**NETWORK PROVIDER AGREEMENT FOR CLINICAL SERVICES**

(Individual)

**THIS AGREEMENT,** made and entered into this \_\_\_\_\_\_ day of \_\_\_\_\_\_, 20\_\_, by and between the **\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** whose administrative offices are located at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(hereinafter also referred to as the "Payor"), and the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ whose administrative offices are located at \_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_, Michigan 4\_\_\_\_\_\_ (hereinafter referred to as the “Provider").

**WITNESSETH:**

**WHEREAS,** the Payor is a community mental health \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (CMH\_\_) established by the Board(s) of commissioners of the County(ies) of \_\_\_\_\_\_\_\_\_\_\_\_\_ 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 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

**WHEREAS,** pursuant to Section 204(b)(1) of Act 258 of the Public Acts of 1974, as amended MCL 330.1001 et seq., (hereinafter referred to as the "Mental Health Code"), \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 (hereinafter referred to as the “PIHP”); and

**WHEREAS,** pursuant to the bylaws 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_ Counties (the “Service Area”) and the MDHHS entered into a MDHHS/PIHP Managed Specialty Supports and Services Contract (hereinafter referred to as the “MDHHS/PIHP Master Contract for Medicaid Funds”) with the PIHP 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 County(ies) of \_\_\_\_\_\_\_\_\_\_\_\_\_; and

**WHEREAS,** the Payor, from time to time, is in need of services from qualified, licensed professionals on an independent and group contractor basis for the Payor's Consumers; and;

**WHEREAS,** the Provider has been presented to the Payor as being a independent qualified professional and as being in the business of providing services on an independent contractor basis and willing to provide such services as required by the Payor 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:

**I. 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.

**II. 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) final rule effective 42 CFR 400, et. seq. June 14, 2002, as amended, and said BBA final rules, regulations, and standards encapsulated in the federal code of regulations, and with the requirements of the aforementioned Specialty Services Waiver Programs under Title XIX of the Social Security Act. This Agreement is in accordance with the standards as contained in the aforementioned Application for participation (AFP) as they pertain to the provisions of specialty services to Medicaid eligibles and the plans of correction and subsequent plans of correction submitted by the PIHP and approved by the MDHHS and any stated conditions, as reflected in the MDHHS approval of the application, unless prohibited by federal or State law.

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 ofservices hereunder and govern in any area not specifically covered by this Agreement.

**III. 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 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.

**IV. 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.

**V. PROOF OF PROVIDER'S BUSINESS STATUS: REQUIREMENTS OF PROVIDER SOLVENCY; AND, CERTIFICATION REGARDING DEBARMENT OR SUSPENSION.**

**A.** The Provider shall furnish the Payor with notice of proof of the Provider's authority to conduct business in the State of Michigan and inwhat business capacity, prior to commencing services under this Agreement, and with notice 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.

**B.** 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 an on-going concern, at any time during the term of this Agreement.

**C.** 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 for 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.

**VI.LICENSES, ACCREDITATIONS, AND CERTIFICATIONS; AND, CREDENTIALING AND PRIVILEGING REQUIREMENTS AND QUALIFICATIONS.**

**A.** Where applicable and Prior to commencing services under this Agreement, the Provider shall furnish the Payor with proof that the Provider has obtained and maintains all certifications, authorizations, National Provider Identification number per Section 5005(b)(2)(6)(a) and Section 12006 when applicable, of the 21st Century Cures Act, and licenses required by federal, State and local laws, ordinances, rules and regulations to practice the Provider's profession in the State of Michigan and to perform Medicaid and/or non-Medicaid services hereunder.

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

**B.** The Provider, as a member of the Payor's service provider network, shall cooperate with the Payor on an ongoing basis and as applicable, shall ensure that the Provider meets the Payor's credentialing and privileging requirements, including annual reprivileging and competency standards, necessary to perform the services required under this Agreement.

**VII. AGREEMENT TERM.**

**A.** This Agreement shall commence on the **\_\_\_\_ of \_\_\_\_,** 20\_**\_\_** and shall continue until the **\_\_\_\_ of \_\_\_\_\_\_\_\_\_\_** at which time this Agreement shall terminate.

**B.** 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.

**VIII. TERMINATION OF AGREEMENT.**

**A.** This Agreement shall terminate effective immediately upon the revocation, restriction, suspension, discontinuation or loss of any certification, accreditation, authorization, or license required by federal, State and local laws, ordinances, rules and regulations for the Provider to provide Medicaid and/or non-Medicaid programs and services within the State of Michigan.

