision pursuant to this Agreement, to provide immediate comfort and protection to and assure immediate medical treatment for a recipient who has suffered physical injury or illness. The PROVIDER agrees to immediately notify the PAYOR Recipient Rights Office of incidents of apparent or suspected abuse, neglect, serious injury or death of a recipient, or of any other event or information that raises questions regarding the health and safety of any Recipient being served hereunder.

19.5 The PAYOR Recipient Rights officer shall have unimpeded access to all PAYOR's Recipients, medical records, or applicable staff records as needed. PROVIDER employees are required to cooperate with PAYOR's Recipient Rights Office at all times.

19.6 Copies of complaints and all acknowledgement letters, intervention letters, investigative reports, summary reports relative to a PAYOR'S recipient, will be provided to the PAYOR'S Rights Office, upon completion, for monitoring/coordination purposes, as well as semi-annual and annual reports.

19.7 Training:

19.7.1. The PROVIDER assures the PAYOR that any individual hired as the PROVIDER's Recipient Rights Officer (RRO) during the term of this agreement shall attend and successfully complete the MDHHS Recipient Rights Training programs within the first 90 days of hire and shall receive annual training in rights issues thereafter. Additionally, all Rights Office staff must comply with the requirements delineated in Attachment C6.3.2.3A as found in **Attachment H** ("Technical Requirement Continuing Education Requirements for Recipient Rights Staff").

19.7.2. The PROVIDER will develop a rights training curriculum which is consistent with Chapters 7 and 7A of the Mental Health Code and meets PAYOR approval, outlined in Attachment C6.3.2.3B as found in **Attachment I.**

19.7.3. A copy of the rights training curriculum will be submitted to the PAYOR for review and approval upon request and within 30 days of request from PAYOR.

19.7.4. Persons employed with the PROVIDER will receive rights training before or within 30 days after being employed, and annually thereafter. The PROVIDER will maintain such training records documenting staff training within 30 days of hire and make said records available to the PAYOR ~~as~~ upon request.

19.8 Appeals:

19.8.1. The PAYOR'S Recipient Rights Appeals Committee will hear appeals by recipients of the PAYOR of investigations conducted by the PROVIDER'S Rights staff, as such PAYOR's Recipient Rights Appeals Committee contact information will be included with every summary report issued. Both parties agree to follow requirements as it relates to Recipient Rights Appeals process as described in Attachment C6.3.2.4 as found in **Attachment G**.

19.8.2. The PROVIDER agrees to abide by the decisions of the PAYOR'S Recipient Rights Appeals Committee within required timelines.

19.9 Policies and Procedures:

19.9.1. The PROVIDER is expected to follow the Recipient Rights provisions of the Mental Health Code, corresponding Administrative Rules, and the Recipient Rights Policies and Procedures delineated in **Attachment C: Recipient Rights Policies & Attestation** to this Agreement and provide copies upon request from PAYOR.

19.9.2. PROVIDER agrees to comply with, in their entirety, their policies and procedures providing for the safeguarding of the rights of Recipients as established.

19.9.3. PROVIDER agrees to protect the rights of all persons using their services as guaranteed in 1974 Public Act 258, as amended, and 330.7001, *et seq*. of the Michigan Administrative Rules.

19.10 The PROVIDER agrees to furnish the PAYOR'S CEO and Recipient Rights Office with immediate notice of any sentinel event involving any Recipientbeing served hereunder. The PROVIDER shall report the death, serious injuries, suspected abuse or neglect and all other alleged rights violations regarding a Recipient hereunder to PAYOR'S CEO and Recipient Rights Office immediately by telephone and then, in writing on PAYOR-designated forms, within twenty-four (24) hours of the occurrence and, as required by law, to (Adult and Children) Protective Services Division of the applicable department of the State of Michigan, law enforcement, and other public agencies.

19.11 The PROVIDER agrees to allow individuals who properly identify themselves as representatives of Disability Rights Michigan access to the premises, recipients, staff, and service records in compliance with Section 748(8), 750, and Section 931 of the Michigan Mental Health Code.

19.12 PROVIDER agrees to maintain the confidentiality of information regarding Recipients in compliance with Sections 748 and 750 of the Mental Health Code.

19.13 PROVIDER agrees to ensure that each person served under this contract is provided with a MDHHS "Your Rights" booklet and that these booklets are made available to Recipients, visitors, and employees in accordance with Section 706 of the Mental Health Code and Administrative Rule 7011.

19.14 PROVIDER shall ensure a summary of section 748 of the Michigan Mental Health Code will be filed in the case record for each CONSUMER in accordance with AR 330.7051(1).

19.15 A Recipient of or an applicant for public mental health services may access several options to pursue resolution of complaints regarding services and supports managed and/or delivered by the PAYOR and its service provider network. The options may be pursued simultaneously. Specification of said options are set forth in the attached document labeled Exhibit G ("CONSUMER GRIEVANCE & DISPUTE RESOLUTION PROCESS"), which is incorporated by reference into this Agreement and made a part hereof. The PROVIDER agrees to comply with said grievance procedures required by the PAYOR and the MDHHS for receiving, processing and resolving promptly any and all complaints, disputes, and grievances for Medicaid and non-Medicaid CONSUMERS or potential CONSUMERS.

20. Consumer Grievance Procedures

Provider agrees to establish policies and procedures that fully comply with the CMHSP's Consumer Grievance and Appeals Policy and Procedure, Recipient Rights Policies and Procedures, and Incident/Sentinel Event Policies and Procedures, which are in accordance with MDHHS requirements. These policies and procedures are detailed in the CMHSP's Provider Manual, located on the CMHSP's website. The CMHSP agrees to distribute regular updates to the manual located on its website, as needed, and Provider agrees to maintain the manual with updates provided by the CMHSP.

21. Consumer Medical Records

21.1 Provider, shall establish and maintain a comprehensive individual Services record system consistent with the provisions of MDHHS Medical Services Administration ("MSA") Policy Bulletin Chapter 1, the Michigan Department of Technology, Management, and Budget Retention General Schedule #20 Community Mental Health Programs Dated March 2, 2007, and appropriate state and federal statutes.

21.2 The CMHSP has the right to full access to all records pertaining to any Consumer and Services rendered pursuant to this Agreement. Provider agrees to furnish the CMHSP with copies of all records pertaining to any Consumer and Services rendered pursuant to this Agreement within 14 days of request. Provider ensures that it is in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") requirements.

All Consumer information, medical records, data and data elements, collected, maintained or used in the execution of this Agreement shall be protected by Provider from unauthorized disclosure as required by state and federal regulations. Provider must provide safeguards that restrict the use or disclosure of information concerning Consumers to purposes directly connected with this Agreement.

21.3 Provider shall comply with all applicable federal and state laws, rules and regulations, including the Mental Health Code and the MDHHS rules, on confidentiality with regard to disclosure of any materials and/or information provided pursuant to this Agreement. Any release of information must be in compliance with the Mental Health Code and all other laws and regulations.

Provider assures that it is in compliance with 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"), HIPAA Enforcement Rule ("Enforcement Rule"), as amended from time to time, (hereafter collectively referred to as "HIPAA Regulations"); and the federal confidentiality law, and underlying regulations, 42 CFR Part 2 ("Part 2"). This includes the distribution of Consumer handbooks and Provider directories to Consumers, and/or the HIPAA Privacy Notice.

22. Compliance Program

22.1 Provider shall implement and maintain a compliance and program integrity plan, the ("Compliance Plan") in accordance with federal and state law, including but not limited to 42 CFR 438.608. The Compliance Plan must include, at a minimum, the following elements:

a) An employee/contractor code of conduct and standards of conduct for compliance with federal and/or state standards; 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, 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).

b) Employee Education Program(s): effective training and education for the compliance officer and the organization's employees;

c) Communication processes between senior management and employees regarding the compliance program; the designation of a compliance officer and a compliance committee that are accountable to senior management;

d) Guidance and reporting system(s);

e) Prompt investigation and complaint resolution processes: Clearly defined practices that provide for prevention, detection, investigation and remediation of any compliance related matters;

f) Corrective action planning and implementation; and

g) Data monitoring and evaluation.

