**FINANCIAL MANAGEMENT SERVICES AGREEMENT**

**THIS AGREEMENT**, made and entered into this \_\_\_\_ Day of \_\_\_\_\_\_, 20\_\_ by and between **\_\_\_\_\_\_\_\_\_**, whose administrative offices are located at \_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_, Michigan \_\_\_\_\_\_\_\_ (hereinafter referred to as the "Payor" or “\_\_\_\_\_\_"), and \_\_\_\_\_\_\_\_\_**,** a financial management services provider, whose principal place of business is located at **\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_, \_\_\_\_, MI \_\_\_\_\_\_\_\_\_** (hereinafter referred to as the “Provider").

**WITNESSETH:**

**WHEREAS**, \_\_\_\_\_\_\_\_\_\_\_\_\_, and \_\_\_\_\_\_\_\_ Community Mental Health \_\_\_\_\_\_ have jointly created a regional entity known as the \_\_\_\_\_\_\_\_\_\_ Regional Entity (\_\_\_), as provided in Sec. 204b of the Michigan Mental Health Code, and

**WHEREAS**, the \_\_\_\_\_, upon successful submission of the Michigan Department of Health and Human Services (MDHHS) Application for Participation in 2013, has entered into a contract with the MDHHS as the specialty Medicaid Prepaid Inpatient Health Plan for the counties of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_, and

**WHEREAS**, the Community Mental Health programs listed above serve those same counties, and have entered into contracts with the \_\_\_\_\_ as comprehensive services providers, and

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

**WHEREAS,** \_\_\_\_\_ entered into, 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**, the Payor, from time to time, is in need of **fiscal intermediary** services from licensed and qualified service provider and,

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

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

**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), as amended, and said BBA final rules, regulations, and standards, and with the requirements of the State of Michigan’s current Specialty Services Waiver Program(s) under Title XIX of the Social Security Act. This Agreement is also 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 any 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 of services 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 Client 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 said Provider’s authority to conduct business in the State of Michigan and in what business capacity, prior to commencing services under this Agreement, and with notice of any related organization of said Provider per alliance, affiliation, joint venture, parent/subsidiary or other business relationship that said 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 said Provider’s solvency and to its continuing in operation as a 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 from debarment, declared ineligible, or voluntarily excluded from covered transactions by any State and/or federal Department or Agency.

**(2.)** The Provider and its principals have not within a three (3) year period preceding this Agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State, or local) transaction or contract under a public transaction, violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property.

**(3.)** The Provider and its principals are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, State, or local) with commission of any of the offenses enumerated in the above-cited subsection C.(2.) of this Section; and,

**(4.)** The Provider and its principals have not within a three (3) year period preceding the commencement of this Agreement had one (1) or more public (federal, State, or local) transactions terminated for cause or default.

**VI. LICENSES, ACCREDITATIONS, AND CERTIFICATIONS.**

**A.** The Provider shall obtain and maintain all approvals, accreditations, certifications and licenses required by the Payor to provide financial management services under this Agreement.

Prior to commencing services under this Agreement, the Provider, as applicable, shall furnish the Payor with notice of primary verification that its staff professionals and other employees who are to provide financial management services under this Agreement, have obtained and maintain all approvals, accreditations, certifications and licenses required by federal, State and local laws, ordinances, rules and regulations to practice their professions in the State of Michigan and to perform the services required hereunder.

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

**VII. AGREEMENT TERM.**

**A.** This Agreement shall commence on the **\_\_\_ day of \_\_\_\_\_\_, 20\_\_** and shall continue until the **\_\_\_\_ day of \_\_\_\_\_\_, 20\_\_** 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 immediately upon the revocation, restriction, suspension, discontinuation or loss of any certification, accreditation, or authorization, or license required of the Provider by the Payor in order to provide financial management services under this Agreement.

**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.; 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 without opportunity to cure upon notice to and/or discovery by the Payor of any failure of the Provider to meet the requirements hereunder of solvency and of continuing as an ongoing business concern or if the Provider generally fails to pay its debts as they become due.

**D.** In the event of a breach of any term or condition of this Agreement by either of the parties hereto, and failure of the breaching party to correct such breach within thirty (30) days after written notice thereof from the other party, such other party may, at its option, terminate this Agreement immediately or at any designated future time by delivering to the breaching party a written notice of termination stating the effective date thereof. The termination of this Agreement shall not be deemed to be a waiver by the non-breaching party of any other remedies it may have in law or in equity.