**B.** This Agreement shall terminate effective immediately upon receipt of notice and/or discovery by the Payor that the Provider is:

**(1.)** listed by a Department or Agency of the State of Michigan as being suspended from service participation in the Michigan Medicaid and/or Medicare programs; and/or,

**(2.)** listed by a Department or Agency of the State of Michigan in its registry for Unfair Labor practices pursuant to 1980 P.A. 278, as amended, MCL 423.321 et seq.; The MDHHS Medical Services Administration; and/or,

**(3.)** listed by the U.S. General Services Administration in its "Excluded Parties List" as to federal funding.

**C.** This Agreement shall terminate effective immediately upon receipt of notice and/or discovery by the Payor of any failure of the Provider to meet the requirements hereunder of solvency and of continuing as a going business concern or if the Provider generally fails to pay its debts as they become due.

**D.** Failure on the part of the Provider to respond in a satisfactory manner to a request from the Payor's Chief Executive Officer or Executive Director (hereinafter referred *to* as the "Payor's CEO"), with regards to correcting deficiencies inthe results of services provided by the Provider, shall constitute immediate basis for termination of this Agreement by the Payor. Immediate termination for the purposes of this subsection of this Agreement shall be defined as meaning termination effective upon the date *in* which the Provider receives written notice of termination and the basis therefore from the Payor.

**E.** Any material breach of this Agreement may result in the nonbreaching party's immediate termination of this Agreement. With said termination effective as of the date of delivery of written notification from the nonbreaching party to the breaching party. The termination of this Agreement shall not be deemed to be a waiver by the nonbreaching party of any other remedies it may have in law or in equity.

**F.** Notwithstanding any other provisions in this Agreement to the contrary, either the Payor or the Provider may terminate this Agreement for any reason by providing the other party with thirty (30) days prior written notification.

**G.** Any termination of this Agreement shall not relieve either party of the obligations incurred prior to the effective date of such termination.

**H*.*** Upon any termination of this Agreement, the Provider shall promptly supply the Payor with all information necessary for the reimbursement of any outstanding Medicaid claims, Medicare claims or third-party reimbursement claims.

**I.** The provider agrees, in the event of termination of this Agreement and nonrenewal, to cooperate with the Payor in the orderly transfer of the Consumers, records, property, programs and services, and other items material hereunder to the Payor and/or other contractors of the Payor, as applicable.

**IX. SERVICE** **AREA.** Payor's service area for the purposes hereunder is the County(ies) of \_\_\_\_\_\_\_\_\_\_\_\_. 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 CEO.

**X. TARGET SERVICE GROUP AND ELIGIBILITY 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 of reference into this Agreement and made a part hereof. The target service group and the eligibility criteria for 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.

**XI. PROVIDERS SERVICES AND RESPONSIBILITIES.**

**A.** The Provider shall provide services for reimbursement from the Payor hereunder for the Payor's Consumers 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.

**B.** The Provider shall perform services hereunder at Payor-authorized service sites during this Agreement. The Provider may have access to the Payor's service site(s) and temporary service space therein, if approved by the Payor's CEO, in order to perform services hereunder. The Provider shall furnish and utilize the Provider's own equipment, tools, materials, and supplies that the Provider deems necessary to perform the services hereunder.

**C.** The Provider shall exercise independent control over the Provider's services rendered under this Agreement, including the manner or methods of services, service duties or tasks, and the professional procedures thereof.

**D.** The provider shall provide the services hereunder in keeping with final results of services, deadlines for final results of services, and applicable schedules of services, as authorized by the Payor's CEO or the CEO's designated representative.

**E.** The scheduling of and amounts of services units which the Provider shall render hereunder shall be flexible during the period of this Agreement and shall be subject to case-to-case assessments by the Payor's CEO or the CEO's designated representative on the need of the Provider's services for the Consumers and their extent and services scheduling requirements thereof. The Provider is not guaranteed under this Agreement a minimum number of consumer cases, consumer appointments, or consumers to be served. The Payor does not guarantee to the Provider hereunder either the scheduling of or the performing of a minimum amount of services units and/or hours of contractual services daily, weekly, monthly, or annually during the period of this Agreement.

**F.**Services performed by the Provider to a Consumer under this Agreement must be in direct accordance with the written Individual Plan of Services (also known as a “Person-Centered Plan”) of said Consumer as developed through a person-centered planning process in a Payor authorized supports/services planning meeting.

**G.** The Provider shall complete services and documentation and records thereof that meet the Payor's requirements hereunder for reimbursement by the Payor. The Provider's services and documentation/records thereof shall comply with the standards o*f* the Payor, MDHHS, an applicable licensing Department or Agency *of* the State of Michigan, Medicaid and Medicare regulations, the PIHP and/or any third party reimbursers. The Provider shall maintain complete and accurate records of all services provided under this Agreement in such form and submit them to the Payor at such time as may be required by the Payor's CEO or the CEO's designated representative(s).