22.2 Upon request, Provider will furnish a copy of the Compliance Plan to the CMHSP. Provider agrees to immediately notify the CMHSP with respect to any inquiry, investigation, sanction or otherwise from the Office of Inspector General ("OIG").

23. Quality Improvement Program/Site Reviews/Performance Monitoring

23.1 Provider shall maintain a fully operational internal Quality Assessment and Performance Improvement Program ("QAPIP").

23.2 Provider agrees, to cooperate fully in the CMHSP's implementation of: (1) performance improvement projects; (2) quantitative and qualitative member assessments periodically, including Consumer satisfaction surveys and other Consumer feedback methodologies; (3) regular measurement, monitoring, and evaluation mechanisms as to Services, utilization, quality, and performance; (4) systems for periodic and/or random compliance review or audit; and, (5) studies to regularly review outcomes for Service recipients as a result of programs, treatment, and community services rendered to individuals in community settings.

23.3 The CMHSP will conduct reviews and audits of Provider performance under this Agreement. The CMHSP will make a good faith effort to coordinate reviews and audits to minimize disruption to Provider operations and to avoid duplication of effort. The focus of Provider review is on the degree to which Provider has implemented the requirements of this Agreement and the degree of compliance with performance standards, performance indicators, and other CMHSP requirements. Provider shall comply with the corrective action requirements of the CMHSP, including compliance with corrective action plan submission and subsequent implementation of approved corrective action plans. Corrective action plans submitted by Provider are deemed approved unless the CMHSP indicates, in writing within thirty (30) days of receipt of the corrective action plan, that such corrective action plan is not approved.

23.4 **Quality Assurance:** Provider shall cooperate with the CMHSP 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 the CMHSP, 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.

24. Dispute Resolution

24.1 Any disagreements with respect to this Agreement, including, without limitation, action taken in this Section against Provider, shall be addressed through the dispute resolution procedures detailed in Provider Manual and/or policies. In the event that dispute remains unresolved following use of such procedure, then the dispute shall be reduced to writing and submitted to each party's Chief Executive Officer. If such disputes cannot be resolved between the CMHSP and Provider, either party may seek resolution through exercise of any available legal and/or equitable remedies, including attorneys fees and costs for enforcemtn of this Agreement..

24.2 All decisions to authorize, deny, continue, or discontinue the CMHSP's payments for Provider's Services to Consumers hereunder shall be those of the CMHSP's CEO. Decisions to continue Services without reimbursement from the CMHSP shall be those of Provider.

25. Notices

25.1 Provider shall notify the CMHSP within ten (10) business days of any of the following events:

a) civil, criminal, or other action or finding of any licensing/regulatory body or accrediting body, the results of which suspends, revokes, or in any way limits Provider's authority to render Covered Services;

b) any actual or threatened loss, suspension, restriction or revocation of Provider's license;

c) any malpractice action filed against Provider or its staff as it relates to Services under this Agreement;

d) any charge or finding or ethical or professional misconduct by Provider;

e) any loss of Provider's professional liability insurance or any material change in Provider's liability insurance;

f) any material change in information provided to the CMHSP in the accompanying Provider network application or in the credentialing information concerning any Provider;

g) any other event which limits Provider's ability to discharge its responsibilities under this Agreement professionally, promptly and with due care and skill; or

h) Provider is excluded from participation in Medicaid

25.2 Any and all notices, designations, consents, offers, acceptances or other communications herein shall be given to either party, in writing, by receipted personal delivery or deposited in certified mail addressed to the addressee shown below (unless notice of a change of address is furnished by either party to the other party hereto) and with return receipt requested, effective upon receipt:

a) Notice to the CMHSP should be addressed to the CMHSP's Chief Executive Officer.

b) Notice to Provider should be addressed to the Provider's Chief Executive Officer.

26. Miscellaneous Provisions

26.1 Binding Effect of the Agreement: This Agreement shall be binding upon the CMHSP and Provider and their respective successors and assigns.

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

26.3 Amendment: Modifications, amendments, or waivers of any provision of this Agreement may be made only by the written mutual consent of the parties hereto.

26.4 Completeness of the Agreement: This Agreement, its attachments, and the additional and supplementary documents incorporated herein by specific reference contain the terms and conditions agreed upon by the CMHSP and Provider and no other prior agreements, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind either the CMHSP or Provider.

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

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

26.7 Notification Regarding Funding: Provider shall immediately notify the CMHSP , in writing, of any action by Provider's governing board or any other funding source, which would require or result in changes to the provision of Services, funding, compliance with the terms and conditions of this Agreement or any other actions with respective to Provider's obligations to perform under this Agreement.

26.8 Research Restrictions on Human Subjects: Provider agrees to submit all research involving human subjects, which is conducted in programs sponsored by the MDHHS or in programs which receive funding from or through the State of Michigan, to the State Department's Research on Human Subjects Committee for approval prior to the initiation of the research.

26.9 Information Requirements: The CMHSP and Provider shall comply with MDHHS information requirements and standards, including those for advance directives. Any marketing or informative materials intended for distribution through written or other media to eligible non-Medicaid Consumers, Medicaid eligible, or the broader community that describe the availability of covered Services and supports and how to access those Services and supports pursuant to this Agreement, must be submitted by Provider or Provider's subcontractors for the CMHSP's approval or disapproval prior to any distribution. Such materials shall meet the following standards:

a) All such materials shall be written at the 4th grade reading level to the extent possible (i.e., sometimes necessary to include medications, diagnoses, and conditions that do not meet the 4th grade criteria).

b) All materials shall be available in the languages appropriate to the people served within the CMHSP's area. Such materials shall be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2002 Federal Register Volume 65, August 16, 2002).

c) All such materials shall be available in alternative formats in accordance with the Americans with Disabilities Act (ADA).

d) Material shall not contain false and/or misleading information.

26.10 Publications: Any drawings, records, documents, papers, reports, charts, maps, graphics or manuscripts prepared for or pertaining to the Services performed hereunder which are published or in any other way are provided to third parties shall acknowledge that they were prepared and/or created pursuant to this Agreement. Such acknowledgement shall include a clear statement that the CMHSP and its elected and appointed officers, employees, and agents are not responsible for the contents of the item(s) published or provided by Provider t third parties.

26.11 Time of the Essence: Time is of the essence in the performance of each and every obligation herein imposed.

26.12 Waivers: No failure or delay on the part of either of the parties to this Agreement in exercising any right, power or privilege hereunder shall operate as a waiver thereof, nor shall a single or partial exercise of any right, power or privilege preclude any other further exercise of any other right, power or privilege. In no event shall the making by the CMHSP of any payment to Provider constitute or be construed as a waiver by the CMHSP of any breach of this Agreement, or any default which may then exist, on the part of Provider, and the making of any such payment by the CMHSP while any such breach or default shall exist, shall in no way impair or prejudice any right or remedy available to the CMHSP in respect to such breach or default.

26.13 Disregarding Titles: The titles of the sections in this Agreement are inserted for the convenience of reference only and shall be disregarded when construing or interpreting any of the provisions of this Agreement.

26.14 Non-Third Party Beneficiary Contract: This Agreement is not intended to be a third party beneficiary contract and confers no rights, nor obligations on anyone other than the parties hereto.

26.15 Cultural Competence/Limited English Proficiency: Provider shall assure equal access for people with diverse cultural backgrounds and/or limited English proficiency. Provider shall demonstrate a commitment to linguistic and cultural competence that includes the ability to apply an understanding of the relationships of language and culture to the delivery of Services. Provider shall ensure the cultural competence of staff including documentation of training in each employee's personnel file.

26.16 Gender: Wherever in this Agreement words, including pronouns, are used in one gender or number, they shall be read or construed in another gender or number whenever they would so apply.

26.17 Ethics: The parties agree and acknowledge that each are subject to and shall comply with the Ethics Policy set forth in Provider Manual.

26.18 Health and Safety: Provider shall immediately notify the CMHSP, and shall arrange for the immediate transfer of Consumers to a different Provider, if the health and/or safety of the Consumer is in jeopardy.

26.19 State of Emergency: Provider shall follow the federal and/or state direction and guidance as it relates To any state of emergencies.

27. Certification of Authority to Sign the Agreement

The persons signing this Agreement on behalf of the parties hereto certify by their signatures that they are duly authorized to sign this Agreement on behalf of the parties, and that this Agreement has been authorized by the parties.

