**PROVIDER NETWORK AGREEMENT**

**FOR CRISIS RESIDENTIAL SERVICES**

**THIS AGREEMENT**, is made and entered into this \_\_\_\_ day of \_\_\_\_\_\_, 20\_\_, by and between **\_\_\_\_\_\_\_\_\_\_\_\_\_\_ COMMUNITY MENTAL HEALTH \_\_\_\_\_\_\_\_\_** whose administrative offices are located at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (hereinafter referred to as the “Payor”), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(hereinafter referred to as “Provider”) on behalf of the Provider’s adult foster care facility located at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (hereinafter referred to as the “Facility).

**WITNESSETH:**

**WHEREAS,** the Payor is a community mental health \_\_\_\_\_\_\_\_\_\_ (CMH\_) established by the Board(s) of Commissioners of the Counties of \_\_\_\_ and \_\_\_\_ pursuant to Act 258 of the Public Acts of 1974, as amended (hereinafter referred to as the "Mental Health Code");

**WHEREAS,** under the authority granted by Section 116 (2) (b) and 3(e) and Section 228 of said Code, the Michigan Department Health and Human Services (hereinafter referred to as the "MDHHS") entered into, effective 10/1/2018 for General Funds (hereinafter referred to as the “MDHHS/CMHSP Master Contract for General Funds”) with the Payor as the community mental health services program of the Counties of \_\_\_\_ and \_\_\_\_; and

 **WHEREAS,** pursuant to Mental Health Code, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ thereafter entered into a Regional Entity arrangement under Section 204(b) et seq. of the Mental Health Code, for the purpose of the preparation, submission, and implementation of an Application to the MDHHS for a Medicaid Prepaid Inpatient Health Plan (PIHP); and

 **WHEREAS,** pursuant to the bylaws June 13, 2013 established under 204(b) et seq. of the Mental Health Code, the said Regional Entity is hereinafter known as the \_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_) and is designated by the community mental health services programs as constituted under the Mental Health Code, to be the Medicaid PIHP; and

**WHEREAS,** the MDHHS approved the 2013 Application for proposal and the \_\_\_\_\_\_\_\_ 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 Medicaid services area of the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_ Counties (the “Service Area”) and the MDHHS entered into, effective January 1, 2014, a MDHHS/PIHP Managed Specialty Supports and Services Contract (hereinafter referred to as the “MDHHS/PIHP Master Contract for Medicaid Funds”) with the \_\_\_\_ for the provision of Medicaid mental health and substance abuse services and supports; and

**WHEREAS,** \_\_\_\_ entered into, effective \_\_\_\_\_\_\_\_\_\_, a PIHP/CMHSP Medicaid Subcontracting Agreement with each CMHSP whereby the PIHP subcontracts to the CMHSP, as a Specialty Services Network Provider, to provide the Medicaid mental health specialty supports and services to Medicaid eligibles within the CMHSP’s specific Counties in said PIHP Medicaid services area; and

**WHEREAS,** given all of the above, the Payor, at its discretion, has the right to direct-operate and/or contract for supports and services to persons who meet the supports/services eligibility criteria in the service area of the Counties of \_\_\_\_ and \_\_\_\_; and

**WHEREAS**, the Payor, from time to time, is in need of medically necessary **crisis residential services** from programs certified by the Michigan Department of Community Health, for service recipients, and

**WHEREAS**, the Provider has been presented to the Payor as being licensed, qualified, and willing to provide such services as required by the Payor and under the terms and conditions set forth herein,

**NOW, THEREFORE**, in consideration of the above and in consideration of the mutual covenants hereinafter contained, IT IS HEREBY AGREED by the Payor and the Provider, as follows:

1. **DEFINITIONS.**

Terms used in this Agreement shall be construed and interpreted as defined in the attached document labeled "Exhibit A" (“GLOSSARY OF TERMS AND DEFINITIONS”), which is incorporated by reference into this Agreement and made a part hereof.

1. **CONTRACT AUTHORITY.** This Agreement is entered into pursuant to the authority granted to the Payor under the Mental Health Code. This Agreement is in accordance with the rules, regulations, and standards (hereinafter referred to as the "MDHHS 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 (BBA), as amended, and said BBA final rules, regulations, and standards, and with the requirements of the State Wavier Programs. This Agreement is in accordance with the standards as contained in the aforementioned Application for Participation (AFP) as they pertain to the provisions of specialty services to Medicaid eligibles and the plans of correction and subsequent plans of correction submitted by the PIHP and approved by the MHDDS and any stated conditions, as reflected in the MDHHS approval of the application, unless prohibited by federal or State law.

The Mental Health Code, the MDHHS Rules, the MDHHS/CMHSP Master Contract for General Funds, and the MDHHS/PIHP Master Contract for Medicaid Funds and applicable State and federal laws shall govern the expenditure of funds and provisions of services hereunder and govern in any area not specifically covered by this Agreement.

1. **AGREEMENT CONTINGENT UPON FUNDING.** This Agreement is contingent upon the Payor’s receipt of sufficient federal, State and local funds, upon the terms of such funding as appropriated, authorized and amended, upon continuation of such funding, and sufficient 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 Payor, that reduces or otherwise interferes with the Payor’s ability to provide or maintain specified supports/services or operational procedures for its service area, the Payor shall provide immediate notice to the Provider if it would result in any reduction of the funding upon which this Agreement is contingent. The Payor shall not refer Consumers to the Provider, without concurrence of the Provider, for treatment hereunder if any such reduction in funding would not enable the Payor to meet its financial obligations hereunder for payments to the Provider for such services, as applicable.
2. **COMPLIANCE WITH THE MDHHS/CMHSP MASTER CONTRACT FOR GENERAL FUNDS AND THE MDHHS/PIHP MASTER CONTRACT FOR MEDICAID FUNDS.** It is expressly understood and agreed by the Provider that this Agreement is subject to the terms and conditions of the MDHHS/CMHSP Master Contract for General Funds and the MDHHS/PIHP Master Contract for Medicaid Funds. The provisions of this Agreement shall take precedence over said Master Contracts unless a conflict exists between this Agreement and the provisions of a said 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 said Master Contract shall prevail. However, a conflict shall not be deemed to exist where this Agreement: (1.) contains additional provisions and additional terms and conditions not set forth in a said Master Contract with the MDHHS; (2.) restates provisions of a Master Contract with the MDHHS to afford the CMHSP or the PIHP the same or substantially the same rights and privileges as MDHHS; or, (3.) requires the Provider to perform duties and services in less time than required of the CMHSP or the PIHP in a said Master Contract with the MDHHS.
3. **PROOF OF PROVIDER’S BUSINESS STATUS; AND SOLVENCY REQUIREMENTS.**
4. The Provider shall furnish the Payor with notice of proof of the Provider’s authority to conduct business in the State of Michigan and in what business capacity, prior to commencing services under this Agreement, and of any related organization of the Provider per alliance, affiliation, joint venture, parent/subsidiary or other business relationship that the Provider is a party to during the term hereunder.
5. Pursuant to 42 CFR 455.104-106 the Provider shall furnish the Payor with notice of proof of financial solvency, prior to commencing services hereunder, and with immediate notice of any change in financial position material to the Provider’s solvency and to its continuing in operation as a going concern, at any time during the term of this Agreement.
6. The person signing this Agreement on behalf of the Provider hereby certifies, by signing, to the best of his or her knowledge and belief that:
	1. The Provider and its principals are not presently debarred, suspended, proposed from debarment, declared ineligible, or voluntarily excluded from covered transactions by any State and/or federal Department or Agency.
	2. The Provider and its principals have not within a three (3) year period preceding this Agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State, or local) transaction or contract under a public transaction, violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property.
	3. The Provider and its principals are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, State, or local) with commission of any of the offenses enumerated in the above-cited subsection C. (2.) of this Section; and,
	4. The Provider and its principals have not within a three (3) year period preceding the commencement of this Agreement had one (1) or more public (federal, State, or local) transactions terminated for cause or default.
7. **LICENSES, ACCREDITATIONS, AND CERTIFICATIONS; AND CREDENTIALING AND PRIVILEGING REQUIREMENTS.**
8. The Provider shall obtain and maintain all approvals, accreditations, certifications and licenses (e.g., MDHHS licensure, CARF accreditation, Medicare and Medicaid certifications, and Medicare distinct part certification) for its crisis residential unit and its programs and services hereunder.

By executing this Agreement, Provider assures that, prior to commencing services under this Agreement, all staff psychiatrists and other professional employees and subcontractors who are to provide services under this Agreement, have obtained and maintain all approvals, accreditations, certifications, National Provider Identification number per Section 5005(b)(2)(6)(a) and section 12006 of the 21st Century Cures Act, Home and Community Based Services regulations (HCBS), and licenses required by federal, state and local laws, ordinances, rules and regulations to practice their professions in the State of Michigan and to perform Medicaid and/or non-Medicaid services hereunder.

If any such license, certification, accreditation, or authorization is ever suspended, restricted, revoked, or expires and is not renewed, the Provider shall immediately notify the Payor, in writing.