**H.** The Provider shall, from time to time, as may be required, meet with the designated representative(s) of the Payor's CEO to discuss the Consumer(s) being served and/or the services required under this Agreement. The Provider shall not be responsible for supervising any employees of the Payor or any work of any employees of the Payor pursuant to this Agreement.

**I.** The Provider agrees that aversive techniques shall not be utilized in management of behavior of any Consumer receiving services hereunder.

**XII. TRAINING AND REQUIREMENTS.**

A. The Provider shall notify the Payor's CEO or the CEO's designated representative immediately whenever:

(1.) as applicable, the Provider's staffing of and staffing/recipient ratio become contrary to those used for projections in the Payor's determination of the reimbursement methodology/rate(s) for services, as set forth in "Exhibit C";

(2.) the Provider's staffing of the services required under this Agreement has not been or cannot be provided; or,

(3.) the need for services to a Consumer is otherwise less than or greater than the Provider's staffing level agreed upon hereunder by the parties.

**B**. The Provider shall maintain staffing consistency and programming continuity in the provision of services to the Consumers hereunder.

**C**. The Provider, pursuant to this Agreement, shall ensure that all services are provided in a manner that demonstrates cultural competency.

**D.** If the Provider determines that additional professional training is required in order to perform services or to maintain professional licenses, certifications, and authorizations required hereunder, the Provider shall be solely responsible for obtaining such training and for any costs thereof.

**E**. The Provider shall complete initial and ongoing training when appropriate, on behavior management, crisis management and recipient rights, including person-centered planning; such recipient rights training shall occur before or within thirty (30) days after the commencement of services hereunder, in concert or through technical consultation with the Payor's Recipient Rights Office. The Payor shall assure sufficient availability of such required in-service training.

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

**XIII. SERVICE ACCESS, PREAUTHORIZATION, DELIVERY, AND UTILIZATION MANAGEMENT.**

**A.** Payor is responsible for service access assurance, preauthorizations, delivery, and utilization management, under this Agreement. Specification of applicable procedures of the Payor's service access assurance, preauthorizations, delivery, and utilization management are set forth in the attached document labeled “Exhibit E (SERVICE ACCESS, PREAUTHORIZATIONS, DELIVERY, AND UTILIZATION MANAGEMENT PROCEDURES)”, which is incorporated by reference into this Agreement and made a part hereof.

**B.** The Payor and the Provider agree that service authorizations for any Consumer hereunder and the Provider's services must be medically necessary and meet the criteria required thereto by the MDHHS and the PIHP. The Provider shall meet the Payor's access standards and treatment deadlines and the Payor's duty to treat and referral requirements pursuant to this Agreement and to the requirements and standards of the MDHHS.

**C.** Any services to be performed by the Provider for a Consumer hereunder must be included in the written Individual Plan of Services (IPOS) pursuant to requirements of Section 712 in Chapter 7 of the Mental Health Code. The Provider, utilizing forms acceptable to the Payor, shall forward reports at (Payor designated) periodic intervals to the Payor concerning progress toward the goals and objectives set forth in the IPS of a Consumer served hereunder during the service period.

**D.** For reimbursement by the Payor hereunder, any services by the provider under this Agreement must be prior authorized by the Payor's CEO or the CEO's designated representative.

**E.** The Provider understands and acknowledges that:

(1.) the Payor must assure, per the requirements of the MDHHS/PIHP Master Contract for Medicaid Funds, that a Medicaid-eligible Consumer is allowed to choose his or her health care professional, i.e., physician, therapist, etc. to the extent possible and appropriate, in accordance with 42 CFR 438.6(m); and,

(2.) pursuant to MDHHS's master contract(s) requirements of PIHP/CMHSPs and CMHSPs as set forth in MDHHS's SELF-DETERMINATION POLICY & PRACTICE GUIDELINES, the Payor must assure, upon the request of any adult Consumer participating thereby, consumer selection *in* the assignment of any provider, under a services contract between the Payor and the provider, to serve the Consumer and also shall assure thereunder the removal of the Consumer from the services of a service provider that fail to meet the Consumer's preferences.

**XIV. BILLING OF AND PAYMENTS FOR VALID SERVICES REIMBURSEMENT CLAIMS.**

**A**. For the period that this Agreement is in effect, the Provider shall be paid by Payor as reimbursement for Payor-authorized services rendered by Provider hereunder, as specified and delineated *in* the attached document labeled "Exhibit F (BILLING OF AND PAYMENTS FOR VALID SUPPORT/SERVICE REIMBURSEMENT CLAIMS)," which is incorporated by reference into this Agreement and made a part hereof. Any services rendered by the Provider hereunder for reimbursement must have been prior authorized by Payor's CEO or the CEO's designated representative.