SIGNATURES TO FOLLOW ON NEXT PAGE

WHEREFORE, intending to be legally bound, the parties hereto have executed this Agreement as of the date set forth below.

"CMHSP"	**"PROVIDER"**
By:_____	By: _____
Print: _____	Print: _____
Its: Chief Executive Officer	Its: _____
Date: _____	Date: _____

Attachment A - ACRONYM AND GLOSSARY DEFINITIONS

Agreement: this Agreement whereby CMHSP(s) purchase Services on a subcontracted basis from the party designated as the "Provider" in the introductory paragraph of this Agreement.

Clean Claim: a clean claim is one that is free and clear of any problems and can be processed without obtaining additional information from Provider of the Service or a third party and as further described in the Social Welfare Act, state of Michigan statutes and federal statutes. 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: the Community Mental Health Services Program operated under chapter 2 of the Michigan Mental Health Code - Michigan Public Act 258 of 1974 as amended.

Compliance Plan: the implementation of a systematic process designed to ensure that the organization is performing business functions in a manner in compliance with the prevailing federal and state laws concerning health care billing practices and fraud detection and/or prevention. These regulations include HIPAA, Stark I and II, Medicare/Medicaid Anti-Kickback Statute and the False Claims Act.

Consumer: an individual who is an eligible person who is:

1. a resident of the Service Area;
2. is covered as a priority population under the Mental Health Code;
3. who meets the Services eligibility criteria; and
4. is receiving Services under this Agreement.

Consumer, Individual, Recipient and Patient are used interchangeably and refer to persons receiving Services under the terms of this Agreement.

Consumer's Financial Information Sheet ("ATP"): Consumer's financial obligation for Services they receive as calculated according to the Michigan Department of Health and Human Services Ability to Pay schedule.

Co-Payment: a payment made to Provider by the Consumer in accordance with the recipient's personal health care insurance plan.

Covered Services: all authorized mental health care Services offered within Provider's current level of credentialing, rendered to a CMHSP-referred or authorized Consumer for which the CMHSP is obligated to reimburse at an established fee and transaction type included in this Agreement between Provider and the CMHSP.

Cultural Competency: acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within Service models to work towards better meeting the needs of minority populations.

Developmental Disability: as described in Section 1100a of the Michigan Mental Health Code, if applied to an individual older than five years, a severe, chronic condition that meets all of the following requirements:

a. is attributable to a mental or physical impairment or a combination of mental and physical impairments;
b. is manifested before the individual is 22 years old;
c. is likely to continue indefinitely;
d. results in substantial functional limitations in three or more of the following areas of major life activities:
    i) self-care;
    ii) receptive and expressive language;
    iii) learning, mobility;
    iv) self-direction;
    v) capacity for independent living; or
    vi) economic self-sufficiency;
e. reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other Services that are of lifelong or extended duration and are individually planned and coordinated; and/or

f. if applied to a minor from birth to age five, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability if Services are not provided.

Health Insurance, Portability and Accountability Act, 1996 ("HIPAA"): Public Law 104-191, 1996 to improve the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of the Social Security Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information. HIPAA provides for improved portability of health benefits and enables better defense against abuse and fraud, reduces administrative costs by standardizing format of specific healthcare information to facilitate electronic claims, directly addresses confidentiality and security of patient information – electronic and paper-based, and mandates "best effort" compliance.

Incident Report: documentation of an event that varies from established policies and procedures for care or Services.

Indigent: an individual without Medicaid/HMP/other insurance that doesn't have resources to pay for Services.

Limited English Proficiency ("LEP"): individuals who cannot speak, write, read or understand the English language at a level that permits them to interact effectively with health care providers and social services agencies.

MDHHS: the Michigan Department of Health and Human Services.

MDHHS/CMHSP Master Contract: the current MDHHS/CMHSP Managed Specialty Supports and Services Contract between the MDHHS and the CMHSP that is a party to the Agreement.

MDHHS/PIHP Master Contract for Medicaid Funds: the current MDHHS/Prepaid Inpatient Health Plan Managed Specialty Supports and Services Contract between Mid-State Healthcare Network and the MDHHS.

Medicaid eligible: an individual who has been determined to be entitled to Medicaid for Service dates rendered. This includes persons entitled to Medicaid who are on a spend-down who have met their deductible for a given month and persons who are retro-eligible for Medicaid.

Medically Necessary or Medical Necessity**:** Services necessary for screening and assessing the presence of a mental illness, and/or required to identify and evaluate a mental illness that is inferred or suspected; and/or intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, including impairment of functioning; and/or designed to provide rehabilitation or habilitation for the recipient to attain or maintain an adequate level of functioning. The determination of a Medically Necessary Service must be based upon a person-centered planning process. Services selected based upon medical necessity criteria should be:

1. Delivered in a timely manner, with an immediate response to emergencies in a location accessible to the recipient.
2. Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner.
3. Provided in a least restrictive appropriate setting (inpatient and residential treatment shall be used only when less restrictive levels of treatment have been unsuccessful or cannot be safely provided).
4. Delivered consistent with national standards of practice, including standards of practice in community psychiatry, psychiatric rehabilitation and in substance abuse, as defined by standard clinical references, generally accepted professional practice or empirical professional experience.
5. Provided in sufficient amount, duration and scope to reasonably achieve their purpose.

Mental Health Code: Act 258 of Public Acts of 1974, as amended.

MSHN: Mid-State Health Network

Performance Improvement ("PI"): the continuous study and adaptation of functions and processes of a health care organization to increase the probability of achieving desired outcomes and to better meet the needs of the members and other users of Services.

Practice Guidelines: MDHHS-developed guidelines for PIHPs and CMHSPs for specific service, support or systems models of practice that are derived from empirical research and sound theoretical construction and are applied to

the implementation of public policy.

Prepaid Inpatient Health Plan ("PIHP"): an organization that manages Medicaid specialty services under the state's approved waiver program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR Part 401 *et seq*., regarding Medicaid managed care. In this Agreement, the PIHP is MSHN.

Protective Services: reporting and referral Services required by Provider under the adult abuse reporting requirements pursuant to Michigan's Social Welfare Act, being MCL 400.11 *et seq.* , or the Child Protection Law, Act 238 of the Public Acts of 1975, as amended, being MCL 722.621 *et seq*.

Provider: the party designated as the "Provider" in the introductory paragraph of this Agreement.

Provider Manual: the instructions and documents prepared by the CMHSP and posted on the website of the CMHSP.

Recipient: means an individual who receives mental health services, either in person or through telemedicine, from the department, a community mental health services program, or a facility or from a provider that is under contract with the department or a community mental health services program. For the purposes of this act, recipient does not include an individual receiving substance use disorder services under chapter 2A unless that individual is also receiving mental health services under this act in conjunction with substance use disorder services.

Rules: rules, regulations, and standards promulgated and adopted by the MDHHS in compliance with the Mental Health Code.

Sentinel Events: an "Event" or "unexpected occurrence" involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Event: any and all of the following:

a) relocation of a Consumer due to licensing issues;
b) relocation of the Service site or administrative operations of Provider for more than 24 hours;
c) conviction of a Provider staff for any offense related to the performance of their job duties/responsibilities;
d) unusual incidents such as emergency medical treatment, hospitalization, medication error, arrest of a Consumer; or behavioral incidents that are unexpected/not addressed, harm to self, and harm to others.

An Event must be put in writing within 24 hours and is generally reported to the CMHSP on an "Incident Report".

Serious Emotional Disturbance ("SED"): as described in Section 1100c of the Michigan Mental Health Code, a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDHHS, and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities.

Serious Persistent Mental Illness ("SPMI"): as described in Section 1100c of the Michigan Mental Health Code, a serious mental illness that is a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDHHS, and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Serious persistent mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbances, but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness.

Service Area: the county or counties served by the CMHSP.

Substance Use Disorders: includes substance dependence and substance abuse, according to selected specific diagnostic criteria given in the most current Diagnostic and Statistical Manual of Mental Disorders.