1. The Provider, as a member of the Payor’s service provider network, shall cooperate with the Payor on an ongoing basis and ensure that the Provider’s staff psychiatrists and other employees and its subcontractors meet the credentialing and privileging requirements of CARF or other appropriate accreditation body, including annual re-privileging and competency standards, necessary to perform services required under this Agreement.
2. **AGREEMENT TERM.**
3. This Agreement shall commence on the **\_\_\_ day of \_\_\_\_\_\_\_\_, 20\_\_** and shall continue until the \_\_\_\_\_ **day of \_\_\_\_\_\_\_**at which time this Agreement shall terminate.
4. Nothing in this agreement shall be construed as requiring either the Payor or the Provider to extend or renew this Agreement or to enter into any subsequent agreements.
5. **TERMINATION OF AGREEMENT.**
6. The Payor or Provider may terminate this Agreement at any time with or without cause, provided however that the party intending to terminate must give the other party at least ninety (90) days prior written notice and therein specify the proposed termination date. Any notice to terminate failing to comply with these notice requirements will be ineffective.
7. If the Payor or Provider default in the performance of any obligation under this Agreement, and such default remains uncured for greater than ten (10) calendar days after receiving written notice of default, the non-defaulting party may promptly terminate this Agreement.
8. Any notice to terminate or subsequent termination will not relieve each party of any performance obligations incurred under this Agreement before giving notice or subsequent termination. Additionally, after giving or receiving notice to terminate, the Provider will fully cooperate with Payor to transfer Consumers and their records by the termination date.
9. This Agreement will terminate immediately, without giving the Provider advance written notice or the opportunity to cure upon the Payor verifying the occurrence of any revocation, restriction, suspension or discontinuation of any certification, accreditation, privilege, license or authorization required by any Governmental Law(s) to operate and/or provide Medicaid and/or non-Medicaid program or service in the State of Michigan, or that preclude or impede Provider’s delivery of any program or service under this Agreement.
10. This Agreement will terminate immediately, without giving the Provider advance written notice or the opportunity to cure upon the Payor verifying that the Provider is:
	* 1. listed by a Governmental entity as being suspended or otherwise ineligible from participating in any Michigan Medicaid and/or Medicare program;
		2. listed by a Governmental entity for Unfair Labor Practices under MCL 423.321 et seq. as amended;
		3. listed on the U.S. General Services Administration’s “Excluded Parties List” thereby precluding federal funding; and/or (4) found in violation of any Governmental Law(s) incorporated into this Agreement, and such violation precludes or impedes Provider’s delivery of any program or service under this Agreement.
11. This Agreement shall terminate immediately, without giving the Provider advance written notice or the opportunity to cure upon the Payor reasonably concluding that the Provider is insolvent or is in imminent risk of insolvency under applicable accounting standards. Within ten (10) days after written request the Provider will furnish Payor with acceptable proof of its financial solvency. Furthermore, Provider will give Payor immediate written notice of any change in financial position material to the Provider’s solvency and corresponding ability to continue its operations during the term(s) of this Agreement.
12. Any immediate termination according to the terms herein above will not relieve each party of any performance obligations incurred under this Agreement before such termination. Upon the event of immediate termination, the Provider will fully cooperate with Payor to transfer Consumers and their records within thirty (30) days of the termination date.
13. By signing this Agreement, the Provider and Payor each represent, warrant and assent that they may not, and will not file a legal, equitable complaint, claim or action based upon the termination of this Agreement. If a party files a complaint, claim or action premised upon termination of this Agreement such matter must immediately be dismissed with prejudice.
14. **SERVICE AREA.** The Payor’s service area for the purposes hereunder is \_\_\_\_ and \_\_\_\_ Counties. Exceptions to this service area and any waiver of the service access/admittance and supports/services payment restrictions hereunder may only be granted with prior authorization by the Payor’s Executive Director (hereinafter referred to as the “Payor’s ED” or “Payor’s CEO”).
15. **TARGET SERVICE GROUP AND ELIGIBILITY CRITERIA FOR SERVICES.** The target service group and eligibility criteria for services hereunder are specified in the attached document labeled "Exhibit B" (“TARGET SERVICE GROUP AND ELIGIBILITY CRITERIA FOR SERVICES”), which is incorporated by reference into this Agreement and made a part hereof. The target service group and the eligibility criteria for supports/services under this Agreement shall meet the eligibility criteria established in the Mental Health Code and shall be consistent with the requirements of the MDHHS/CMHSP Master Contract for General Funds and with the MDHHS/PIHP Master Contract for Medicaid Funds, including the applicable attachments thereto on service selection guidelines.

For the purposes of this section and other sections of this Agreement, an indigent person requiring treatment shall mean a Payor’s Consumer who is not covered by Medicaid and who is unable to pay and is ineligible for other third-party reimbursements (e.g., Medicare, Blue Cross/Blue Shield, etc.) pursuant to the ability to pay determination requirements and other related requirements under Chapter 8 (“Financial Liability for Mental Health Services”) of the Mental Health Code.

1. **PROVIDER’S SERVICES AND RESPONSIBILITIES.**
2. The Provider shall perform crisis residential services for reimbursement by the Payor hereunder as specified in the attached document labeled "Exhibit C" (“SCOPE OF INDEPENDENT CONTRACTOR SERVICES”), which is incorporated by reference into this Agreement and made a part hereof.
3. The Provider shall relate and coordinate the services provided hereunder with all other community mental health programs and services provided by or under the auspices of the Payor.
4. **STAFFING AND TRAINING REQUIREMENTS.**
5. The Provider, pursuant to this Agreement, shall ensure that:
	* 1. active treatment is provided by the Provider’s staff to each Medicaid covered and non-Medicaid Consumer hereunder at the medically necessary level of care; and,
		2. all services hereunder are to be provided by the Provider’s staff in a manner that demonstrates cultural competency.
6. The Provider shall maintain staffing consistency and programming continuity in the provision of services to Consumer(s) hereunder.
7. The Provider’s staff, when performing services under this Agreement, shall comply with:
	* 1. all applicable provisions and requirements for services in the Mental Health Code, the MDHHS Rules, Medicaid regulations, and the MDHHS/PIHP Master Contract for Medicaid Funds and the MDHHS/CMHSP Master Contract for General Funds; and,
		2. all applicable policies, guidelines, and standards established by the Payor.

Orientation of and ongoing training and education of the Provider’s staff shall include offerings on recipient rights, limited English proficiency, cultural diversity, person-centered planning, and behavior management and on the Payor’s programs. The Provider assures the Payor that, pursuant to this Agreement, all individuals employed by the Provider or the Provider’s subcontractors shall receive training related to recipient rights protection before or within thirty (30) days after the commencement of such employment Training in cultural diversity and person-centered planning, is required annually. The Payor’s Recipient Rights Office reserves the right to review and approve all recipient rights training information and materials prior to use.

The Payor’s staff shall offer continuing education or training materials to the Provider’s staff as needed or when necessitated by changes in the Payor’s programs or in recipient rights requirements.

The Payor shall assure sufficient availability of all such required in-service training pursuant to “Exhibit D” (“MINIMUM TRAINING REQUIREMENTS”), which is incorporated by reference into this Agreement and made a part hereof.

1. **SERVICE ACCESS, PREAUTHORIZATIONS, AND UTILIZATION MANAGEMENT.**
2. The Payor is responsible under this Agreement for service access assurance, service preauthorizations, and utilization management, under this Agreement and pursuant to its managed care and single entry/exit responsibilities required under its contracts with the PIHP and MDHHS, as described in “Exhibit E” (“SERVICE ACCESS PREAUTHORIZATIONS, DELIVERY,AND UTILIZATION MANAGEMENT PROCEDURES”), which is incorporated by reference into this Agreement and made a part hereof .
3. Any services to be performed by the Provider for a Consumer hereunder must be included in an individualized written plan of supports and services pursuant to the requirements of Section 712 in Chapter 7 of the Mental Health Code.
4. Any services by the Provider under this Agreement for reimbursement by the Payor must be prior authorized by the Payor’s CEO or the CEO’s designated representative.
5. The Payor and the Provider agree that placement of any Consumer hereunder and the Provider’s services must be medically necessary and meet the criteria required thereto.
6. **BILLING AND PAYMENT FOR VALID SERVICE REIMBURSEMENT CLAIMS.** The parties hereto agree that a primary purpose of this Agreement is to provide for reimbursement by the Payor to the Provider for services rendered to any of the Payor’s Consumers who are Medicaid covered or who are assessed by the Payor as being indigent for the purpose hereunder. Therefore, it is agreed by the parties hereto that the Provider shall bill the Payor and the Payor shall reimburse the Provider only for services to such Consumers within the service, service recipient, billing, and payment requirements and limitations specified and delineated in this Agreement and in the attached document labeled "Exhibit F" (“BILLING OF AND PAYMENTS FOR VALID SERVICE REIMBURSEMENT CLAIMS”), which is incorporated by reference into this Agreement and made a part hereof.
7. **QUALITY AND PERFORMANCE IMPROVEMENT; PERFORMANCE INDICATORS; CONSUMER ASSESSMENTS AND OUTCOMES MANAGEMENT STUDIES.**
8. The Provider shall maintain a fully operational internal quality improvement

 program.