It is expressly understood and agreed by the Payor and the Provider that any payment of claims reimbursement fees hereunder *is* based upon the intent and the belief that their relationship is that of an independent contractor. In the event *a* federal or State court or administrative agency rules at any time that the relationship between the Payor and the Provider is one of an employer/employee, the compensation to be paid the Provider shall be the sum appropriately billed less the sum required to be withheld to pay for income and social security taxes to the proper federal, State and local governments. If withholding for payment of taxes from the Provider's compensation is found to be required, the Provider shall reimburse the Payor in full for any taxes, interest and penalties that the Payor is required to pay on compensation received by the Provider under this Agreement, prior to the commencement of withholding for taxes thereon.

**B. Revenue/Cost Projections; Subsequent Rate Determinations.** The Provider, by signing this Agreement, verifies that it provided the Payor with projected revenue and cost analyses (using formats acceptable to theparties) and all source documents for review in the subsequent determination by the Payor of the claims reimbursement methodology/rate(s) for authorized services hereunder.

**C. Determination of Financial** **Status and Benefits Status of** **Consumers.** For each Consumer served under this Agreement, the Payor's shall complete an initial determination and periodic redeterminations of financial status and public and/or private benefits status. The Payor shall be responsible for establishing each Consumer's eligibility for third party reimbursement status, Supplemental Security Income benefit status, and other benefits status, if any. The Provider will assist the Payor's staff, when possible, in securing and maintaining such benefits status of each Consumer hereunder.

**D. Coordination of Benefits.** For the purposes of this Agreement, the Payor 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 specialty 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.

**E. Third Party Liability** **Requirements.** Except where the Provider is allowed per Exhibit F, the Payor is generally required to identify and seek recovery from all liable third parties, consistent with the requirements of the Mental Health Code, the MDHHS/CMHSP Master Contract for General Funds, and with the MDHHS/PIHP Master Contract for Medicaid Funds. The Payor 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 or as outlined in Exhibit F.

**F. 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.

**G. 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. Provider shall notify Payor immediately of any receipt of such monies for such purposes hereunder.

**H. Unallowable Services/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.

**I. Disallowed Expenditures and Financial Payment.** Inthe event that the MDHHS, the Payor, the State of Michigan, or the federal government ever determines in any final revenue and expenditure reconciliation and/or any final finance or service audit that the Provider has been paid inappropriately per the Payor's expenditures of 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.

**XV.QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT; PERFORMANCE INDICATORS; CONSUMER ASSESSMENTS AND OUTCOMES MANAGEMENT STUDIES.**

**A.** The Provider, pursuant to this Agreement, shall participate in the Payors Quality Assessment and Performance Improvement Program (QAPIP.

**B.** 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.

**C.** 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 surveys, focus groups 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.

**D.** 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.

**XVI. REPORTING REQUIRMENTS; ACCOUNTING PROCEDURES.**

**A**. The Provider shall report financial, program, service and consumer data and additional statistical and other management information in the manner and at the times prescribed by the Payor's CEO.

**B**. The Provider understands and acknowledges that the Payor, pursuant to the requirements of the MDHHS, must account for its costs incurred and must make and report expenditures as payments for services rendered by the Provider under this Agreement on the basis of accrual accounting and reporting methodology. Thereto, in the Provider's billings to the Payor for service reimbursement, the costs allowed hereunder must be readily ascertainable and verifiable and timely as to the applicable fiscal year.

**C**. The Provider shall maintain compensation records and other time keeping records sufficient *to* document the provision of services required under this Agreement.

**D**. The Provider must comply with 2 CFR, Part 200, Subpart F section 200.501 audit requirements when applicable.

**E.** Any breach of this Section shall be regarded as a material breach of this Agreement and may be a cause for termination thereof by the Payor.

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

**A.** Parties to the MDHHS/PIHP Master Contract for Medicaid funds and to the MDHHS/CMHSP Master Contract for General Funds for purposes thereof, Payor for purposes hereof, the federal government, 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 for a minimum of ten (10) years after the termination of this Agreement and in accordance with the Michigan Department of Attorney General State Operations Division General Schedule #20 Community Mental Health Programs Dated March 2, 2007.

**B.** 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 l395 x(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 serviceson 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.

**C.** Provider shall provide access to Payor's designated representative(s) to eva1uate, through inspection or other means on a retrospective or current basis, the appropriateness, quality, and timeliness of services performed hereunder and Provider's compliance with standards required thereto.

D. 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.

**E.** 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.

F. 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 therefor, 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.