Attachment B - STATEMENT OF WORK

<INSERT PROVIDER NAME>
<INSERT FISCAL YEAR>
IMD Status: _____ (yes or no)

I. TARGET SERVICE GROUP AND ELIGIBILITY CRITERIA FOR SERVICES

a. The target service group for Services under this Agreement is as follows:

Mentally Ill (MI) and Intellectually and/or Developmentally Disabled (I/DD) adults, older adults, and adolescents who meet Provider's admission criteria, who are residents of [INSERT] counties or residents of other counties referred by CMHSP and approved for admission by an authorized representative of [CMHSP].

b. Residents of [INSERT] counties who reside at state facilities of the MDHHS may be admitted to Provider's inpatient unit following the screening, evaluation, referral, and approval by the CMHSP.

II. DESCRIPTION OF SERVICES:

a. Following is a description of specific services, requirements and guidelines for treatment of persons referred by the CMHSP who require psychiatric hospitalization. The hospital shall engage in joint, continuous quality improvement projects with the CMHSP to improve Consumer care and realize improvements in mutual financial performance.

b. The hospital shall assist the CMHSP in achieving its Medicaid expenditure performance target. Methodology shall include joint planning, data sharing, assistance with rapid triage/disposition of Consumer, and placement in appropriate levels of clinical intensity of Service in cooperation with the CMHSP.

c. The hospital shall work in conjunction with the CMHSP to achieve a decrease in the readmission rate of Consumers admitted to their inpatient setting. Readmission is defined as the Consumer requiring a return to inpatient care within a specific time frame after discharge for prior psychiatric inpatient treatment at the hospital's facility.

d. Inpatient Psychiatric Services: includes professional fees; comprehensive psychiatric assessment (includes assessing for trauma, co-morbid conditions, in particular, substance use disorders, and domestic violence/ environmental safety concerns) and diagnosis; neurological and/or psychological testing; individual, group and family psychotherapy; activity therapy; dietary and specialized nutritional services; medication management/stabilization, if indicated; laboratory and other tests relating to mental health diagnosis and treatment; discharge planning to include coordination of transportation; court hearing expert witness testimony, if required; coordination and Service site for probate court hearings for CMHSP's Consumers; routine sharing of referral and clinical information and coordination of care with the Consumer's primary physician and CMHSP's staff and any other Provider under contract to the CMHSP, as authorized by the Consumer.

e. All Consumers admitted into Provider's inpatient Services shall have access to the same quality of Services that are provided to Provider's other patients.

f. Only board-certified and/or board-eligible psychiatrists, who meet Provider's credentialing and privileging requirements, will serve as Provider's admitting and attending physicians for Consumers hereunder in Provider's inpatient care unit.

g. The CMHSP is the single-entry point for all psychiatric hospitalizations of its Consumers who are enrolled in Medicaid or are indigent. Any relocation of such Consumers hereunder involving Provider and another inpatient facility must have the prior approval of the CMHSP.

III. SERVICE CODES and RATES

a. Medicaid Application: Provider shall make reasonable documented attempts that uninsured Consumers

apply for benefits, including Medicaid, and that CMHSP required Ability to Pay ("ATP") forms are completed. The Provider and CMHSP shall cooperate and coordinate efforts as necessary. Provider shall maintain a record for review by the CMHSP that applications and required forms have been completed. If Consumer does not agree to provide information to complete the ATP assessment, Provider shall bill the Consumer for the full amount of the Services received but may also direct the Consumer to the CMHSP to coordinate the completion of the ATP assessment. Provider agrees to cooperate and provide demographic and insurance information gathered during admission on a case-by-case basis as needed in order to assist the CMHSP in completing the Consumer's ATP assessment.

b. CMHSP shall pay Provider for Services Provider renders to Consumers pursuant to the schedule below. The rates in the table below shall apply to Services rendered by Provider. Enhanced compensation for Consumers with high acuity care and/or requiring 1:1 staffing may be negotiated by Provider as needed.

Service Title	Billing Code	Unit Type	Rate
Inpatient Care: Adult All-Inclusive room and board plus ancillaries	0100	Per Diem	$
Inpatient Care: Children All-Inclusive room and board plus ancillaries	0100	Per Diem	$
Inpatient Care: Adult	0114 0124 0134	Per Diem	$
Inpatient Care: Children	0114 0124 0134	Per Diem	$
Inpatient Physician Services *May not be used in conjunction with 0100*	99221-99233	Per Diem	$

IV. EMERGENCY/URGENT/ELECTIVE MEDICAL/SURGICAL SERVICES

The per diem rate excludes emergency medical/surgical services, and urgent or elective medical/surgical services. In the event a Consumer requires emergency medical/surgical services, he or she will be transferred to an appropriate hospital, as determined by an Administrator of Provider and prior approval by the CMHSP will not be required.

V. AVAILABILITY OF BEDS FOR CMHSP REFERRALS

Provider agrees to accept clinically appropriate referrals, voluntary and involuntary, from the CMHSP to Provider's psychiatric unit and shall make inpatient psychiatric beds available for use by Consumers referred by the CMHSP, subject to availability. Nothing herein shall be construed, however, to imply or require Provider to guarantee the availability of any predetermined number of beds for persons referred by the CMHSP, nor shall anything herein imply or require that the CMHSP be responsible for guaranteeing payment for, or purchasing services for, any predetermined number of days of care or beds from Provider.

VI. REFUSAL OF ADMISSIONS

a. Provider shall maintain a record of all denials of CMHSP-authorized admissions and the reason(s) for such denials. Provider agrees to provide this information to the CMHSP on request. The CMHSP may use this information to collaborate with Provider to improve access for CMHSP authorized admissions, to establish contractual performance targets, to develop incentives or sanctions for improved/problematic admission-denial patterns, or for other performance monitoring and improvement activities. Provider is expected to use denial information it is required to maintain to improve its performance and reduce the frequency of denials for reasons within its control.

b. Provider shall communicate the reason for denial to the CMHSP orally at the time of refusal and subsequently in writing if so requested by the CMHSP.

c. Upon request by the CMHSP or a person referred by the CMHSP, Provider shall provide to the requestor, documentation of the clinical basis for denying admission. Such documentation shall be submitted on the most current MDHHS Form if the Consumer was seen for evaluation.

VII. **PRIOR AUTHORIZATION**

a. Prior Authorization Requirements: Services provided under this Agreement must conform to the requirements for Medical Necessity and prior authorization must be obtained for payment consideration of inpatient Services. An authorization letter does guarantee the payment for the Services

b. listed in the authorization letter that are properly rendered to the Consumer provided that they conform in every way to Service code definitions, Medical Necessity criteria, documentation requirements, and other applicable standards, terms or conditions.

c. Direct hospital admissions of eligible Consumers which by-pass the responsible CMHSP's Emergency Services Department must be approved by the CMHSP's Utilization Management Staff within the next business day of admission and an authorization for Services must be issued for payment consideration of inpatient Services.

d. Special Consideration of Concomitant Substance Abuse: The underlying psychiatric diagnosis must be the primary cause of the Consumer's current symptoms or represents the primary reason observation and treatment is necessary in the hospital setting.

e. All patients to be admitted to Provider's psychiatric inpatient Service unit under this Agreement must be screened, evaluated, and authorized by the CMHSP prior to admission. On a twenty-four (24) hour daily basis, the CMHSP shall provide appropriate personnel with the CMHSP to make such determinations.

f. The CMHSP shall furnish Provider with necessary clinical, social, and demographic documentation to foster the admitting and discharge process.

VIII. **ADMITTING PROCEDURES**

a. Psychiatric admission services shall be available seven (7) days per week, twenty-four (24) hours per day. Provider shall not offer hours of operation that are less than the hours of operation offered to commercial members or not comparable to Medicaid fee-for-service ("FFS") if Provider serves only Medicaid members.

b. Provider shall attempt to notify the CMHSP by telephone or other mutually agreed upon communication methods within two hours as to whether or not a referred Consumer will be accepted for admission.

c. Provider shall receive and admit all individuals approved by the CMHSP for admission to Provider's facility in a reasonable timely manner not to exceed two (2) hours.

d. Provider shall accept both voluntary and involuntary admission of the CMHSP's Consumers. The procedures for such admissions shall be in compliance with the Mental Health Code. Written procedures for voluntary and involuntary admissions must be included in the clinical procedures of Provider.

    1. Provider shall admit involuntary committed Consumers who meet the criteria of Sections 40l (a), (b), and (c) of the Mental Health Code.