1. The Provider shall meet the performance indicators set forth in the attached document labeled "Exhibit G" (“PERFORMANCE INDICATORS AND OBJECTIVES”), which is incorporated by reference into this Agreement and made a part hereof.
2. The Provider agrees, pursuant to this Agreement, to cooperate fully in the Payor’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.
3. **REPORTING REQUIREMENTS; ACCOUNTING PROCEDURES AND INTERNAL FINANCIAL CONTROLS.**
4. The Provider shall report financial, program, service and Consumer/potential Consumer data and additional statistical and other management information in the manner and at the times prescribed by the Payor’s CEO, or designee.
5. The Provider's accounting procedures and internal financial controls shall conform to generally accepted accounting principles in order that the costs allowed by this Agreement can be readily ascertained and expenditures verified therefrom. In the Provider’s billings to the Payor, costs allowed by this Agreement also must be readily ascertainable and verifiable.
6. The Provider must comply with 2 CFR, Part 200, Subpart F section 200.501 audit requirements when applicable.
7. **PROGRAM AND FINANCIAL BOOKS, DOCUMENTS, AND RECORDS; AUDITS; REVIEWS; AND PROGRAM/SERVICE EVALUATIONS.** The parties to the MDHHS/PIHP Master Contract for Medicaid funds and to the MDHHS/CMHSP Master Contract for General Funds for purposes thereof, the Payor for purposes hereof, the federal government, the State of Michigan, or their designated representatives shall be allowed to inspect, review, copy, and/or audit all financial records and license, accreditation, certification and program reports of the Provider and to review all clinical records of the Provider pertaining to performance of this Agreement, to the full extent permitted by applicable federal and State law. Clinical and financial records and supporting documentation of the Provider must be retained and be available for audit, review or evaluation purposes in accordance with Michigan Department of Attorney General State Operations Division General Schedule #20 Community Mental Health Programs Dated March 2, 2007.

1. If the Secretary of the U.S. Department of Health and Human Services, the Controller General of the United States or their duly authorized representatives (hereinafter referred to as the "Requesting Parties") request access to books, documents, and records of the Payor or Provider at any time within ten (10) years of the termination of this Agreement, in accordance with Section 952 of the Omnibus Reconciliation Act of 1980 [42 USC 1395x(v)(1)(I)] and the regulations adopted pursuant thereto, the Payor and the Provider agree to provide such access to the extent required. Furthermore, the Provider and the Payor agree that any contract between them and any other organization to which the Provider or the Payor is to a significant extent associated or affiliated with, owns or is owned by or has control of or is controlled by (hereinafter referred to as "Related Organization"), and which performs services on behalf of the Provider or the Payor will contain a clause requiring the Related Organization to similarly make its books, documents, and records available to the Requesting Parties.
2. The Provider shall provide access to the Payor’s designated representative(s) to evaluate, through inspection or other means on a retrospective or current basis, the appropriateness, quality, and timeliness of supports/services performed hereunder and the Provider’s compliance with standards required thereto.
3. The Provider agrees that the MDHHS and the U. S. Department of Health and Human Services may evaluate, through inspection or other means, the appropriateness, quality, and timeliness of supports/services performed under this Agreement.
4. The Provider will ensure compliance with federal requirements regarding the use of electronic visit verification (EVV), when applicable. Compliance may be demonstrated in the form of (a) verification of EVV processes during an on-site review and/or (b) the use of EVV data in the claim adjudication process. Client validation of service start and stop time is encourage to the extent possible.
5. Refusal by the Provider to allow the Payor hereby, the parties to the MDHHS/PIHP Master Contract for Medicaid funds and the MDHHS/CMHSP Master Contract for General Funds therefore, the federal government, the State of Michigan or their designated representatives access to the Provider’s records, program and supports/services for audit, review, or evaluation shall be regarded as a material breach of this Agreement and may be a cause for termination thereof by the Payor.
6. **COMPLIANCE WITH THE LAW; APPLICABLE LAW AND VENUE.**
7. The Provider materially represents warrants and agrees that it will provide all programs and services under this Agreement in compliance with all applicable Governmental Laws. This Agreement shall be governed, controlled, interpreted, construed and enforced in accordance with the laws of Michigan, without giving effect to any choice or conflict of law provision that would cause the application of the laws of any other jurisdiction. By signing this Agreement, the Payor and Provider irrevocably consent to the sole venue for resolving any and all disputes or claims whatsoever in the county of the Provider’s primary administrative office as set forth in the opening clause of this Agreement. In the event that any action may be brought in Federal Court the Payor and Provider irrevocably agree that venue for such action shall be the Federal Judicial District of Michigan, \_\_\_\_\_\_\_ District, \_\_\_\_\_\_ Division
8. By signing this Agreement, the Provider and Payor irrevocably agree that any claim, action, or violation arising under, or whatsoever related to the performance of, this Agreement must be brought within two (2) years after the accrual of such claim, action or violation.
9. When providing supports/services under this Agreement, the Provider, its officers, employees, servants, and agents shall abide by all applicable provisions and requirements for supports/services as set forth in the Mental Health Code, the MDHHS Rules, Medicaid and Medicare regulations, the MDHHS/CMHSP Master Contract for General Funds, the MDHHS/PIHP Master Contract for Medicaid funds, and in policies, procedures, standards and guidelines established by the Payor therefore.
10. The Provider shall comply under this Agreement with the requirements of the Balanced Budget Act of 1997 (BBA), as amended, and said BBA final rules, regulations, and standards, and with the requirements of the aforementioned Specialty Services Waiver Programs.
11. The Provider shall abide by and post a copy of the Whistleblower's Protection Act (Act 469 of the Public Acts of 1980) in a conspicuous place at its service location(s) and its headquarters.
12. The Provider shall comply with the Anti-Lobbying Act, Title 31 USC, Section 1352 (added under Section 319 of Public Law 101-121), as revised by the Lobbying Disclosure Act of 1995 (P.L 104-65), USC 1601 et seq., the Part 93 of 45 CFR, and the Section 503 of the Department of Labor, Health, and Human Services, and Education and Related Agencies Appropriation Act (Public Law 104-208). If the Provider, with the Payor’s prior consent, subcontracts any supports/services required of the Provider under this Agreement, any such subcontract must include the language of this Subsection.
13. The Provider shall comply with Hatch Political Activity Act, 5 USC 1501-1508, and Intergovernmental Personnel Act of 1970, as amended by Title VI of the Civil Service Reform Act, Public Law 95-454, 42 USC 4728. Federal funds cannot be used for partisan political purposes of any kind by any person or organization involved in the administration of federally assisted programs.
14. If any laws or administrative rules or regulations that become effective after the date of the execution of this Agreement substantially change the nature and conditions of this Agreement, they shall be binding to the parties, but the parties retain the right to exercise any remedies available to them by law or by any other provisions of this Agreement.
15. **NONDISCRIMINATION.**
16. In performing its duties and responsibilities under this Agreement, the Provider shall comply with all applicable federal and State laws, rules and regulations prohibiting discrimination.
17. The 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, gender identity, sexual orientation, height, weight, or marital status pursuant to the Elliott Larsen Civil Rights Act of 1976 PA 453, as amended (MCL 37.2201 et seq.) and pursuant to 42 CFR 438.206(c)(2).
18. The Provider shall comply with the provisions of the Michigan Persons with Disabilities Civil Rights Act of 1976 PA 220, as amended (MCL 37.1101 et seq.).
19. The 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.
20. The 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 IV 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).
21. The Provider shall comply with the Age Discrimination Act of 1975 (42 USC 6101 et seq.).
22. The Provider shall not refuse to treat and not discriminate in the treatment of the Consumer 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, handicap, color, national origin or ancestry, religion, gender identity, sexual orientation, political affiliation or beliefs pursuant to 42 CFR 438.206(c)(2) and Section 1557 Patient Protection and Affordable Care Act including 6504(a) claims processing and data.
23. **HEALTH AND SAFETY OF CONSUMERS; RECIPIENT RIGHTS AND CONSUMER GRIEVANCE PROCEDURES.**
24. The Provider shall monitor the health, safety and welfare of each Client while he or she is under its service supervision pursuant to this Agreement. The Provider shall provide immediate comfort and protection to and secure immediate medical treatment for a Client if he/she suffers physical injury. The Provider shall notify the Payor’s CEO immediately of any event or information that raises questions regarding the health and safety of any Client being served hereunder.
25. Pursuant to the requirements of the Mental Health Code and of the MDHHS that mental health services be provided in a safe, sanitary, and humane treatment environment, the Provider shall conduct pre-employment criminal history background checks and, at least every two years, current employment criminal history background checks. Provider must conduct a search that reveals information substantially similar to information found on an Internet Criminal History Access Tool (ICHAT) check and a national and state sex offender registry check for each new employee, subcontractor, subcontractor employee, or volunteer (including students and interns)who works under this Contract.
26. ICHAT: https://apps.michigan.gov/
27. Michigan Public Sex Offender Registry: https://mspsor.com/
28. National Sex Offender Registry: http://www.nsopw.gov
29. Conduct a Central Registry (CR) check for each new employee, subcontractor, subcontractor employee, or volunteer (including students and interns)who under this Contract works directly with children.
30. Central Registry: https://www.michigan.gov/mdhhs/0,5885,7-339-73971\_7119\_50648\_48330-180331--,00.html
31. Require each new employee, subcontractor, subcontractor employee, or volunteer (including students and interns) who works under this Contract, works directly with enrollees, or who has access to enrollee information to notify the Contractor in writing of criminal convictions (felony or misdemeanor), pending felony charges, or placement on the Central Registry as a perpetrator, at hire or within ten (10) days of the event after hiring.
32. Use information from the Medicaid Provider Manual (General Information for Providers; Section 6 – Denial of Enrollment, Termination and Suspension; Item 6.1 – Termination or Denial of Enrollment) and the Social Security Act (Subsection 1128(a)(b)), to determine whether to prohibit any employee, subcontractor, subcontractor employee, or volunteer (including students and interns) from performing work directly with enrollees or accessing enrollee information related to enrollees under this Contract, based on the results of a positive ICHAT response, reported criminal felony conviction, or perpetrator identification.
33. Use information from the Medicaid Provider Manual (General Information for Providers; Section 6 – Denial of Enrollment, Termination and Suspension; Item 6.1 – Termination or Denial of Enrollment) and the Social Security Act (Subsection 1128(a)(b)), to determine whether to prohibit any employee, subcontractor, subcontractor employee or volunteer (including students and interns)from performing work directly with children under this Contract, based on the results of a positive CR response or reported perpetrator identification.
34. The Payor may remove the Client(s) immediately from the Provider's services hereunder without prior notification to the Provider whenever, in the judgment of the Payor’s CEO or CEO’s designated representative, the health or safety of the Client(s) is in jeopardy.
35. The Provider shall strictly comply with all Recipient Rights provisions of the Mental Health Code and of the MDHHS Rules. The Provider agrees to post a copy of a Payor-provided Summary of Rights, as guaranteed by the Mental Health Code and the MDHHS Rules, in a conspicuous place at its headquarters. The Clients shall be protected from rights violations while they are receiving services under this Agreement. The Provider shall report alleged rights violations regarding a Client hereunder to Payor-designated staff representatives immediately by telephone and then, in writing on Payor-designated forms, within twenty-four (24) hours of occurrence.