**E.** 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 sixty (60) days prior written notification.

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

**G.**  The Provider agrees, in the event of termination of this Agreement, to cooperate with the Payor in the orderly close-out and transition of services.

**H.** The Provider agrees, in the event of termination of this Agreement and nonrenewal, to cooperate with the Payor in the orderly transfer of records, services documentation and property, and other items material hereunder to the Payor, as applicable.

**I.** Within thirty (30) days following the date of termination of this Agreement and nonrenewal, the Provider shall provide to the Payor, all financial, performance, and other reports required under this Agreement.

**IX. PAYOR ADMINISTRATIVE RESPONSIBILITIES AND DUTIES; CERTAIN SERVICES OF A FISCAL AGENT ACTING ON BEHALF OF THE PAYOR, SPECIFICALLY FINANCIAL MANAGEMENT SERVICES TO BE PERFORMED BY THE PROVIDER.** The Payor must solely maintain its administrative responsibilities and duties for general administration, program and service administration, financial fiduciary, quality assurance administration and quality improvement, monitoring, and oversight, in order to meet requirements of the MDHHS/CMHSP Master Contract for General Funds and of the MDHHS/PIHP Master Contract for Medicaid Funds and therefore also maintain all said responsibilities and duties under this Agreement.

The Payor has elected, at its discretion, to subcontract for the performance of certain services of a fiscal agent acting on behalf of the Payor, which are specified as financial management services the attached document labeled "Exhibit B" (“CERTAIN SERVICES OF A FISCAL AGENT ACTING ON BEHALF OF THE PAYOR, SPECIFICALLY FINANCIAL MANAGEMENT SERVICES, TO BE PERFORMED BY THE PROVIDER”), which is incorporated by reference into this Agreement and made a part hereof, on its behalf by purchasing them from the Provider under this Agreement.

**X. BILLING OF AND PAYMENTS FOR VALID SERVICE FEE CLAIMS.** For the period that this Agreement is in effect, the Provider shall be paid as reimbursement for Payor-authorized financial management services performed by said Provider hereunder, as specified and delineated in the attached document labeled "Exhibit C: BILLING OF AND PAYMENTS FOR VALID SERVICE FEE 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 the Payor’s CEO (a/k/a Executive Director) or said CEO’s designated representative.

**XI. QUALITY IMPROVEMENT; PERFORMANCE INDICATORS AND OBJECTIVES; CLIENT ASSESSMENTS AND OUTCOMES STUDIES.**

**A.** The Provider, in acting as a fiscal agent on behalf of the Payor pursuant to this Agreement, shall meet the Quality Assessment and Performance Improvement Program (QAPIP) requirements and standards of the Payor.

**B.** The Provider, in acting as a fiscal agent on behalf of the Payor pursuant to this Agreement, shall meet the performance indicators and objectives set forth in the attached document labeled "Exhibit D" (“PERFORMANCE INDICATORS AND OBJECTIVES”), which is incorporated by reference into this Agreement and made a part hereof.

**C.** The Provider agrees, in acting as a fiscal agent on behalf of the Payor 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 Client surveys, focus groups and other Client 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 Clients as a result of services rendered pursuant to the purposes of this Agreement.

**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.

**XII. PAYOR-REQUIRED PROCESSES AND PRACTICES FOR THE IMPLEMENTATION OF FINANCIAL MANAGEMENT SERVICES.** The Provider, in acting as a fiscal agent on behalf of the Payor for the purposes hereunder, shall abide by and execute specific processes and practices, which meet the requirements of the Payor, for the implementation of financial management services pursuant to this Agreement, as specified and delineated in the attached document labeled "Exhibit E: PAYOR-REQUIRED PROCESSES AND PRACTICES FOR THE IMPLEMENTATION OF FINANCIAL MANAGEMENT SERVICES" which is incorporated by reference into this Agreement and made a part hereof.

**XIII. REPORTING AND RECORDS REQUIREMENTS; ACCOUNTING PROCEDURES AND INTERNAL FINANCIAL CONTROLS.**

**A.** The Provider shall report financial, service and Client data and additional statistical and other management information to the Payor, as applicable, in the manner and at the times prescribed by the Payor’s CEO.

**B.** The Provider shall maintain accounts and source records in which any and all revenues received pursuant to this Agreement are ascertainable and verifiable and include date of receipt and sources of funds and in which all services, costs and expenditures made pursuant to this Agreement can be readily ascertained and verified therefrom. TheProvider, for the purposes of this Agreement, shall ensure that all applicable employment, payroll and other time keeping records, are maintained in a manner sufficient to document the provision of services.