**XVIII. APPLICABLE LAW AND VENUE; COMPLIANCE WITH THE LAW.**

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

**B.** The Payor and the Provider agree that the venue for the bringing of any legal or equitable action under this Agreement shall be established in accordance the statutes of the State of Michigan and/or Michigan Court Rules. In the event that any action is brought under this Agreement in Federal Court, the venue for such action shall be the Federal Judicial District of Michigan, \_\_\_\_\_\_ District, \_\_\_\_\_\_\_ Division.

**C.** The Provider, its officers, employees, servants, and agents shall perform all their respective duties and obligations under this Agreement in compliance with all applicable federa1, State, and local laws, ordinances, rules and regulations.

**D.** When providing services under this Agreement, the Provider, its officers, employees, servants, and agents shall abide by all applicable provisions and requirements for services as set forth in the Mental Health Code, the MDHHS Rules, Medicaid and Medicare regulations, the MDHHS/CMHSP Master Contract for General Funds, MDHHS/PIHP Master Contract for Medicaid funds, and in policies, procedures, standards and guidelines established by the Payor therefore.

**E.** 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.

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

**G.** 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.

**H.** 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 seg., 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 services required of the Provider under this Agreement, any such subcontract must include the language of this Subsection.

**I.** 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.

**J.** The Provider shall comply with Public Law 103-227, also known as the Pro-Children Act of 1994, 20 USC 6081 et seq., which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of eighteen (18), if the services are funded by federal programs either directly or through State or local governments. by federal grant, contract, loan or loan guarantee. Said Act also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. Said Act does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare, Or Medicaid: or, facilities where Women, Infants, and Children (WIC) coupons are redeemed.

The Provider, in addition to compliance with Public Law 103-227, shall ensure that any service or activity funded in whole or in part through this Agreement will be delivered in a smoke-free facility or environment. If activities or services are delivered in residential facilities or in facilities or areas that are not under the control of the Provider (e.g., a mall, residential facilities or private residence, restaurant or private work site), the activities or services shall be smoke free.

If the Provider, with the Payor's prior consent, subcontracts any services required of the Provider under this Agreement, any such subcontract which contains provisions for children's services must include the language of this Subsection.

**K.** The Provider shall comply with all applicable standards, orders, or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act, as amended (33 U.S.C. 1251 et seq.).

**L.** 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.

**M.** 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.

**XIX. NONDISCRIMINATION.**

**A.** 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.

**B.** In the event that theProvider wishes to add an employee(s) during the course of this agreement the Provider shall not discriminate against any employee or applicant for employment with respect to hire, tenure, terms, conditions, or privileges of emp1oyment or a matter directly or indirectly related to employment because of race, color, religion, national origin, age, sex, height, weight, or marital status pursuant to the Elliott Larsen civil Rights Act of 1976 PA 453, as amended (MCL 37.2201 et seq).

**C.** 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.).

D. 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.

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

**F.** 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).

**G.** The Provider shall comply with the Age Discrimination Act of 1975 (42 USC 6101 et seg.).

**H.** The Provider shall not refuse to treat and not discriminate in the treatment of any Consumer or referral, under this Agreement, based on the individual's source of payment for services, or on the basis of age, height, weight, marital status, arrest record, race, creed, 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.

**I.** 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.

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

1. 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.
2. 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.
3. ICHAT: https://apps.michigan.gov/
4. Michigan Public Sex Offender Registry: https://mspsor.com/
5. National Sex Offender Registry: [http://www.nsopw.gov](about:blank)
6. 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.
7. Central Registry: [https://www.michigan.gov/mdhhs/0,5885,7-339-73971\_7119\_50648\_48330-180331--,00.html](about:blank)
8. 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.
9. 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.
10. 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.
11. 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.
12. 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.

**XXI. ESTABLISHMENT, RETENTION, AND ACCESS T0 CONSUMER RECORDS; RELEASE OF CONSUMER INFORMATION AND CONFIDENTIALITY.**

**A.** 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 I, and appropriate State and federal statutes.

**B.** The Payor shall have the sole and exclusive right to retention of all records pertaining to any Consumer and services rendered pursuant to this Agreement. All such records and reports and any copies thereof still in the Provider's possession at the termination of this Agreement shall be submitted to the Payor's CEO.

**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 750of the Mental Health Code.

The Provider shall assure that the 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.

**G.** 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.

**XXII. RELATIONSHIP OF THE PARTIES.**

**A.** 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.

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

**C.** It is expressly understood and agreed by the parties hereto that the Provider shall not in any way be deemed to be or hold himself or herself out as an employee of the Payor. Thereto, the Provider 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.

**D.** It is expressly understood and agreed by the parties hereto that the Payor is not responsible for providing independent contractors such as the Provider with workers' compensation coverage or unemployment insurance coverage Or for any 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 pertaining to any payments for valid service reimbursement claims for performing independent contractor services.