The Provider shall comply with the mechanisms established by the Payor for protecting recipient rights and shall accept the final jurisdiction of the Payor’s Recipient Rights policies, procedures, and process and agrees to implement appropriate remedial action for substantiated violations of rights guaranteed by the Mental Health Code and the Rules. The Payor shall furnish the Provider with copies of applicable recipient rights policies of the Payor.

The Payor may remove the Client(s) from the Provider's services, upon notice to the Provider, for any violation or reasonable suspicion of a violation of recipient rights which, in the judgment of the Payor’s CEO or CEO’s designated representative, has caused or may cause physical or emotional harm to the Client(s) and/or, in the judgment of the Payor’s CEO or CEO’s designated representative, there is a failure by the Provider to provide the services required under this Agreement.

The Provider agrees that the Payor’s Recipient Rights Office representatives shall have access at any time to any Client and all applicable staff, services records, and services of the Provider pursuant to this Agreement, in order for them to fulfill the monitoring function of that Office and/or to conduct a thorough investigation. The Provider shall have policies and procedures for and shall provide or assure that appropriate action is taken to ensure protection for complainants and rights staff if evidence of harassment or retaliation occurs regarding alleged rights violations or rights complaint. Access to the Provider’s training records also shall be provided to the Payor’s Recipient Rights Officer.

1. The Provider shall report any sentinel event involving any Client hereunder immediately to Payor’s CEO or said CEO’s designated representative and, as applicable, to the appropriate Department or Agency of the State of Michigan, law enforcement agencies, or other public agencies, as required by law. Provider agrees that individuals who properly identify themselves as representatives of Michigan Protection and Advocacy Services, designated and acting pursuant to Section 931 of the Mental Health Code, may have access during reasonable hours to the applicable residence(s) and to the applicable service recipient(s) and shall have access to the applicable service record(s) hereunder upon requirement of the Payor, as holder of record under Section 748 of said Code, to be in compliance with federal law and Section 748(8) of said Code. Provider shall provide Payor’s Recipient Rights Officer with copies of all investigative reports and summary reports involving the Payor’s Clients.

1. A Client of or an applicant for specialty supports/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. Specification of said options are set forth in the attached document labeled “Exhibit H (RECIPIENT RIGHTS AND CLIENT GRIEVANCE PROCEDURES)” 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 MDHHS for receiving, processing and resolving promptly any and all complaints, disputes, and grievances for Medicaid and non-Medicaid Clients or potential Clients.

1. 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 Client served 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.

1. Any breach of this Section shall be regarded as a material breach of this Agreement and may be a cause for termination thereof by the Payor.
2. **ESTABLISHMENT, RETENTION AND ACCESS TO CONSUMER RECORDS, RELEASE OF CONSUMER INFORMATION AND CONFIDENTIALITY.**
3. The Provider, pursuant to this Agreement, shall establish and maintain a comprehensive individual service record system consistent with the provisions of MDHHS Medical Services Administration (MSA) Policy Bulletin Chapter 1, and appropriate state and federal statutes.
4. The Payor has the right to full access to all records pertaining to any Consumer and services rendered pursuant to this Agreement. The Provider agrees to furnish Payor with copies of all records pertaining to any Consumer and services rendered pursuant to this Agreement upon reasonable request.

**C)** To the extent that the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended (HIPAA) is pertinent to the services that the Payor purchases and the Provider provides under this Agreement, the Provider ensures that *it* is in compliance with HIPAA requirements.

**D)** HITECH- Health Information Technology for Economic and Clinical health act, as title XIII of division a and title IV of division B of the ARRA. To Use Protected Health Information in accordance with the American recovery and Reinvestment Act of 2009 Pub. L 111-5, as amended (ARRA), specifically the “HITECH ACT” and any associated federal rules and regulations. The [HITECH Act](http://www.hipaasurvivalguide.com/hitech-act-text.php) now imposes data breach notification requirements for unauthorized uses and disclosures of "unsecured PHI." Under the [HITECH Act](http://www.hipaasurvivalguide.com/hitech-act-text.php) "unsecured PHI" essentially means "unencrypted PHI."

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

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

The 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 regards to disclosure of any materials and/or information provided pursuant to this Agreement. Any release of information must be in compliance with Sections 748, 748a, and 750 of the Mental Health Code.

The Provider shall assure services to and information contained in the records of Consumers served under this Agreement, or other such recorded information required to be held confidential by federal or State law, rule or regulation, in connection with the provision of services or other activity hereunder shall be privileged communication. Privileged communication shall be held confidential and shall not be divulged without the written consent of either the Consumer or a person responsible for the Consumer, except as may be otherwise required by applicable law or regulation. Such information may be disclosed in summary, statistical, or other form, which does not directly or indirectly identify particular individuals.

1. **RELATIONSHIP OF THE PARTIES.**
2. In performing its responsibilities under this Agreement, it is expressly understood and agreed that the Provider’s relationship to the Payor is that of an independent contractor. This Agreement shall not be construed to establish any principal/agent relationship between the Payor and the Provider.
3. It is expressly understood and agreed by the 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 Payor is party to any employer/employee relationship of the Provider.
4. It is expressly understood and agreed that the 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, servants or agents of the Payor. The Provider’s staff psychiatrists, employees, servants, agents, and subcontractors shall not be entitled to any fringe benefits from the Payor, such as, but not limited to, health and accident insurance, life insurance, longevity, economic increases, or paid vacation and sick leave.
5. The Provider shall be responsible for paying all salaries, wages, or other compensation due its staff psychiatrists, employees, servants, 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. The 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 Payor with proof of said coverage.
6. **CONFLICT OF INTEREST AND DISCLOSURE OF OWNERSHIP.** The Provider affirms that no principal, representative, agent or another acting on behalf of or legally capable of acting on behalf of the Provider is currently an employee of the MDHHS or any of its constituent institutions, an employee of the Payor or of a party to a contract with the Payor or administering or benefiting financially from a contract with the Payor, or serving in a policy-making position with an agency under contract with the Payor; nor is any such person related to the Provider currently using or privy to such information regarding the Payor which may constitute a conflict of interest. Any breach of this Section shall be regarded as a material breach of this Agreement and may be a cause for termination thereof by the Payor.

In contracts that exceed Twenty-Five Thousand Dollars and No Cents ($25,000.00) the Provider agrees to disclose ownership in accordance with the policies and procedures of the Payor as specified in the attached document labeled “Exhibit I” (“DISCLOSURE AND OWNERSHIP”), which is incorporated by reference into this Agreement and made a part hereof in accordance with 42 CFR §455, Subpart B-Disclosure of Information by Providers and Fiscal Agents.

1. **INDEMNIFICATION, DEFENSE, HOLD HARMLESS.** To the fullest extent provided by law the Provider will indemnify, defend and hold harmless the Payor, the PIHP and their respective local units of government together with their respective directors, officers, employees, volunteers, agents or representatives from and against any and all legal or equitable claims, causes of action, demands, liabilities, losses, damages, costs, expenses and reasonable attorneys’ fees attributable to any act or omission of Provider in breach of this Agreement and/or applicable standards of care based in law, equity, contract, tort or another theory for relief.

Without waiving its governmental rights, privileges and/or immunities, to the fullest extent provided by law the Payor will indemnify, defend and hold harmless the Provider together with its directors, officers, employees, volunteers, agents or representatives from and against any and all legal or equitable claims, causes of action, demands, liabilities, losses, damages, corrective actions, costs, expenses and reasonable attorneys’ fees attributable to any act or omission of Payor in breach of this Agreement and/or applicable standards of care based in law, equity, contract, tort or another theory for relief. The indemnification, defense, and hold harmless responsibilities under this section will be limited to the sum of liabilities, losses, damages, costs, and expenses exceeding any sum paid on behalf of Provider or paid directly to Provider by any insurance or other indemnity coverage. This provision shall survive the termination, expiration and/or non-renewal of this Agreement.