    2. Medically indigent Consumers who are involuntarily committed to Provider and who are neither Consumers of Provider or Consumers of the CMHSP at the time of commitment, shall become Consumers of the CMHSP and shall become the financial responsibility of the CMHSP under this Agreement following an authorization for Services by the CMHSP and the CMHSP securing the Consumer's written consent.

e. Involuntary Commitment: When Provider and the CMHSP determine involuntary commitment is appropriate, Provider shall be responsible for completing the application for the 2nd Certification for such Court action. The 1st Certification for involuntary commitment shall be done by the Emergency Room licensed physician or fully licensed psychologist at the hospital where the Consumer has presented for treatment or by the CMHSP's psychiatrist, fully licensed psychologist or physician depending on the circumstance. The hospital shall provide space, technology, and Services to facilitate court hearings for

involuntary admissions within the time frames and guidelines set forth in the Mental Health Code. Court hearings shall be held at the hospital's facility or at the appropriate county probate court.

f. CMHSP may require Provider to utilize MI-SMART Form during admission procedures.

IX. CONTINUING STAY CRITERIA

a. After a Consumer has been certified for admission to an inpatient psychiatric setting, Services must be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in an inpatient setting. Treatment within an inpatient psychiatric setting is directed at stabilization of incapacitating signs or symptoms, amelioration of severely disabling functional impairments, arrestment of potentially life-threatening self/other harm inclinations, management of adverse biologic reactions to treatment and/or regulation of complicated medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regime in addressing these concerns, and to determine whether the inpatient setting remains the most appropriate, least restrictive, level of care for treatment of the Consumer's problems and dysfunctions.

b. Continuing treatment in an inpatient setting may be certified when signs, symptoms, behaviors, impairments, harm inclinations or biologic/medication complications, similar to those which justified the Consumer's admission certification, remain present, and continue to be of such a nature and severity that inpatient psychiatric treatment is still Medically Necessary. It is anticipated that in those reviews which fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

c. The CMHSP is responsible for monitoring patient progress. To the extent possible, Provider will coordinate care with other entities and individuals involved with the care of the Consumer that is being served.

d. Continued stay authorization requests are to be submitted to the CMHSP. The CMHSP will, in turn, provide appropriate continued stay authorizations.

e. The CMHSP is responsible for monitoring patient progress. All CMHSP Consumers are referred to the CMHSP for aftercare Services prior to and/or upon inpatient hospital discharge. Exceptions to this procedure require approval of the Consumer and/or the CMHSP. Other staff of the CMHSP may assist in the discharge process as designated.

f. All discharge planning will begin immediately at admission, continue as part of the ongoing treatment planning and review process and involve the Consumer, the Consumer's family, significant others, as indicated, and Provider's staff and the CMHSP's staff.

g. The need for continuing stay or treatment shall be determined collaboratively between the CMHSP's authorized representative and Provider's authorized representative at CMHSP determined intervals. Provider shall cooperate with the CMHSP's continuing stay review and discharge planning processes and instructions. The CMHSP's determination is final.

h. The appropriateness of inpatient admissions and inpatient length of stay shall be monitored on a case-by-case basis through Provider's Utilization Review ("UR") Program. Findings from that UR process may be reviewed by the CMHSP's designated Utilization Management staff.

X. TREATMENT AND DISCHARGE/TRANSFER PROCEDURES

a. Active discharge planning must begin at admission to the inpatient unit and continue as part of the ongoing treatment planning and review process.

b. As soon as possible following admission, but not later than the second day, the hospital psychiatrist, therapist, case manager or Hospital UM staff shall consult with the CMHSP's assigned case manager and/or psychiatrist to determine initial treatment objectives and interventions, estimated length of inpatient stay and plan for follow-up Services.

c. Provider shall be responsible to use its best efforts to schedule mutually convenient times for the CMHSP to participate in treatment and discharge planning. Regularly scheduled treatment team meetings will

address this requirement.

d. Provider shall consult with the CMHSP's case manager/hospital liaison staff to develop individual treatment plans.

e. The CMHSP shall refer or provide ongoing community support and psychiatric services, as appropriate, within seven (7) days of discharge.

f. Provider shall notify the CMHSP of the pending discharge of CMHSP referred Consumers at least 48 hours preceding the discharge. Special consideration shall be given to weekend discharge with regard to additional supports needed to ensure safe transition of care to include transportation from the hospital to the next point of care or the Consumer's home. In cases where such notification involves placement of the Consumer, the CMHSP shall exercise best efforts to ensure the prompt placement of said Consumers. The CMHSP agrees to continue to pay Provider for the Consumer's stay until it has found an appropriate placement for the Consumer.

g. At the time of discharge, Provider may provide a supply of medications sufficient to carry through from date of discharge to next business day, but not less than a two (2) day supply and will issue a prescription for not less than fourteen (14) days.

h. During the discharge and referral by Provider of a Consumer hereunder to follow-up aftercare services of the CMHSP, Provider shall provide referral and summary of care documents to the CMHSP. Said documents shall include at a minimum: patient name, referring Provider's name, diagnosis, a multidisciplinary team summary of patient problems, treatment course, nature of significant family and interpersonal relationships, current medication list, current medication allergy list, prognosis, recommendations, and when available should include: demographic information, immunizations, laboratory test results, vital signs, smoking status, functional status (including activities of daily living, cognitive and disability status), care team members, care plan (goals and follow up instructions), and reason for referral. Whenever possible this document should meet meaningful use and MIPS requirements for summary of care and be sent directly from Provider's EHR and be incorporated into the CMHSP's EHR.

i. Assessment, discharge procedures, and aftercare planning shall be conducted by Provider's staff and the CMHSP's staff functioning as a multi-disciplinary treatment team.

j. Provider shall provide a discharge summary to the CMHSP, which shall include diagnosis and a multidisciplinary team summary of patient problems, treatment course, nature of significant family and interpersonal relationships, current medications, prognosis, and recommendations.

k. When prescribing medications (oral or injectable, brand name or generic, formulary or non-formulary) at the time of discharge, consideration shall be given to the Consumer's diagnosis, presenting symptoms, response to and cost of medications, and insurance coverage.

l. All CMHSP's Consumers are referred to the CMHSP for aftercare services prior to and/or upon inpatient hospital discharge. Exceptions to this procedure require approval of the Consumer and/or the CMHSP. Other staff of the CMHSP may assist in the discharge process as designated.

XI. **CLAIM SUBMISSION:**

a. **Claims:** All claims should be received by the CMHSP the timeframe indicated in *Attachment C – Local Practices & Reporting Requirements* and should be free and clear of any problems and able to be processed for payment consideration without obtaining additional information from Provider of the Service or a third party. 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. In cases where a Clean Claim is not submitted by Provider within one (1) year of the Consumer's discharge, the CMHSP shall not be required to authorize payment, unless otherwise mutually agreed upon in advance between Provider and the CMHSP.

b. **Manner/Method of Claim Submission:** Provider shall be responsible for submitting claims for payment consideration in accordance with standard claims processing requirements. The CMHSP shall not be responsible for processing claim(s) for payment consideration for any claim submitted by Provider that is

inconsistent with national and/or state claim submission and processing guidelines. CMHSP, at its discretion, may require all clams to be submitted with all proper documentation for purposes of auditing the claim prior to reimbursement.

c. **Reimbursement for Valid Claims Payments**. The CMHSP shall make contractual payments to Provider in accordance with the requirements of the Mental Health Code, the MDHHS Rules, the MDHHS/CMHSP Master Contract, and applicable state and federal laws, including Medicaid regulations.

d. **Requirements for and Limitations for Billing of Claims and Payments of Claims**. Provider shall submit valid claims for CMHSP-authorized Services rendered to Medicaid covered or indigent Consumers hereunder. All valid claims of Provider shall specify billable Services hereunder. In order to be considered valid claims for which payments from the CMHSP may be made, Provider's billing of a Service claim must be received by the CMHSP as outlined in *Attachment C – Local Practices & Reporting Requirements following the completion of the period in which the Services were rendered hereunder.* The CMHSP shall authorize and process Service claims payments to Provider within thirty (30) days following receipt of complete and accurate billing statement from Provider.