**C.** The Provider understands and acknowledges that, in acting as a fiscal agent on behalf of the Payor pursuant to this Agreement, said Provider’s accounting and financial reporting must be in compliance with MDHHS accounting and reporting requirements of the Payor, including accrual accounting and reporting and generally accepted accounting principles (GAAP) for governmental units.

**D.** The Provider shall establish and maintain a comprehensive record system pertaining to the financial management services performed and Clients served pursuant to this Agreement, including, but not limited to the following:

**(1.)** contracts and agreements; monthly financial reports; budgets; payroll set-up documentation; standard monthly, quarterly and annual payroll reports; and,

**(2.)** individual employee files containing, but not limited to, the following information: W-4, MI W-4, I-9, employment agreement, Recipient Rights Attachment and Training Certificate, Criminal Background Check report, Driving Record report if required, pay rate information, employment hiring (and termination) information, insurance, unemployment claims and worker compensation claims, etc.

**E.** TheProvider shall have either a certified public auditing firm perform an annual independent audit or an audit approved by the Payor of it in substantial conformance with the American Institute of Certified Public Accountants Guide to assess:

**(1.)** compliance with the appropriate standard accounting practices and procedures and internal financial controls;

**(2.)** compliance with the terms of this Agreement, as to the accuracy of revenues, expenditures and cost allocations as reported to the Payor; and,

**(3.)** compliance with applicable federal and State laws governing its operations. The Provider shall submit a complete and accurate copy of such independent audit for each fiscal year by no later than six (6) months after the close of said fiscal year.

In the absence of an audit performed by an independent certified public accountant, the Provider shall allow the Payor, or a representative of the Payor, to perform a review of the Payor’s records to determine its compliance with the conditions of this Section.

**F.** 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.

**XIV. 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, the Payor for purposes hereof, the federal government, the State of Michigan, or their designated representatives shall be allowed to inspect, review, copy, and/or audit all program and financial records and license, accreditation, certification and reports of the Provider and to review all service records of the Provider pertaining to performance of this Agreement, to the full extent permitted by applicable federal and State law. Service and financial records and supporting documentation of the Provider must be retained and be available for audit, review or evaluation purposes for ten (10) years after the termination of this Agreement.

**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 the Provider at any time within ten (10) years of the termination of this Agreement, in accordance with Section 952 of the Omnibus Reconciliation Act of 1980 [42 USC 1395x(v)(1)(I)] and the regulations adopted pursuant thereto, the Payor and said 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 said Provider or the Payor is to a significant extent associated or affiliated with, owns or is owned by or has control of or is controlled by (hereinafter referred to as "Related Organization"), and which performs services on behalf of said 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.** The Provider shall provide access to the Payor’s designated representative(s) to evaluate, through inspection or other means on a retrospective or current basis, the appropriateness, quality, and timeliness of services performed hereunder and said Provider’s compliance with standards required thereto.

**D.** 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 services performed under this Agreement.

**E.** Refusal by the Provider to allow the Payor hereby, the parties to the MDHHS/PIHP Master Contract for Medicaid funds and MDHHS/CMHSP Master Contract for General Funds therefore, the federal government, State of Michigan or their designated representatives access to records, program and 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.

**XV. COMPLIANCE WITH APPLICABLE LAW.**

**A.** This Agreement shall be construed according to the laws of the United States and 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 shall perform all duties and obligations required of said Provider under this Agreement in compliance with all applicable federal, State, and local laws, ordinances, rules and regulations, including but not limited to, those federal and State laws, rules and regulations. Thereto, the Provider shall abide by all applicable federal and State laws regarding employment and payroll taxes and shall remain current with all applicable employment and tax requirements.

**D.** In acting as a fiscal agent on behalf of the Payor pursuant to 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.** 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.

**XVI. NONDISCRIMINATION.** In performing duties and responsibilities required under this Agreement, the Provider shall comply with all applicable federal and State laws, rules and regulations prohibiting discrimination. The Provider shall not discriminate against any employee or applicant for employment with respect to hire, tenure, terms, conditions, or privileges of employment or a matter directly or indirectly related to employment nor any applicant or recipient of services because of race, color, religion, national origin, age, gender identity, sexual orientation, handicap, height, weight, marital status, political affiliation or beliefs and Section 1557 Patient Protection and Affordable Care Act including 6504(a) claims processing and data. 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 non-breaching party.