This Section shall survive the termination or cancellation of this Agreement.

1. **INSURANCE.** Each party shall procure, pay the premium on, keep and maintain during the term of this Agreement insurance coverage in such amounts as necessary to cover all claims, which may arise out of activities to be carried out pursuant to its obligations hereunder. The Provider shall ensure that all of its employees, other staff and subcontractors are covered by all appropriate liability and malpractice insurance for the services, which they perform under this Agreement. The Provider shall submit certification of its insurance coverage to the Payor prior to prior to commencing services under this Agreement. The Provider also shall provide the Payor with written notice at least thirty (30) days prior to any reduction or termination of insurance coverage required hereunder.
2. **MISCELLANEOUS PROVISIONS.**
3. **Non-exclusive Agreement**. It is expressly understood and agreed by the parties hereto that this Agreement shall be non-exclusive and that this Agreement is not intended and shall not be construed to prevent either party from concurrently and/or subsequently entering into and maintaining similar agreements with other public or private entities for similar or other services.
4. **Relationship with Other Contractors of the Payor.** The relationship of the Provider, pursuant to this Agreement, with other contractors of the Payor shall be that of independent contractor. The Provider, in performing its duties and responsibilities under this Agreement, shall fully cooperate with the other contractors of the Payor. The Payor’s requirements of such cooperation shall not interfere with the Provider’s performance of services required under this Agreement.
5. **Information Requirements**. The Payor and the 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 individuals, Medicaid eligibles, 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 the Provider or the Provider’s subcontractors for the Payor’s approval or disapproval prior to any distribution.
6. **Publications**. Any drawings, records, documents, papers, reports, charts, maps, graphics or manuscripts prepared for or pertaining to the supports/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 Payor and its elected and appointed officers, employees, and agents are not responsible for the contents of the item(s) published or provided by the Provider to third parties.
7. **Time of the Essence**. Time is of the essence in the performance of each and every obligation herein imposed.
8. **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.
9. **Notice**. Any and all notices, designations, consents, offers, acceptances or other communications herein shall be given to either party, in writing, by receipted personal delivery or deposited in certified mail 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:

Notice to the Payor should be addressed to: **Joseph “Chip” Johnston, Executive Director, Centra Wellness Network, 310 N. Glocheski Drive, \_\_\_\_, MI 49660.**

Notice to the Provider should be addressed to:

1. **Return of Property**. Upon the termination of this Agreement, the Provider shall return immediately to the Payor all documents, correspondence, files, records, papers or other property of any kind of the Payor that the Provider, its officers, employees, and agents may have in their possession or control.
2. **MONITORING THE AGREEMENT; RESOLUTION OF CONTRACT ISSUES AND SERVICE DISPUTES**.
3. The performance of the terms of this Agreement shall be monitored on an ongoing basis by the designated representatives of the Payor and of the Provider. The Payor’s CEO shall appoint administrative and program liaisons to be available to communicate with the Provider’s liaisons. Issues between the Payor and the Provider as to specific provisions of this Agreement and implementation thereof shall be addressed by the designated representatives of said respective parties.
4. If differences as to essential terms and conditions of this Agreement and implementation thereof are not resolved by the respective designated executives of both parties, these unresolved issues may be referred by the Payor’s CEO to the governing board of the Payor and/or by the Provider’s CEO to the governing body of the Provider. If such disputes cannot be resolved between the Payor and the Provider, either party may seek resolution through exercise of any available legal and/or equitable remedies.
5. As the single point of entry/exit for public mental health services unit’s service area, the Payor may determine on a case-by-case basis that alternative services are more appropriate than admission or continuation of stay in the Provider’s crisis residential unit.

 All decisions to authorize, deny, continue, or discontinue the Payor’s payments for the Provider’s services to Consumers hereunder shall be those of the Payor’s CEO. Decisions to continue services without reimbursement from the Payor shall be those of the Provider

1. **WAIVERS**.
2. 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.
3. In no event shall the making by the Payor of any payment to the Provider constitute or be construed as a waiver by the Payor of any breach of this Agreement, or any default which may then exist, on the part of the Provider, and the making of any such payment by the Payor while any such breach or default shall exist, shall in no way impair or prejudice any right or remedy available to the Payor in respect to such breach or default.
4. **AMENDMENT**. Modifications, amendments, or waivers of any provision of this Agreement may be made only by the written mutual consent of the parties hereto.
5. **ASSIGNMENT**.
6. Neither this Agreement nor any rights or obligations hereunder shall be assignable by the Provider without the prior written consent of the Payor nor shall the duties imposed herein be delegated without the prior written consent of the Payor. Any attempted assignment in violation of this section shall be void ab initio.
7. This Agreement shall be binding upon the Payor and the Provider and their respective successors and permitted assigns.
8. If the Provider, with the Payor’s prior consent, subcontracts any services required of the Provider under this Agreement, any such subcontract shall be in writing and include a full specification of the subcontracted services. The Provider shall make best efforts to ensure that its sub-contractors are in substantial compliance with the terms and conditions of this Agreement. Any such subcontract shall not terminate the legal responsibility of the Provider to assure that services required of the Provider hereunder are fulfilled.

Prior to the execution of any such subcontract, the Provider shall furnish the Payor with notice of verification that:

* + 1. the subcontractor and its professional staff, if any, maintain all approvals, licenses, certifications, registrations, accreditations, and authorizations required by federal, State and local laws, ordinances, rules and regulations to perform the subcontracted services for Medicaid and non-Medicaid Consumers;
		2. the subcontractor is not listed by a Department or Agency of the State of Michigan as being suspended from participation in Michigan Medicaid and/or Medicare programs;
		3. the subcontractor is not listed by a Department or Agency of the State of Michigan in its registry for Unfair Labor Practices;
		4. the subcontractor is not listed by the U.S. General Services Administration in its “Excluded Parties List” as to federal funding;
		5. the subcontractor maintains workers' compensation and unemployment insurance coverages for its employees; and,
		6. the subcontractor maintains liability insurance coverages for the services. The Provider shall immediately notify the Payor, in writing, if, subsequent to execution of any such subcontract, the Provider discovers that any of the above-cited verifications are no longer true.
1. **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.
2. **COMPLETENESS OF THE AGREEMENT**. This Agreement, the attached Exhibits, and the additional and supplementary documents incorporated herein by specific reference contain all the terms and conditions agreed upon by the Payor and the Provider and no other agreements, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind either the Payor or the Provider.
3. **SEVERABILITY AND INTENT**.
4. If any provision of this Agreement is declared by any Court having jurisdiction to be invalid, such provision shall be deemed deleted and shall not affect the validity of the remainder of this Agreement, which shall continue in full force and effect. If the removal of such provision would result in the illegality and/or unenforceability of this Agreement, this Agreement shall terminate as of the date in which the provision was declared invalid.
5. This Agreement is not intended by the Payor or the Provider to be a third-party beneficiary contract and confers no rights on anyone other than the parties hereto.
6. **CERTIFICATION OF AUTHORITY TO SIGN THE AGREEMENT**. The person signing this Agreement on behalf of the respective party represents, warrants and certifies that they are duly authorized to sign this Agreement on behalf of the respective party, that this Agreement has been duly authorized for their signature, and that each represents, warrants, and assents to be bound by and to all terms this this Agreement.

The undersigned duly authorized representatives voluntarily and knowingly hereby intentionally sign this Agreement upon the month, day and year written below.

The authorized representatives of the parties hereto have fully executed this Agreement on the day and the year first above written.

**PAYOR: \_\_\_\_ \_\_\_\_ COMMUNITY MENTAL HEALTH \_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Date

**PROVIDER:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date

**EXHIBIT A**

**GLOSSARY OF TERMS AND DEFINITIONS**

Terms used in this Agreement shall be construed and interpreted as defined below:

1. Agreement means this Agreement whereby the \_\_\_\_ \_\_\_\_ Community Mental Health ­­­­­­­­\_\_\_\_\_\_\_\_\_ purchases services on a subcontracted basis from the party designated as the "Provider" in the introductory paragraph (i.e. on page 1) of this Agreement.
2. Consumer means an individual who is an eligible person covered under the Medicaid waiver carve-out or who is elsewise a service area resident covered as a priority population under the Mental Health Code and who meets the service eligibility criteria and is receiving specialty supports and services under this Agreement.
3. Medicaid eligible means an individual who has been determined to be entitled to Medicaid and has been issued a Medicaid card. This includes persons entitled to Medicaid who are on a spenddown and persons who are retro-eligible for Medicaid.
4. Mental Health Code means Act 258 of Public Acts of 1974, as amended.
5. MDHHS means the Michigan Department of Health and Human Services.
6. MDHHS/CMHSP Master Contract means the current MDHHS/CMHSP Managed Specialty Supports and Services Contract between the MDHHS and the \_\_\_\_ \_\_\_\_ Community Mental Health.
7. Payor means the \_\_\_\_ \_\_\_\_ Community Mental Health \_\_\_\_\_\_\_\_\_\_\_\_\_\_.
8. Potential consumer means an individual who is a customer residing in the Payor’s service area. A potential consumer is not a person receiving specialty services under this Agreement
9. Provider means the party designated as the "Provider" in the introductory paragraph (i.e. on page 1) of this Agreement.
10. Rules means rules, regulations, and standards promulgated and adopted by the MDHHS in compliance with the Mental Health Code.
11. Sentinel events means 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” mean relocation of a consumer due to licensing issues, relocation of the service site or administrative operations of the provider for more than 24 hours, conviction of a provider or a providers staff for any offense related to the performance of their job duties/responsibilities, and the usual incidents such as emergency medical treatment, hospitalization, medication error, arrest of a consumer, behavioral incidents that are unexpected/not addressed, harm to self, and harm to others. An “Event” must be in writing within 24 hours.