Provider's submittal of valid claims for any Service fees hereunder shall constitute Provider's verification that the required Services and Service documentation have been completed, in compliance with the reimbursement requirements of the CMHSP, the MDHHS, Medicaid, and/or third party reimbursers and is on file currently. If Provider's Services and Service documentation are not in compliance with the reimbursement requirements of the MDHHS, the CMHSP, Medicaid, and/or third party reimbursers, Provider shall not be paid and/or shall return payments received from the CMHSP in such instances.

e. Denial of payment due to non-compliance with claims submission and/or financial requirements may be appealed in accordance with the CMHSP's provider appeal policy and/or procedure.

f. The CMHSP may request Provider to submit documentation to receive payments as Electronic Funds Transfers ("EFT")/Direct Deposits before payment can be made. Provider is required to update the CMHSP any time this information has changed. These forms will be provided to Provider or can be obtained from the CMHSP's website. Said contract reconciliation shall be completed in full compliance with the Mental Health Code, the MDHHS Rules, the MDHHS/CMHSP Master Contract for General Funds, the MDHHS/PIHP Master Contract for Medicaid Funds and applicable state and federal laws, including Medicaid regulations. If CMHSP does not offer payments via EFT, Provider must supply a valid remit to address and advise CMHSP in writing of any changes to their address.

g. **Revenue/Cost Projections; Subsequent Rate Determinations.** Provider, upon request by the CMHSP, shall provide the CMHSP with projected revenue and cost analyses (using formats acceptable to the parties) and all source documents for review in the subsequent determination by the CMHSP of the claims reimbursement methodology/rate(s) for authorized Services hereunder.

h. **Coordination of Benefits:** Provider shall submit itemized claims for coordination of benefits ("COB") billing purposes detailing the daily revenue code and daily physician HCPC Service code to fulfill CMHSP's State of Michigan reporting and COB requirements. Any dual eligible Consumer with a deductible/coinsurance will be paid by the CMHSP in total up to the agreed upon payment amount for the billed Service(s) identified in this Agreement after all other payments, contractual adjustments, and any applicable co-payment, Consumer pay, or Medicaid Spend Down amounts have been deducted. The CMHSP shall only be responsible for and limit reimbursement to Provider for any amount less than the agreed upon amount for the billed Service(s) identified in this Agreement. In cases where third party coverage reimbursement exceeds the agreed upon amount for the billed Service(s) identified in this Agreement, no additional payment will be authorized by the CMHSP. In all cases where the CMHSP is the secondary CMHSP, Provider shall submit an Explanation of Benefits ("EOB") from the primary insurance coverage carrier along with the claim for Service reimbursement to the CMHSP.

i. **Third Party Liability Requirements.** Provider is required to identify and seek recovery from all liable third parties, consistent with the requirements of the Mental Health Code, the MDHHS/CMHSP Master Contract and with the MDHHS/PIHP Master Contract. Provider shall be responsible under this Agreement for seeking Service reimbursements, if applicable, from third party liability claims for the Consumer hereunder, pursuant

to federal and state requirements. Provider shall not seek or collect any Service fee payments directly from the Consumer, legal guardian, parents or relatives, etc. or any reimbursement fee payments from Medicare, and/or private insurers, the state of Michigan, health maintenance organizations, or other managed care entities acting on behalf of private insurers, etc., for Provider's Services rendered hereunder, unless authorized to do so, in writing, by the CMHSP.

j. **Payment in Full.** Payments from the CMHSP for valid claims for CMHSP-authorized Services rendered by Provider to the CMHSP's Consumer under this Agreement shall constitute payment in full. Provider shall be solely responsible for its payment obligations and payments to its subcontractors, if any, for performing Services required of Provider under this Agreement. Payments from Provider to its subcontractors for performing Services required of Provider hereunder shall be made on a timely basis and on a valid claim basis.

   Provider and/or its subcontractors, if any, shall not seek or collect any Service fee payments directly from the Consumer, legal guardian, parents or relatives, etc., unless specifically authorized by the CMHSP, in writing, to do so. It is expressly understood and agreed by Provider that:

   1. Provider and/or its subcontractors shall not require any co-payments, recipient pay amounts, or other cost sharing arrangements for Provider's Services required hereunder and/or for Services of a subcontractor, unless specifically authorized by the CMHSP, the state or federal regulations and/or policies thereof.

   2. Provider and/or its subcontractors shall not bill the individual for any difference between a Services charge of Provider nor of a subcontractor and the CMHSP's payment for Provider's Services required hereunder.

   3. Provider and/or its subcontractors shall not seek nor accept additional supplemental payments from the individual, his/her family, or representative, for Provider's Services required hereunder and/or for the Services of a subcontractor.

k. **Refunding of Payments.** Provider shall not bill the CMHSP for Services rendered hereunder in any instances in which Provider received monies directly for them from another funding source or from another party that provides for, reimburses, offsets, or otherwise covers payment retroactively, currently, or subsequently for such Services. At any time it is determined, after Services claims reimbursement to Provider has been made by the CMHSP, that Provider received monies directly for the Services from another funding source or from another party that provides for, reimburses, offsets, or otherwise covers payment retroactively, currently, or subsequently for such Services, Provider shall refund to the CMHSP an amount equal to the sums reimbursed by third party CMHSPs and/or paid by any other source. Provider shall notify the CMHSP immediately of any receipt of such monies for such purposes hereunder.

l. **Unallowable Services/Cost Claims and Financial Paybacks.** Should Provider fail to fulfill its obligations as required under this Agreement, thereby resulting in unallowable Medicaid or non-Medicaid program Services and/or cost claims, it shall not be reimbursed by the CMHSP hereunder for any such Services and/or cost claims; thereto, Provider shall repay to the CMHSP as financial paybacks of any claims payments made by the CMHSP to Provider for such unallowable Services and/or cost claims. This requirement shall survive the termination of this Agreement and such repayment shall be made by Provider to the CMHSP within sixty (60) days of CMHSP's final disposition notification to Provider that financial payback by Provider is required.

m. **Compliance.** If Provider does not remain in compliance with the applicable requirements of this Agreement, in the sole judgement of the CMHSP, the CMHSP may take actions to void, pend or deny claims, initiate recoveries and/or sanctions, or take other actions as reasonably necessary to compel Provider compliance.

n. **Disallowed Expenditures and Financial Repayments.** In the event that the MDHHS, the CMHSP, the state of Michigan, or the federal government ever determines in any final revenue and expenditure reconciliation and/or any final finance or Service audit that Provider has been paid inappropriately per the CMHSP's expenditures of federal, state, and/or local funds pursuant to this Agreement for Medicaid or non-Medicaid program Services claims and/or cost claims which are later disallowed, Provider shall fully repay the CMHSP for such disallowed payments within sixty (60) days of the CMHSP's final disposition notification of the

disallowed payment.

Attachment C - RECIPIENT RIGHTS POLICIES & ATTESTATION

In accordance with MCL 330.1752 Section 752, each community mental health services program, each licensed hospital, and each Service provider under contract with the department, a community mental health services program, or a licensed hospital shall establish written policies and procedures concerning recipient rights and the operation of an office of recipient rights. Provider attests to the following policies and procedures providing for the safeguarding of the rights of Consumers.

POLICIES & PROCEDURES

1. Complaint and Appeal Process
2. Consent to Treatment and Services
3. Sterilization, Contraception, and Abortion
4. Fingerprinting, Photographing, Audiotaping, and use of 1-way glass
5. Abuse and Neglect, including detailed categories of type of severity
6. Confidentiality and Disclosure
7. Treatment by Spiritual Means
8. Qualifications and Training for Recipient Rights Staff
9. Change in Type of Treatment
10. Medication Procedures
11. Use of Psychotropic Drugs
12. Use of Restraint
13. Right to be Treated with Dignity and Respect
14. Least Restrictive Setting
15. Services Suited to Condition

Policies and Procedures that address all of the following matters with respect to residents:

1. Right to entertainment material, information and news
2. Comprehensive examinations
3. Property and funds
4. Freedom of movement
5. Resident labor
6. Communication and visits
7. Use of seclusion

By signature below, Provider acknowledges, agrees and certifies that Provider will accept and comply with the policies and procedures set forth in this Attachment C, as the same may be amended from time to time. By signature below, Provider acknowledges, agrees and certifies that Provider will accept and comply with the MDHHS LPH Policy Review Tool - Attachment B policy standards.