**XVII.HEALTH AND SAFETY OF CLIENTS; RECIPIENT RIGHTS AND CLIENT GRIEVANCE PROCEDURES.**

**A.** The Provider, in acting as a fiscal agent on behalf of the Payor hereunder, agrees to immediately notify the Payor’s CEO of any event or information that raises questions regarding the health and safety of any Client receiving services pursuant to this Agreement.

**B.** The Provider assures the Payor that, pursuant to this Agreement, all individuals employed by the said Provider shall receive training related to recipient rights, including person-centered planning and rights protection, before or within thirty (30) days after the commencement of such employment. Such recipient rights training shall occur in concert or through technical consultation with the Payor’s Recipient Rights Office.

**C.** The Provider shall strictly comply with all Recipient Rights provisions of the MDHHS Administrative Rules and of the Payor’s policies and shall implement appropriate remedial action for substantiated allegations of rights violations.

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, in acting as a fiscal agent on behalf of the Payor,agrees to comply with Client grievance procedures required by the Payor and the MDHHS for receiving, processing and resolving promptly any and all complaints, disputes, and grievances.

F. 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 non-breaching party.

**XVIII. ESTABLISHMENT OF CLIENT RECORDS SYSTEM, RELEASE OF CLIENT INFORMATION AND CONFIDENTIALITY.** The Payor must establish and maintain a comprehensive individual service record system consistent with the provisions of MDHHS Medical Services Administration (MSA) Policy,and appropriate State and federal statutes, pursuant to the requirements of MDHHS/CMHSP Master Contract for General Funds and the MDHHS/PIHP Master Contract for Medicaid funds.

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 pursuant to this Agreement, the parties hereto assure that each is in compliance with the HIPAA requirements.

All Client information, medical records, data and data elements, collected, maintained, or used in the execution of this Agreement shall be protected by the parties hereto from unauthorized disclosure as required by State and federal regulations.

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](about:blank) now imposes data breach notification requirements for unauthorized uses and disclosures of "unsecured PHI." Under the [HITECH Act](about:blank) "unsecured PHI" essentially means "unencrypted PHI."

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

The parties hereto must provide safeguards that restrict the use or disclosure of information concerning Clients to purposes directly connected with the execution of this Agreement.

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

Each party hereto shall comply with all applicable federal and State laws, rules and regulations on confidentiality with regards to disclosure of any materials and/or information provided pursuant to this Agreement.

**XIX. 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.

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

**C.** It is expressly understood and agreed by the Provider that said Provider’s officers, employees, servants and agents performing services pursuant to this Agreement shall not in any way be deemed to be or hold themselves out as the employees, servants or agents of the Payor. The Provider’s officers, employees, servants and agents 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.** The Provider shall be responsible for paying all salaries, wages, or other compensation due its officers, employees, servants and agents for performing services under this Agreement, and for the withholding and payment of all applicable taxes, including, but not limited to, income and Social Security taxes, to the proper federal, State and local governments. The Provider shall be responsible for providing workers’ compensation coverage and unemployment insurance coverage for its employees, as required by law.

**XX. 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.

The Provider agrees to disclose ownership in accordance with the policies and procedures of the Payor as specified in the attached document labeled “Exhibit F (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.

**XXI.** **INDEMNIFICATION AND HOLD HARMLESS.** The Provider, shall, at its own expense, protect, defend, indemnify, save and hold harmless the Payor, its elected or appointed officers, employees, servants and agents from all claims, damages, costs, lawsuits and expenses including, but not limited to, all costs from administrative proceedings, court costs and attorney fees, that the Payor and its elected or appointed officers, employees, servants or agents may incur as a result of any acts, omissions, or negligence of the Provider, its officers, employees, servants and agents that may arise out of this Agreement.

The Provider's indemnification responsibilities under this section shall include the sum of damages, costs and expenses which are in excess of the sum paid out on behalf of or reimbursed to the Payor and/or its officers, employees, servants and agents by the insurance coverage obtained and/or maintained by said Provider pursuant to the requirements of this Agreement.