"Injuries" that require emergency room visits or admissions to hospitals include those resulting from abuse or accidents.

"Serious challenging behaviors" include property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence.

"Medication Errors" mean a) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage. It does not include instances in which consumers have refused medication.

1. Service area means \_\_\_\_ and \_\_\_\_ Counties the Payor’s service area for its Master Contract with MDHHS and for this Agreement.

**EXHIBIT B**

**TARGET SERVICE GROUP AND ELIGIBILITY CRITERIA FOR SERVICES**

1. The target service group for services under this Agreement is as follows:

Adults living with Mental Illness (MI), as appropriate, who are residents of \_\_\_\_, and \_\_\_\_ Counties or residents of other counties referred by Payor and approved for admission by an authorized representative of \_\_\_\_ \_\_\_\_ Community Mental Health \_\_\_\_\_\_\_\_\_\_\_\_\_.

1. The eligibility criteria for services under this Agreement are as follows: **Adults meeting psychiatric inpatient admission criteria or are at risk of admission but have symptoms and risk levels that permit them to be appropriately treated in setting less intensive than the hospital.**

The individual must meet all three criteria outlined below:

Diagnosis: The beneficiary must be diagnosed with mental illness, reflected in a primary, validated, current version of DSM or ICD diagnosis (not including V Codes).

Severity of Illness: (signs, symptoms, functional impairments and risk potential)

At least one of the following manifestations is present:

* Severe Psychiatric Signs And Symptoms
* Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance hallucinations, delusions, extreme agitation, profound depression) severe enough to cause seriously disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care.
* Disorientation, seriously impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.
* A severe, life-threatening psychiatric syndrome or an atypical or unusually complex psychiatric condition exists that has failed, or is deemed unlikely, to respond to less intensive levels of care, and has resulted in substantial current dysfunction.
* Disruptions of Self-Care and Independent Functioning
* The person is unable to attend to basic self-care tasks and/or to maintain adequate nutrition, shelter, or other essentials of daily living due to psychiatric disorder.
* There is evidence of serious disabling impairment in interpersonal functioning (e.g., withdrawal from relationships; repeated conflictual interactions with family, employer, co-workers, and neighbors) and/or extreme deterioration in the person’s ability to meet current educational/occupational role performance expectations.
* Harm to Self
* Suicide: Attempt or ideation is considered serious by the intention, degree of lethality, extent of hopelessness, degree of impulsivity, level of impairment (current intoxication, judgment, and psychological symptoms), history of prior attempts, and/or existence of a workable plan.
* Self-Mutilation and/or Reckless Endangerment: There is evidence of current behavior, or recent history. There is a verbalized threat of a need or willingness to self-injure or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations.
* Other Self-Injurious Activity: The person has a recent history of drug ingestion with a strong suspicion of overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.
* Harm to Others
* Serious assaultive behavior has occurred, and there is a risk of escalation or repetition of this behavior in the near future.
* There is expressed intention to harm others and a plan and/or means to carry it out and the level of impulse control is non-existent or impaired (due to psychotic symptoms, especially command or verbal hallucinations, intoxication, judgment, or psychological symptoms, such as persecutory delusions and paranoid ideation).
* There has been significant destructive behavior toward property that endangers others.
* Drug/Medication Complications or Coexisting General Medical Conditions Requiring Care
* The person has experienced severe side effects from using therapeutic psychotropic medications.
* The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment or re-initiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary’s condition or to the nature of the procedures involved.
* There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric hospitalization, and the coexisting general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care.
* *Special Consideration* - Concomitant Substance Abuse: The underlying or existing psychiatric diagnosis must be the primary cause of the beneficiary’s current symptoms or represent the primary reason observation and treatment is necessary in the psychiatric unit or hospital setting.

Intensity of Service: The person meets the intensity of service requirements if inpatient services are considered medically necessary for the beneficiary’s treatment/diagnosis, the beneficiary can be appropriately serve in settings less intensive than a hospital, and if the person requires at least one of the following:

* Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications.
* Close and continuous skilled medical observation is necessary due to otherwise unmanageable side effects of psychotropic medications.
* Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) is needed to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur.
* A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary’s signs and symptoms.
* Services must be delivered according to an individual plan based on an assessment of immediate need.

**EXHIBIT C**

**SCOPE OF INDEPENDENT CONTRACTOR SERVICES, SERVICE DESCRIPTIONS,**

 **AND REIMBURSEMENT RATE**

**Example**

It is expressly understood and agreed by the parties hereto that the Provider’s **Crisis Residential Services** to be provided to the Payor’s Consumers for subsequent reimbursement from the Payor per valid claims under this Agreement may include the following:

|  |  |  |
| --- | --- | --- |
| Service Description | CPT/Service Code | Rate |
| Crisis Residential, Per Diem |  |  |
| 1:1 Enhanced Staffing, per 15-minute unit | H2015 |  |

**For Individuals with no insurance during their stay, the cost of prescription medications will be reimbursed by Payor when prior-authorized by Payor designated staff.**

**Planning for transportation at time of discharge will be initiated by the Provider prior to date of discharge. Payor staff will assist with coordination and payment if required for discharge transportation.**

Per the \_\_\_\_/MDHHS Contract:

6.2 COVERED SERVICES

Services must be designed to resolve the immediate crisis and improve the functioning level of the beneficiaries to allow them to return to less intensive community living as soon as possible.

The covered crisis residential services include:

* Psychiatric supervision;
* Therapeutic support services;
* Medication management/stabilization and education;
* Behavioral services;
* Milieu therapy; and
* Nursing services.

6.2.B. ADULT CRISIS RESIDENTIAL SERVICES

The program must include on-site nursing services (RN or LPN under appropriate supervision).

For settings of six beds or fewer: on-site nursing must be provided at least one hour per day, per resident, seven days per week, with 24-hour availability on-call.

For 7-16 beds: on-site nursing must be provided eight hours per day, seven days per week, with 24-hour availability on-call.

6.5 LOCATION OF SERVICES

Services must be provided to beneficiaries in licensed crisis residential foster care or group home settings not exceeding 16 beds in size. Homes/settings must have appropriate licensure from the state and must be approved by MDHHS to provide specialized crisis residential services. Services must not be provided in a hospital or other institutional setting.

6.6 DURATION OF SERVICES

Services may be provided for a period up to 14 calendar days per crisis residential episode. Services may be extended and regularly monitored, if justified by clinical need, as determined by the interdisciplinary team.

* 1. INDIVIDUAL PLAN OF SERVICE
* The plan must be developed within 48 hours of admission and signed by the beneficiary (if possible), the guardian, the psychiatrist, and any other professionals involved in treatment planning, as determined by the needs of the beneficiary. If the beneficiary has an assigned case manager, the case manager must be involved in the treatment as soon as possible and must also be involved in follow-up services.
* The plan must contain clearly stated goals and measurable objectives, derived from the assessment of immediate need, stated in terms of specific observable changes in behavior, skills, attitudes, or circumstances, structured to resolve the crisis. Identification of the activities designed to assist the beneficiary to attain his/her goals and objectives.
* Discharge plans, the need for aftercare/follow-up services, and the role of, and identification of the case manager. If the length of stay in the crisis residential program exceeds 14 days, an interdisciplinary team must develop a subsequent plan based on comprehensive assessments. The team is comprised of the beneficiary, the parent or guardian, the psychiatrist, the case manager and other professionals whose disciplines are relevant to the needs of the beneficiary, including the individual ACT team, outpatient services when applicable. If the beneficiary did not have a case manager prior to initiation of the intensive/crisis residential service, and the crisis episode exceeds 14 days, a case manager must be assigned and involved in treatment and follow-up care. (The case manager may be assigned prior to the 14 days, according to need.)