_____ _____

Signature, Provider Authorized Representative Date

_____

Print, Provider Authorized Representative

Return this form with signed contract.

Attachment D - CMHSP CONTACT INFORMATION

Department	Name	Phone	Email
Emergency Services for Pre-Admission Screening			
Hospital Liaison			
Continuing Stay Authorizations			
Access/Intake (post appointment 7 day follow up)			
Eligibility/Finance Office (Medicaid/ATP)			
Claims Processing			
Discharge Planning			

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 requirement is pursuant to a Medicaid and/or PIHP Master Contracts 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 Provider's 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 Disclosure of Ownership & Controlling Interest Statement (the "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 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. The 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 a 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 <u>*any other*</u> 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 <u>*also have*</u> 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 Provider Entity, or any person who has an Ownership or Controlling Interest in Provider Entity, or who is an Agent or Managing Employee of 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* 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 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 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 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 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 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 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 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 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 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: any person who has been delegated the authority to obligate or act on behalf of a Provider Entity.

CHIP: the federal insurance program for children, Child Health Insurance Program. In Michigan this is known as MIChild.

Controlling Interest: 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 Provider's assets, A's interest in 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 Provider's assets, B's interest in Provider's assets equates to 4 percent and need not be reported.

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

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

Indirect Ownership Interest: 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:

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 Provider or by a person(s) or other entity with an ownership or control interest in Provider.

Attachment F - Regional Training Grid

Attachment G - DEPARTMENT OF HEALTH AND HUMAN SERVICES RECIPIENT RIGHTS APPEAL PROCESS (C 6.3.2.4)

Chapter 7A of the Michigan Mental Health Code, PA 258 of 1974 as amended, establishes the right of public mental health Service recipients or someone on their behalf to file complaints alleging a violation of rights guaranteed by Chapter 7 of the Code. Chapter 7A also assures that an appeal can be taken regarding the findings, remedial action, or timeliness of the complaint investigation. The purpose of this is to establish a process for handling these appeals to assure all recipients and those acting on their behalf receive due process including its essential elements of notice and an opportunity to be heard by a fair and impartial decision-making entity.

I. **Definitions**

A. Appeals Committee: A committee appointed by the MDHHS Director or by the board of a community mental health services program ("CMHSP"). The governing board of a licensed private psychiatric hospital/unit ("LPH/U") shall designate the appeals committee of the CMHSP to hear appeals brought by or on behalf of a recipient of that CMHSP. For non-CMHSP recipients, the LPH/U, may appoint its own Appeals Committee in compliance with section 774(4)(a) of the Code or, by agreement with MDHHS, designate the MDHHS Appeals Committee to hear appeals against the LPH/U under section 774(4)(b) of the Code.

B. Appellant: The complainant or, if different than the complainant, the recipient or his/her legal guardian, if any, who seeks review by an appeals committee or the MDHHS pursuant to sections 784 and 786 of the Code.

C. Complainant: The individual who files a recipient rights complaint.

D. Legal Guardian: A judicially appointed guardian or parent with legal custody of a minor recipient.

E. Office: Any of the following:

i) With respect to a rights complaint involving Services provided directly by the MDHHS, the state Office of Recipient Rights created under section 754 of the Code.
ii) With respect to a rights complaint involving Services provided directly or under contract to a community mental health services program, the office of recipient rights created by the community mental health services program under section 755 of the Code.
iii) With respect to a rights complaint involving Services provided directly or under contract to a licensed private psychiatric hospital/unit, the office of recipient rights created by the licensed hospital under section 755 of the Code.

F. Respondent: The Service provider that had responsibility at the time of an alleged rights violation for the Services with respect to which a rights complaint has been filed.

G. Responsible Mental Health Agency ("RMHA"): A MDHHS hospital or center; a community mental health services program; a licensed private psychiatric hospital or unit.

II. **Procedure — Appeals Committee**

a) The office of recipient rights with the MDHHS, a CMHSP, or an LPH/U shall assure that training is provided to the Appeals Committee, as required by Section 755(2)(a) of the Code.

b) Every complainant, recipient if different than the complainant, and the recipient's legal guardian, if any, shall be informed in the Summary Report issued by the MDHHS facility director, executive director of a CMHSP or the director of an LPH/U of the right to appeal to the designated Appeals Committee. Notice shall include information on the grounds for appeal as stated in section 784(2), the time frame for submission of the appeal, advocacy organizations that may assist with filing the written appeal, and an offer of assistance by the office of recipient rights in the absence of assistance from an advocacy organization.

c) Not later than 45 calendar days after receipt of the Summary Report under section 782 of the Code, the appellant may file a written appeal with the Appeals Committee having jurisdiction to act upon it.

d) If the Summary report contains a plan of action, the office of recipient rights is provided written notice and evidence of the completion of the plan. If the Summary report contains a plan of action, and the completed action is different than that proposed, the MDHHS facility director, CMHSP executive director or director of the LPH/U shall assure that the office of recipient rights, the complainant, recipient if different than the complainant, his/her legal guardian, if any, shall be provided written notice including specific information as to the action that was taken and the date that it occurred. The complainant, recipient, if different that the complainant, and his/her legal guardian, if any, shall be afforded 45 days after receipt of the notice to appeal the appropriate Appeals Committee on the grounds of inadequate action taken to remedy a rights violations.

e) Grounds for appeal to the Appeals Committee shall be as follows:

    i. The investigative findings of the office are not consistent with the facts or with law, rules, policies or guidelines
    ii. The action taken or plan of action proposed by the respondent does not provide an adequate remedy
    iii. An investigation was not initiated or completed on a timely basis

f) Within 5 business days of receipt of the appeal, members of the appeals committee shall review the appeal to determine if it meets the criteria stated above. This review may be conducted by the full Committee or by an individual member or subcommittee designated by the full Committee to fulfill this responsibility. The Committee shall maintain a log of all appeals received and the disposition of each.

g) Within 5 business days of receipt of the appeal, written notice that the appeal has been accepted shall be provided to the appellant and a copy of the appeal shall be provided to the respondent and RMHA. The appellant shall also be informed within the same time frame if the appeal has not been accepted as it did not meet the criteria set forth in e. above.

h) Within 30 calendar days after receipt of a written appeal that is found to state one or more of the grounds cited in e. above, the Appeals Committee shall meet in closed session and review the facts as stated in all complaint investigation documents. Any member of the Appeals Committee who has a personal or professional relationship with an individual involved in the appeal shall abstain from participating in that appeal. The Committee shall not consider additional allegations that were not part of the original complaint at issue on appeal but shall inform appellant of his/her right to file the complaint with the office.

i) At the meeting in h. preceding, the Appeals Committee shall do one of the following:

    i. Uphold the investigative findings of the office and the action taken or plan of action proposed by the respondent;
    ii. Return the investigation to the office and direct that it be reopened or reinvestigated;
    iii. Uphold the investigative findings of the office but direct that the respondent take additional or different action to remedy the violation;
    iv. If the Committee confirms that the investigation was not initiated or completed in a timely manner, recommend that the MDHHS-ORR director, executive director of the CMHSP or director of the LPH/U take appropriate supervisory action with the investigating rights officer/advisor;
    v. If the RMHA is a CMHSP or an LPH/U, recommend that the board or governing body request an external investigation by MDHHS-Office of Recipient Rights.

j) The Appeals Committee shall document its decision in writing within 10 working days following the decision and shall provide copies of such to the respondent, appellant, recipient if different than

appellant, the recipient's legal guardian, if any, the RMHA and the office. Documentation shall include justification for the decision made by the Committee.

k) If the Appeals Committee directs that the office reopen or reinvestigate the complaint, the office shall submit another investigative report in compliance with section 778(5) within 45 calendar days of receipt of the written decision of the Committee to the MDHHS facility directors, CMHSP executive director or the director of the LPH/U. The 45 calendar day time frame may be extended at the discretion of the Appeals Committee upon a showing of good cause by the office. At no time shall the time frame exceed 90 days.