**XXIII. 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.

**XXIV. INDEMNIFICATION AND** **HOLD HARMLESS.**

**A.** The Provider, at its own expense, shall protect, defend, indemnify and hold harmless the Payor, its elected and appointed officers, employees, servants and agents from all claims, causes of action, demands, liabilities, losses, damages, costs, and expenses, that they may incur as a result of any acts, omissions, or negligence by the Provider that may arise out of this Agreement.

**B.** As required under Subsection A. of Section XIV of this Agreement, if the Provider is found by a federal or State court or administrative agency to be an employee of the Payor, the Provider shall indemnify the Payor in full for any taxes, interest and penalties that the Payor is required to pay on compensation received by the Provider under this Agreement prior to commencement of withholding for taxes thereon.

**C.** The Provider's indemnification and hold harmless responsibilities under this Section shall include the sum of claims, damages, costs, lawsuits and expenses which are in excess of the sum reimbursed to the Payor and its elected and appointed officers, employees, servants and agents by the insurance coverage obtained and/or maintained by the Provider pursuant to the requirements of this Agreement.

**XXV. LIABILITY INSURANCE.** The Provider shall procure, pay the premiums on, keep and maintain during the term of this Agreement professional liability insurance with contractual coverage of limits not less than $\_\_\_\_\_\_\_\_\_\_\_ per occurrence and \_\_\_\_\_\_\_\_\_\_\_ annual aggregate for all services to be performed hereunder. The Provider shall submit certification of its insurance coverage to the Payor prior to the execution of this Agreement. The Provider shall furnish the Payor with written notification at least thirty (30) days prior to any reduction or termination of the insurance required herein. The Provider shall maintain such other insurance as it deems appropriate for its own protection. 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.

**XXVI. MISCELLANEOUS PROVISIONS.**

**A. 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.

**B. Relationships 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.

**C. 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 how to access those services pursuant to this Agreement, must be submitted by the Provider or the Provider's subcontractors for Payor's approval or disapproval prior to any distribution.

**D. Publications.** Any drawings, records, documents, papers, reports, charts, maps, graphics or manuscripts prepared for or pertaining to the services performed hereunder which are published or in any other way are provided to third parties shall acknowledge that they were prepared and/or created pursuant to this Agreement. Such acknowledgement shall include a clear statement that the 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.

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

**F. 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.

**G. 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, 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, or by electronic medium that is acceptable to each party and legally binding:

Notice to Payor should be addressed to: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Note include email addresses)**

Notice to the Provider should be addressed to:

**H. Return.** Within fourteen (14) days after the termination of this Agreement, the Provider shall, at the written request from the Payor's CEO, return to the Payor all documents, correspondence, files, papers or other property of any kind of the Payor that the Provider may be in possession of or control, including, but not limited to, copies of other records, as required hereunder.

**XXVII. MONITORING THE AGREEMENT; RESOLUTION OF CONTACT ISSUES AND SERVICE DISPUTES.**

**A.** The performance of the terms of this Agreement shall be monitored on an ongoing basis by the designated representatives of the Payor and by the Provider. The Payor's CEO (A.K.A. Executive Director) shall appoint administrative and program liaisons to be available to communicate with the Provider.

**B.** Contract issues between the Payor and the Provider as to specific provisions of this Agreement and implementation thereof and/or service disputes hereunder shall be addressed by the designated representative(s) of the Payor and the Provider. Unresolved contract issues, as to specific provisions of this Agreement and implementation thereof, and/or service disputes hereunder shall be referred to Payor's CEO for a final determination. The Payor's CEO shall furnish the Provider with written notice of any such final determination hereunder.

**XXVIII. WAIVERS.**

**A.** 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.

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

**XXIX.** **AMENDMENT.** Modifications, amendments, or waivers of any provision of this Agreement may be made only by the written mutual consent of the parties hereto.

**XXX. ASSIGNMENT.**

**A.** 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 subcontracted or delegated without the prior written consent of the Payor. Any attempted assignment in violation of this section shall be void ab initio.

**B.** This Agreement shall be binding upon the Payor and the Provider and their respective successors and permitted assigns.

**XXXI. 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.

**XXXII. COMPLETENESS 0F 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.

**XXXIII. SEVERABILITY AND INTENT.**

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

**B.** 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.

**XXXIV. CERTIFICATION OF AUTHORITY TO SIGN THE AGREEMENT.**

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

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

# PAYOR:

# BY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

# Date

# PROVIDER:

# BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

# 

# Date

**EXHIBIT A**

**GLOSSARY OF TERMS AND DEFINITIONS**

Unless preempted by federal and/or State of Michigan Authorities, in which instance such Authorities shall control, the Parties assign the following terms and meanings to this Contract:

**Contract** means this government-funded Contract for the provision and procurement of Medicaid and/or non-Medicaid services to or for Consumer, as detailed herein below.