**Exhibit D**

**Minimum Training Requirements**

**Example**

|  |  |  |
| --- | --- | --- |
| **Minimum Training Requirements** **Contract Providers** |  |  |
| **Renewal Key**:Source Document Key1. BALANCED BUGET ACT (bba)
2. hEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (hipaa)
3. dEFICIT REDUCTION ACT (dra)
4. mICHIGAN dEPT. OF HEALTH AND HUMAN SERVICES (mdhhs)
5. mICHIGAN aDMINSTRATIVE CODE
6. MICHIGAN MENTAL HEALTH CODE
7. OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (osha)
8. CODE OF FEDERAL REGULATIONS (cfr)

**I = Initially****A = Initially + Annually****2 = Initially and Every Two Years** |  |  |
| **TRAINING** | **TIMELINE TO COMPLETE** | **REQ. SOURCE** | **Professional Services** | **Medical Professional** | **Aide Level Staff** | **Case Holder[[1]](#footnote-1)** | **Individual/Group Therapist** |
| Advanced Directives | Within first 90 days | 1 |  |  |  | I | I |
| Appeals and Grievances | Within first 90 days | 1, 4, 6 | A | A |  | A | A |
| CAFAS and/or PECFAS | Within first 90 days | 4 |  |  |  | 2 | 2 |
| Corporate and Regulatory Compliance | Within first 90 days | 1, 3 | A | A | A | A | A |
| First Aid | Within first 30 days | 5 | A |  | 2 |  |  |
| CPR | Within first 30 days | 5 | A |  | 2[[2]](#footnote-2) |  |  |
| Cultural Competency and Diversity | Within 90 days | 4,6,8 | A | A | A | A | A |
| Environmental Safety | Within 90 days | 5,6 | I | I | I | I | I |
| **TRAINING** | **TIMELINE TO COMPLETE** | **REQ. SOURCE** | **Professional Services** | **Medical Professional** | **Aide Level Staff** | **Case Holder** | **Individual/Group Therapist** |
| Blood Borne Pathogens/Infection Control | Within 30 days | 5,6,7 | A | A | A | A | A |
| HIPAA Privacy and Security | Within 30 days | 2,4,5,8 | A | A | A | A | A |
| Limited English Proficiency (LEP | Within 90 days | 1,4 | A | A | A | A | A |
| Medication Administration | Within 90 days | 5 |  |  | I – *If necessary* |  |  |
| Non-Physical Interventions | Within 90 days | 8 |  |  | I-*if necessary* | I | I |
| Person/Family Centered Planning | Within 30 days | 4,6,8 | A | A | A | A | A |
| Recipient Rights | Within 30 days | 4,5,8 | A | A | A | A | A |
| Trauma Informed Services | Within 90 days | 4 | A | A | A | A | A |
| Culture of Gentleness | Within 90 days | 4 |  |  | *A-if necessary* |  |  |

 Case managers supports coordinators, home based staff, wraparound

 If licensed setting only

<https://www.improvingmipractices.org/about-site/state-training-guidelines-workgroup>

**EXHIBIT E**

**SERVICE ACCESS, PREAUTHORIZATIONS, DELIVERY,**

**AND UTILIZATION MANAGEMENT PROCEDURES**

 **EXHIBIT F**

**BILLING AND PAYMENTS FOR VALID SERVICE REIMBURSEMENT CLAIMS**

**Example**

The parties hereto agree that a primary purpose of this Agreement is to provide for reimbursement by the Payor to the Provider for services rendered to any of the Payor’s Consumers who are Medicaid covered or who are assessed by the Payor as being indigent for the purpose hereunder.

For the purposes of this Exhibit and other sections of this Agreement, an indigent person requiring treatment shall mean a Payor’s Consumer who is not covered by Medicaid and who is unable to pay and is ineligible for other third-party reimbursements (e.g., Medicare, Blue Cross/Blue Shield, etc.) pursuant to the ability to pay determination requirements and other related requirements under Chapter 8 (“Financial Liability for Mental Health Services”) of the Mental Health Code.

Therefore, it is agreed by the parties hereto that the Provider shall bill the Payor and the Payor shall reimburse the Provider only for services to such Consumers within the service, service recipient, billing, and payment requirements and limitations specified and delineated in this Agreement and in this Exhibit as follows:

1. **Determination of Financial Status and Benefits Status of Consumers.**

The Provider shall inform the Payor immediately regarding any change in payor status/coverage for any of the Payor’s Consumers. The Payor shall have access to and be able to review any Provider information and documentation as regards said matters.

The Provider agrees that it shall initiate application for, charge, bill, and diligently seek to collect all third-party benefits as applicable from insurers and government agencies for Payor-authorized services rendered to the Payor’s Consumers hereunder for whom reimbursement may be available, including (but not by way of limitation) public and private insurance plans, entitlements or other assistance, and other health benefit plans.

The Provider shall seek authorization from third-party payors, as applicable, for extension(s) of stay(s) in all instances where such extensions are deemed clinically necessary, in accordance with the requirements and time frames of each applicable third-party payor and shall document approval or denial of any request of said extension of hospitalization.

Pursuant to this Agreement, the Provider agrees to comply with the Third-Party Liability requirements in federal regulations for Medicaid coverage.

The Payor’s payments to the Provider shall be contingent upon receipt of accurate billings of valid claims which indicate the Payor’s Consumer(s) serviced, benefit status, and the services provided.

To insure the maximum third-party reimbursement and verified county of residency, as required by the Mental Health Code, the Provider shall provide the Payor with:

(1.) Access to admission and financial records for Consumers under this Agreement; and,

(2.) Access to any such Consumer when necessary to obtain additional information needed in the Payor’s monitoring of the financial liability determination process.

1. **Coordination of Benefits.**

For purposes of this Agreement, the Provider shall be responsible for the coordination of public and private benefits of each Consumer hereunder. The Provider acknowledges that the Payor shall be the payor of last resort for Payor-authorized services to Payor-authorized Consumers under this Agreement subject to the terms and conditions herein. The payments from the Payor to the Provider under this Agreement are intended only to cover the allowable costs of the services net of and not otherwise covered by payments provided by other funding, entitlements or benefits and by liable third parties, as applicable, for which each recipient of services hereunder may be eligible.

1. **Third Party Liability Requirements.**

Under this Agreement, it is a requirement of the Payor to identify and seek recovery from all liable third parties, consistent with the requirements of the Mental Health Code, the MDHHS/CMHSP Master Contract for General Funds, and with the MDHHS/PIHP Master Contract for Medicaid Funds. Therefore, the Provider shall be responsible under this Agreement for seeking service reimbursements, if applicable, from third party liability claims for Consumers hereunder, pursuant to federal and State requirements.

The Provider shall not seek or collect any service fee payments directly from consumers, legal guardians, 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 Payor.

Medicaid covered deductibles of Medicare recipients of the Provider’s crisis residential unit services shall be the responsibility of the Payor at Payor-authorized reimbursement rates, upon the Payor’s pre-authorization that the services are medically necessary.

1. **Payment in Full.**

Payments from the Payor for valid claims for Payor-authorized services rendered by the Provider to the Payor’s Consumers under this Agreement shall constitute payment in full. The Provider shall be solely responsible for its payment obligations and payments to its subcontractors, if any, for performing services required of the Provider under this Agreement. Payments from the Provider to its subcontractors for performing services required of the Provider hereunder shall be made on a timely basis and on a valid claim basis.

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

1. The Provider and/or its subcontractors shall not require any co-payments, recipient pay amounts, or other cost sharing arrangements for the Provider’s services required hereunder and/or for services of a subcontractor, unless specifically authorized by the Payor, the State or federal regulations and/or policies thereof.
2. The Provider and/or its subcontractors shall not bill individuals for any difference between a services charge of the Provider or of a subcontractor and the Payor’s payment for the Provider’s services required hereunder.
3. The Provider and/or its subcontractors shall not seek nor accept additional supplemental payments from the individual, his/her family, or representative, for the Provider’s services required hereunder and/or for the services of a subcontractor.
4. **Preauthorized Service Periods and Reimbursements.**

The initial preauthorized service period for reimbursement by the Payor to the Provider for crisis residential services to Consumers, who are Medicaid covered or who are indigent for the purposes hereunder, shall be a minimum of twenty-four (24) hours or until the next business day. For the purposes of this section and other sections of this Agreement, a unit of service shall constitute one (1) day of care.

If the Payor finds that alternative services are more appropriate than continued care within the Provider’s crisis residential unit, the Payor will immediately arrange for such alternative services and will not accept responsibility for reimbursement to the Provider beyond the previous designated period. If the Payor’s CEO and staff determine that continued care is necessary, an extension of days will be authorized, with subsequent extensions reviewed as outlined above.

1. **Requirements for and Limitations for Billing of Claims and Payment of Claims.**

The Provider shall provide a billing statement with valid claims for Payor-authorized services rendered to Medicaid covered or indigent Consumers hereunder in a payor approved format. In order to be considered valid claims for which payments from the Payor may be made, the Provider’s billing of a service claim must be received by the Payor within:

1) Sixty (60) days after the actual services were rendered for a Payor-authorized Consumer whose Medicaid or indigent status has been established without pending third party approval; or,

2) Sixty (60) days after Medicaid or indigent status is no longer pending third party approval for a Payor-authorized Consumer of services rendered by the Provider. The Payor’s CEO shall authorize and process service claims payments to the Provider within thirty (30) days following receipt of complete and accurate billing statement from the Provider.

1. **Refunding of Payments.**

The Provider shall not bill the Payor for services rendered hereunder in any instances in which the 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. If at any time it is determined, after services claims reimbursement to the Provider has been made by the Payor, that the 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, the Provider shall refund to the Payor an amount equal to the sums reimbursed by third party payors and/or paid by any other source. However, said refund by the Provider shall not exceed the full amount of the original payment by the Payor. The Provider shall notify the Payor immediately of any receipt of such monies for such purposes hereunder.

1. **Contractual Account Reconciliation.**

Upon early termination of this Agreement, a contractual account reconciliation shall be completed wherein the claims billed by the Provider and the claims paid by the Payor shall be reviewed in order to assure that payments made by the Payor or still outstanding during the term hereunder have been in accordance with the provisions of this Agreement and have been identified appropriately and accounted for separately by the Provider and the Payor as to the benefit status of the Consumers (i.e., Medicaid covered or indigent) hereunder. 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.