   i. Within 10 business days of receipt of the reinvestigate report, the MDHHS facility director, executive director of the CMHSP or the director of the LPH/U shall issue another Summary Report in compliance with section 782. The Summary Report shall be submitted to the appellant, recipient if different than the appellant, the recipient's legal guardian, if any, the office and the Appeals Committee.
   ii. If the findings of the office remain unsubstantiated upon reinvestigation, the appellant may file a further appeal to the MDHHS-APPEALS - Level 2 Appeal, if the appellant continues to assert that the investigative findings of the office are not consistent with the facts or with law, rules, policies or guidelines. The Summary Report shall contain information regarding the appellant's right to further appeal, the time frame for the appeal and the ground for appeal. The report shall also inform the appellant of advocacy organizations that may assist in filing the written appeal or offer the assistance of the office in the absence from an advocacy organization.
   iii. If the investigative findings result in the substantiation of a previously unsubstantiated rights violation but the appellant disagrees with the adequacy of the action or plan of action proposed by the respondent, the appellant may file an appeal on such grounds to the Appeals Committee. The Summary Report shall inform the appellant of this right as well as further information as stated in ll b above.

l) If the Appeals Committee upholds the findings of the office and directs that the respondent take additional or different action, that direction shall be based on the fact that appropriate remedial action has not been taken in compliance with section 780 of the Code.

   a. The Appeals Committee shall base its determination upon any or all of the following:
      i. Action taken or proposed did not correct or remedy the rights violation.
      ii. Action taken or proposed was/will not be taken in a timely manner.
      iii. Action taken or proposed did not/will not prevent a future recurrence of the violation.
   b) Written notice of this direction for additional or different action to be taken by the respondent shall also be provided to the RMHA if different than the respondent and the office.
   c) Within 30 calendar days of receipt of the determination from the Appeals Committee, respondent shall provide written notice to the Appeals Committee that the action has been taken or justification as to why it was not taken. The written notice shall also be sent to the appellant, recipient if different than appellant, the recipient's legal guardian, if any, the RMHA if different than the respondent, and the office.
   d) If the action taken by the respondent is determined by the Appeals Committee and/or the appellant still to be inadequate to remedy the violation, the appellant shall be informed by the Appeals Committee of his/her right to file a recipient rights complaint against the RMHA, i.e. MDHHS facility director, executive director of a CMHSP or the director of an LPH/U for violation of section 754(3)(c) or 755(3)(b) of the Code.

m) If the Appeals Committee recommends that the board or governing body of the RMHA (a CMHSP or a LPH/U), request an external investigation by MDHHS-Office of Recipient Rights, the Board of Directors may make the request to MDHHS-ORR, in writing, within 5 business days of receipt of the request from the Appeals Committee.

a. Within 10 business days of receipt of the investigative report from MDHHSORR, the executive director of the CMHSP or the director of the LPH/U shall issue a Summary Report in compliance with section 782. The Summary Report shall be submitted to the appellant, recipient if different than the appellant, the recipient's legal guardian, if any, the office and the Appeals Committee.
b. The complainant, recipient if different than the complainant, and the recipient's legal guardian, if any, shall be informed in the Summary Report issued by the executive director of a CMHSP or the director of an LPH/U of the right to appeal to the MDHHS Appeals Committee. Notice shall include information on the grounds for appeal as stated in section 784(2), the time frame for submission of the appeal, advocacy organizations that may assist with filing the written appeal, and an offer of assistance by the office of recipient rights in the absence of assistance from an advocacy organization.
c. Not later than 45 calendar days after receipt of the Summary Report, the appellant may file a written appeal with the MDHHS Appeals Committee.
d. If the Summary report contains a plan of action, the office of recipient rights is provided written notice and evidence of the completion of the plan. If the Summary report contains a plan of action, and the completed action is different than that proposed, the CMHSP executive director or director of the LPH/U shall assure that the office of recipient rights, the complainant, recipient if different than the complainant, his/her legal guardian, if any, shall be provided written notice including specific information as to the action that was taken and the date that it occurred. The complainant, recipient if different that the complainant and his/her legal guardian, if any, shall be afforded 45 calendar days after receipt of the notice to appeal the appropriate Appeals Committee on the grounds of inadequate action taken to remedy a rights violations.

III. MDHHS Appeals

a) An appeal to MDHHS Appeals may be taken only upon the ground that the investigative finding of the office were inconsistent with the facts or with law, rules, policies or guidelines; and only after a decision on an appeal has been made by the appropriate Appeals Committee to uphold the findings of an investigation, or, upon reinvestigation, the findings of the office remain unsubstantiated.

b) Within 45 calendar days after receiving written notice of the decision of the Appeals Committee under section ll. I. l. or the Summary Report in ll. K. 2., the appellant may file a written appeal with MDHHS appeals. The written appeal shall be mailed to:

MDHHS-APPEALS
Level 2 Appeal
Lewis Cass Building, 1 st floor
P.O. Box 30807
Lansing, MI 48909
FAX: (517) 241-7973

c) Upon receipt of the appeal, MDHHS-APPEALS shall give written notice of the receipt to the respondent, local office of recipient rights holding the record of the complaint and the RMHA. If the appeal involves the findings of a rights advisor with the MDHHS Office of Recipient Rights, the Director of that office shall also receive written notice of receipt of the appeal. The respondent, local office holding the record of the complaint, MDHHS-ORR Director, and the RMHA shall ensure that MDHHS has access to all necessary documentation and other evidence cited in the complaint and local appeal.

d) MDHHS-APPEALS shall review the record generated by the local appeal. [t shall not consider additional evidence or information that was not available during the local appeal.

e) Within 30 calendar days after receiving the appeal, MDHHS-APPEALS shall review the appeal and do one of the following:
   i. Uphold the findings of the office.
   ii. Affirm the decision of the Appeals Committee.

iii. Return the matter to the director of the department's Office of Recipient Rights, the executive director of the CMHSP or the director of the LPH/U with instruction for additional investigation or consideration.

f) MDHHS-APPEALS shall provide copies of its action to the respondent, the appellant, recipient if different than appellant, the recipient's legal guardian, if any, the board of a CMHSP, the governing body of the LPH/U and the local office of recipient rights holding the record. If the appeal involves the findings of a MDHHSORR rights advisor, the MDHHS-ORR director shall also be provided copies of the action. If MDHHS-APPEALS upholds the findings of the office, notice shall be provided to the appellant of his/her legal right to seek redress through the circuit court.

g) If MDHHS-APPEALS instructs that additional investigation be conducted, the director of MDHHS-ORR, the executive director of the CMHSP or the director of the LPH/U shall assure that such investigation is completed in a fair and impartial manner within 45 calendar days of his/her receipt of the written notice from MDHHS-APPEALS. The 45 calendar day time frame may be extended at the department's discretion upon a showing of good cause by the MDHHS-ORR director, CMHSP executive director or LPH/U director. At no time shall the time frame exceed 90 calendar days. In cases of re-investigation by MDHHS-ORR, the director of that office shall be responsible for the submission of the investigative report to the appropriate MDHHS facility director.

h) Within 10 business days of the receipt of the investigative report, the facility director, executive director of the CMHSP, or the director of the LPH/U shall issue a Summary Report in compliance with section 782 of the Code to the department, appellant, recipient if different than appellant and the recipient's legal representative, if any,

a. If the findings of the additional investigation remain the same as those appealed, the department shall inform appellant, recipient if different than appellant and the recipient's legal guardian, if any, in writing of the right to seek redress through the circuit court. Copies of this notice will be provided to the deputy director of the MDHHS Mental Health/Substance Abuse Services (if the investigation was conducted by staff of the MDHHS-ORR) the director of MDHHS Quality Management and Service Innovation (if the investigation was conducted by a CMHSP) or the Licensing Officer with the Psychiatric Licensure Unit of the MDHHS Division of Health Facility Licensing and Certification (if the investigation was conducted by an LPH/U).
b. If the additional investigation results in the substantiation of previously unsubstantiated violation but the appellant, recipient if different than the appellant and/or the recipient's legal guardian, if any, disagrees with the adequacy of the action taken or plan of action proposed to remedy the violation, the department shall inform the individual(s) of the right to appeal this to the local Appeals Committee.

Attachment H - Continuing Education Requirements for Recipient Rights Staff (C 6.3.2.3A)

Contract Manager to insert PDF from GF contract

Attachment I - RR Training Standards for CMH and Provider Staff TR (C 6.3.2.3B)

CMH Contract Manager to insert PDF from GF contract