**Authorities** means, collectively, applicable: (i) federal, State and/or local constitutions, statutes, regulations, rules, plans, resolutions, manuals, contracts, common law doctrines, directives, authorizations, policies and/or ordinances, as amended; (ii) healthcare industry best practices and/or standards; and (iii) remaining requirements and/or standards governing this publicly funded Contract, all of which are incorporated herein.

**Clean Claim** means the legal standard and condition applied to claims for reimbursement to the extent required under the Social Welfare Act, MCL 400.111i, Michigan Medicaid Provider Manual, and Master Contract, as amended, and will pass State and Federal Audit documentation.

**Consumer** means the Payor preauthorized recipient or beneficiary of Medicaid and/or non-Medicaid services, as identified in this Contract.

**Individual Plan of Services (IPOS)** means that individualized assessment and service planning is accomplished in partnership with each consumer through a person-centered process, and for minors, a family-centered process. This process shall result in a written Individualized Plan of Services in accordance with standards of treatment established in the Michigan Mental Health Code (P.A. 258 of 1974, MCL 330.1712), the Michigan Department of Administrative Rules (R. 7199) and the most current Medicaid Provider Manual.

**License** means authorization by the Michigan Department of Licensing and Regulatory Affairs to provide services specific to the license issued.

**Master Contract** means the Managed Mental Health Supports/Services Contract for General Funds between Payor and the Michigan Department of Health & Human Services (“MDHHS”).

**Medically Necessary**means mental health services and/or supports that, under generally accepted healthcare standards, Payor concludes, are reasonably necessary to diagnosing or treating any serious mental illness, emotional disturbance or developmental disability.

**Payor**means “\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,” and with respect to all rights afforded under or by this Contract, its directors, officers, executives, employees, servants, agents, designates and representatives.

**Person Centered Plan** means a process for planning and supporting the individual receiving services that builds upon the individual’s capacity to engage in activities that promote community life and that honors the individual’s preferences, choices, and abilities.  The person-centered planning process involves families, friends, and professionals as the individual desires or requires in accordance with the Michigan Mental Health Code (P.A. 258 of 1974, MCL 330.1700(g) and MCL 330.1712(1)) and as specified in the most recent Michigan Department of Health and Human Services Person-Centered Planning Practice Guidelines (MDHHS Managed Mental Health Support and Services Contract).

**Policies** mean, collectively, Payor’s published “Provider Network Policies,” as amended, available at: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](about:blank), all of which are incorporated herein.

**Provider** means **“\_\_\_\_\_**,” and its directors, officers, executives, employees, members, servants, subcontractors, agents, designates and representatives.

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

**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 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 declined/refused medication.

**Service area** means \_\_\_\_\_\_\_\_\_\_\_ Counties, the Payor’s service area for this Agreement.

1. Special compensation means payment to the operator of an adult foster care facility to ensure the provision a specialized program in addition to the basic payment for adult foster care.
2. Specialized program means a program of services, supports, or treatment that are provided in an adult foster care facility to meet the unique programmatic needs of individuals with developmental disability or mental illness as set forth in the resident’s individual plan of services and for which the operator of the adult foster care facility receives special compensation.
3. Specialized residential setting means an adult foster care facility certified to provide a specialized program, per the MDHHS Rules effective as of March 9, 1996.

**EXHIBIT B**

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

The target service group for services under this Agreement is as follows: Persons living with Intellectual and/or Developmental Disabilities, Adults living with Mental Illness, and/or Children Living with Serious Emotional Disturbance.

The eligibility criteria for services under this Agreement are as follows:

1. Persons living with Intellectual and/or Developmental Disabilities
   1. "Intellectual and/or Developmental disability" means either of the following:
      1. If applied to an individual older than 5 years of age, a severe, chronic condition that meets all of the following requirements:
         1. Is attributable to a mental or physical impairment or a

combination of mental and physical impairments.

* + - 1. Is manifested before the individual is 22 years old.
      2. Is likely to continue indefinitely.
      3. Results in substantial functional limitations in 3 or more of the following areas of major life activity:
         1. Self-care.
         2. Receptive and expressive language.
         3. Learning.
         4. Mobility.
         5. Self-direction.
         6. Capacity for independent living.
         7. Economic self-sufficiency.
    1. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.
    2. If applied to a minor from birth to 5 years of age, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in subdivision (a) if services are not provided.