The contractual account reconciliation shall be completed in accordance with the following procedures:

1. The Provider shall submit a preliminary reconciliation proposal to the Payor no later than thirty (30) days after the end of the Payor’s fiscal year. Service claims occurring during this agreement period for which denial or approval is pending as to Medicaid eligibility also shall be identified and accounted for separately, in completing the preliminary reconciliation proposal.
2. After considering the Payor’s preliminary reconciliation response, the Provider shall submit a final reconciliation proposal, including updated data on Medicaid eligibility determinations, to the Payor no later than thirty (30) days after the Payor’s preliminary response. Thereafter, the Payor shall make a final determination of claims pending, claims denied and claims approved for payment within thirty (30) days of the Provider’s final response.
3. Claims approved for payment by Payor to the Provider as final account reconciliation for the fiscal year shall be paid within sixty (60) days after notification of the Payor’s final determination.
4. **Unallowable Service/Cost Claims and Financial Paybacks.**

Should the 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 Payor hereunder for any such services and/or cost claims; thereto, the Provider shall repay to the Payor as financial paybacks of any claims payments made by the Payor to the 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 the Provider to the Payor within sixty (60) days of Payor’s final disposition notification to the Provider that financial payback by the Provider is required.

1. **Disallowed Expenditures and Financial Repayments.**

In the event that the MDDHS, the Payor, the State of Michigan, or the federal government ever determines in any final revenue and expenditure reconciliation and/or any final finance or service audit that the Provider has been paid inappropriately per the Payor’s expenditures of 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, the Provider shall fully repay the Payor for such disallowed payments within sixty (60) days of the Payor’s final disposition notification of the disallowances, unless the Payor authorizes, in writing, additional time for repayment.

1. **Revenue/Cost Projections for Subsequent Rate Determinations.**

The Provider, by signing this Agreement, acknowledges that it provided the Payor with projected service revenue and service cost analyses (using formats acceptable to the parties) and all source documents for subsequent review in the determination of the claims reimbursement rates for authorized services under this Agreement.

 **EXHIBIT G**

**PERFORMANCE INDICATORS AND OBJECTIVES**

**Example**

The performance of the Provider, as well as compliance with contract standards, shall be monitored on an ongoing basis by a representative(s) of the Payor in conjunction with the Provider. The representative shall be available to communicate with the Provider on any contractual issues. Also, the Payor’s CEO, or designee, shall assign a designated representative(s) who shall act as the general liaison with the hospital in terms of access and utilization, authorization of hospitalization, and determination of continued stay reviews. Said representative(s) shall maintain regular contact with the Provider.

1. The provider will forward all bills eligible for payment to the claims department of Provider within sixty (60) days of discharge 98% of the time.
2. All consumers discharged from the provider will be seen or have been arranged to be seen for after care within 7 days of discharge 100% of the time.
3. The number of consumers discharged and readmitted within 15 days to any other crisis residential unit or inpatient facility shall be less than 10%.
4. Consumers admitted to crisis residential units shall have received and will understand their individual Recipient Rights and their right to Grievance and Dispute Resolution 100% of the time.
5. The average length of stay in Crisis Residential for all Payor authorized admissions will be less than 6.0 days for the current fiscal year.
6. Clinical case records shall include copies of all medication reviews documenting thereby that medication management are occurring.

Quality and Competency Monitoring of the provider shall occur minimally on an annual basis. The areas of monitoring may include any or all of the following. This listing is not intended to be all-inclusive.

* Professional license(s)/registration(s)/certification(s) for staff: current and free from disciplinary actions and complaints.
* Professional Liability insurance: current.
* Workers’ Compensation insurance: current.
* Staff training is evident (Recipient Rights, Person-Centered Planning, Limited English Proficiency, Cultural Diversity, Compliance Plan, Electronic Information Management Security, Corporate Compliance)
* Sentinel Event Reports
* Accreditation Survey Reports/Plans of Corrections
* Medicaid Sanctions Listing: not sanctioned
* Customer Satisfaction Results
* Recipient Rights Reports
* Policy and Procedure Reviews
* Service Authorization/Utilization Management reports
* Medicaid Claims Verification Reports
* Compliance Reports
* Quality Improvement Reports
* Observation of Service Provision
* Timeliness and accuracy of billings
* Review Discharge Planning Practices
* Review of Admissions Practices & General Access to Services

**EXHIBIT H**

**RECIPIENT RIGHTS, CONSUMER AND PROVIDER APPEALS, CONSUMER GRIEVANCE**

**EXHIBIT I**

**ENTITY DISCLOSURE/DISCLOSURE OF OWNERSHIP**

**EXAMPLE**

Disclosure of Ownership – Payor/PIHP shall comply with all requirements to obtain, maintain, disclose and furnish required information about ownership and control interests, business transactions, and criminal convictions. Payor/PIHP shall assure that all contracts, agreements, purchase orders, or leases to obtain space, supplies, equipment, or services are also in compliance with federal and State requirements.

1. Payor/PIHP will require disclosure statements for:
2. **Any Contractor who receives $25,000 or more per year**.

Payor/PIHP requires each applicable contractor to identify their “managing employee(s)” in policy or procedure. 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 operation of an institution, organization, or agency.

1. Payor/PIHP defines their managing employees as: CEO and CFO. Payor/PIHP Board Members will also be required to submit disclosure statement.
2. All applicable disclosing entities (a Medicaid provider other than individual practitioner or group of practitioners) or a fiscal agent (a contractor that processes or pays vendor claims on behalf of the Disclosing Entity).
3. Whenever, there is a change in ownership or control of the provider entity.
4. Disclosure statement for individuals and/or entities with 5% or more direct and/or indirect ownership will include the following required information:
5. Name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include primary business address, every business location and PO Box location.
6. Date of birth and social security number of each person with an ownership or control interest in the disclosing entity.
7. In the case of a corporation, other tax identification number for an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five percent or more interest.
8. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with an ownership or control interest in the disclosing entity, as a spouse, parent, child, or sibling, or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child, or sibling.
9. The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.
10. The name, address, date of birth, and Social Security number of any managing employee of the disclosing entity.
11. The identity of any individual who has an ownership or control interest in the provider or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person’s involvement in any program under Medicaid, Medicare, or Title XX services program since the inception of those programs.
12. Disclosure statement for entities without ownership(e.g. PIHP & CMHSPs) will include the following required information:
13. Name and address of the disclosing entity. The address must include primary business address, every business location, and P.O. Box location.
14. Other tax identification number of the disclosing entity, if applicable.
15. The name, address, date of birth, and Social Security number of all managing employees and Board of Directors of the disclosing entity.
16. Disclosure of ownership or controlling interest in any other Provider entity, subcontractor, or wholly owned supplier.
17. Disclosure of criminal convictions, sanctions, exclusions, debarment and termination.
18. Payor/PIHP has a process to obtain disclosure information from its providers/contractors at any of the following times:
19. When the provider submits a provider application;
20. Upon execution of the provider agreement;
21. During re-credentialing or re-contracting.
22. Within 35 days of any change in ownership of a disclosing agency.
23. Monitoring of Provider Networks: Payor/PIHP will conduct search of all required databases at time of hire or contract and monthly thereafter for as long as the individual or entity is employed or under contract. The database searches will also be performed monthly on all disclosing entities and on any individuals with ownership or control interest identified on the disclosure form. Network Providers will communicate all database search matches to Payor/PIHP within 3 business days of discovery. Network Providers shall demonstrate evidence of monthly searches and findings, upon request, and at least annually as part of the annual performance and compliance review. Payor/PIHP ensures all contractors have a process for obtaining attestation of criminal convictions and full disclosers (identified in 42CFR Part 455 Subpart B) from managing employees, board of directors, individuals with beneficial ownership, and individuals with an employment, consulting or other arrangement with the contractor or subcontractor. Payor/PIHP will monitor for compliance at least annually.
24. Reporting Criminal Convictions: Payor will notify PIHP within three business days when disclosures are made by subcontractors with regard to those offenses as detailed in sections 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act. PIHP will notify the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) Division of Program Development, Consultation and Contracts of any applicable disclosures within 3 business days.
25. Contract Language: Payor/PIHP requires contractors, through written agreements, to have processes for obtaining attestation of criminal convictions and full disclosure of ownership statements identified in 42 CFR Part 455 Subpart B. Contractors must also have procedures to report to Payor/PIHP any individuals with criminal convictions described under 1128 (a) and 1128 (b)(1)(2) or (3) of the Act, or individuals that have had civil monetary penalties or assessments imposed under section 1129 A of the Act.
26. Reporting Criminal Convictions -Contract providers will notify Payor/PIHP within three business days when disclosures are made by subcontractors with regard to those offenses as detailed in sections 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act. Payor/PIHP will notify the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) Division of Program Development, Consultation and Contracts of any applicable disclosures within 3 business days.
27. Failure to fully complete the disclosure form as required within 35 days of request or the submission of false or misleading information to Payor/PIHP will be subject to contractual sanctions up to and including immediate suspension of funding and termination of the contractual agreement.
1. Case managers supports coordinators, home based staff, wraparound [↑](#footnote-ref-1)
2. If licensed setting only [↑](#footnote-ref-2)