1. Adults Living with Mental Illness
   1. "Mental Illness" means a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.
   2. An individual who has a mental illness, and who as a result of that mental illness is unable to attend to those of his or her basic physical needs such as food, shelter, or clothing that must be attended to in order for the individual to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs.
   3. Does not have an illness related to or secondary to mental retardation, substance abuse, or dementia.
2. Children living with Serious Emotional Disturbance (SED) MHC 330.110d(2)
   1. Means a diagnosable mental, behavioral or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnosis criteria specified in the most recent diagnostic and statistical manual or mental disorders published by the American Psychiatric Association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits the minor’s role of functioning in family, school, or community activities.
   2. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:
      1. A substance abuse disorder
      2. An intellectual/developmental disorder

**EXHIBIT C**

**SCOPE OF INDEPENDENT CONTRACTOR SERVICES**

It is expressly understood and agreed by the parties hereto that the Provider’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ services to be provided for subsequent reimbursement from the Payor per valid claims under this Agreement shall include the following:

**Exhibit D**

**\_\_\_\_\_Minimum Training Requirements**

**Example**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| \_\_\_\_ Minimum Training Requirements  Contract Providers | | | | | |  |  |
| Renewal Key:  Source Document Key   1. 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

2 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 FOR AND PAYMENT FOR VALID**

**SERVICE REIMBURSEMENT CLAIMS**

**EXAMPLE**

**A.** The Payor shall make contract payments to the Provider in accordance with the requirements of 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 methodology/rate(s) for reimbursement from the Payor to the Provider for valid claims for Payor-authorized services rendered by the Provider under this Agreement shall be on a per (unit) basis. The per unit rate(s) to be paid by the Payor to the Provider as reimbursement for valid claims for Payor-authorized services rendered by the provider during the term of this Agreement shall be as follows;

DOLLARS ($- ) per (unit) for services rendered by the Provider as a qualified, licensed professional.

(Optional language)

The total amount of contractual payments from the Payor to the Provider for all Payor-authorized services rendered by the Provider during the term of this Agreement shall not exceed the contractual maximum obligation of DOLLARS ($ ).

(Optional language)

The Provider shall be solely responsible for transportation to and from Payor-designated service sites and any associated expenses. The Provider shall not be paid by the Payor for the time spent by the Provider in travel to and from Payor-designated service sites. Travel, transportation, and associated costs of the Provider have been considered in the Payor's determinations of the claims reimbursement methodology/rate(s) for authorized services under this Agreement.

**B.** The Provider shall provide a monthly billing statement with valid claims for each month in which Payor-authorized services are rendered under this Agreement in a Payor approved format. All monthly billing statements of the Provider shall specify billable services hereunder. In order to be considered valid claims for which payments from the Payor may be made, the Provider's billing of services claims must be received by the Payor within THIRTY (30) days following the completion of the month in which the services were rendered by the Provider hereunder. The Payor shall authorize end process services claims payments to the Provider within THIRTY (30) days following receipt of a complete and accurate billing statement from the Provider.

The Provider's submittal of a billing statement of claims for any reimbursement hereunder shall constitute the Provider's verification that the required services and documentation have been completed, in compliance with the reimbursement requirements of the Payor, the MDHHS, Medicaid, Medicare and/or third party reimbursers and ison file currently. If the Provider's services and service documentation are not in compliance with the reimbursement requirements of the MDHHS, the Payor, Medicaid, Medicare and/or third party reimbursers, the Provider shall not be paid and/or shall return payments received from the Payor in such instances.

C. Upon early termination of this Agreement, a final contract reconciliation shall be completed wherein the claims billed by the Provider and the claims paid by the Payor and the total of the funds paid by the Payor to the Provider for the fiscal year shall be reviewed and reconciled indirect accordance with the service and financial provisions hereunder in order to assure that the Payor's payments to the Provider have not exceeded the Payor's obligations under this Agreement. Said 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. Any amount due to the Payor or to the Provider as a final contract account reconciliation hereunder shall be paid within sixty (60) days after notification of the Payor's final determination.

### EXHIBIT G

**PERFORMANCE INDICATORS AND OBJECTIVES**

**EXAMPLE**

1. Service documentation submitted (enter desired frequency) of the service provided.
2. Documentation provided in a Payor approved format
3. Billing accurately reflects services rendered.
4. Services provided reflect Person-Family Centered Planning Processes.
5. Provider must review and engage consumer’s natural supports whenever identified.
6. Services provided meet access, preauthorization requirements.
7. Provision of service reflects general acceptable standards of practice.
8. Billings submitted to the Payor must meet the time frame noted in Exhibit F.
9. Provider will participate in training and set up activities necessary to submit billing via Provider’s electronic billing portal
10. Provider will submit all claims for reimbursement through Payor’s electronic claims submission portal.
11. Provider will ensure that all providers are appropriately credentialed and eligible for service provision as dictated by consumer’s insurance coverage plan.

**Exhibit H**

**Recipient Rights and Appeals process**

**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.

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)