**XXII.** **INSURANCE COVERAGES.**

**A.** During the duration of this Agreement, the Provider shall procure, pay the premium on, keep and maintain liability insurance covering the acts, omissions or negligence of the Provider and said Provider’s officers, employees, servants and agents while performing services required under this Agreement. Thereto, the insurance coverages secured and maintained by the Provider shall include Payor as an Additional Insured under is Commercial General Liability coverage and shall be in amounts necessary to cover all claims which may arise out of activities to be carried out pursuant to said Provider’s obligations under this Agreement with limits of not less than the following:

**(1).** Workers' Compensation: When and as required by law.

**(2).** Employers' Liability: When and as required by law.

**(3).** Professional Liability Coverage (Errors and Omissions) of not less than $\_\_\_\_\_\_\_\_\_\_\_ per occurrence.

**(4).** General Liability Insurance of not be less than $\_\_\_\_\_\_\_\_\_\_\_\_\_ per occurrence/$\_\_\_\_\_\_\_\_\_ aggregate, combined single with the following coverage inclusions:

**(a)** Broad Form General Liability Endorsement or equivalent, if not

in policy proper.

**(b)** Contractor Liability Insurance coverage.

**(c)** Contractual Liability.

**(5).** Employee Dishonesty Bond with limits of $\_\_\_\_\_\_\_\_\_\_\_\_\_ per occurrence.

**B.** The Provider shall submit certification of said insurance coverages to the Payor prior to the execution of this Agreement. The Provider shall provide the Payor with written notification at least thirty (30) days prior to any change, reduction or loss of the insurance coverages required under this Agreement.

**C.** The Provider shall maintain such other insurance as said Provider deems appropriate for the Provider’s own protection.

**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.

**XXIII. 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.** 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 the services required under this Agreement.

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

**D.** **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.

**E.** **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: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_.(Note include email addresses)**

**F. Return of Property.** Within fourteen (14) days after any termination of this Agreement and non-renewal, the Provider shall return to the Payor all documents, tapes, correspondence, files, papers or other property of any kind of the Payor that the Provider, its officers, employees, and agents may have in their possession or control.

**XXIV. MONITORING THE AGREEMENT; RESOLUTION OF CONTRACT 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 of the Provider. The Payor’s CEO (a/k/a Executive Director) for shall appoint administrative and program liaisons to be available to communicate with the Provider’s liaisons.

**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 representatives of said respective parties. Unresolved contract issues, as to specific provisions of this Agreement and implementation thereof, and/or service disputes hereunder shall be referred to the Payor’s CEO a final determination. The Payor’s CEO shall furnish the Provider with written notice of any such final determination hereunder.

**XXV. WAIVERS.**

**A.** No failure or delay on the part of either the Payor or the Provider in exercising any right, power or privilege under this Agreement 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.

**XXVI. AMENDMENT.** Modifications, amendments, or waivers of any provision of this Agreement may be made only by the written mutual consent of the Payor and the Provider.

**XXVII. ASSIGNMENT.** 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 otherwise delegated without the prior written consent of the Payor. Any attempted assignment in violation of this section shall be void from the beginning. This Agreement shall be binding upon the Payor and the Provider and their respective successors and permitted assigns, if any.

**XXVIII. 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.

**XXIX. COMPLETENESS OF THE AGREEMENT.** This Agreement, the attached Exhibits, and the additional and supplementary documents incorporated herein by specific reference contain all the terms and conditions agreed upon by the Payor and the Provider, and no other agreements, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind either the Payor and the Provider.

**XXX. 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.

**XXXI. 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.

**IN WITNESS WHEREOF,** the authorized representatives of the parties hereto have fully executed this Agreement on the day and the year first above written.

**PAYOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

Date

**PROVIDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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 Client, 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.

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

**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”).

**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

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

**EXHIBIT B**

**ADMINISTRATIVE SUPPORT SERVICES TO BE PERFORMED BY**

**THE PROVIDER ACTING ON BEHALF OF THE PAYOR**

**(EXAMPLE)**

The Payor has elected, at its discretion, to subcontract for the performance of certain administrative support services, specifically financial management services, from the Provider, acting administratively on behalf of the Payor, under this Agreement. Thereto, the financial management services to be performed by the Provider for subsequent fee-for-service reimbursement from the Payor per valid claims pursuant to this Agreement shall include **fiscal intermediary services** as follows:

**A.** If, as an option defined and allowed also by the MDHHS, the Provider is designated as the Employer Agent by an eligible Payor-authorized Client, who participates in a Client Choice Voucher System administered by the Payor as a Client Self-Determination Initiative and who elects to become a common law employer of employee(s) as service provider(s), the Provider, if also authorized by the Payor, shall perform as said Employer Agent (pursuant to federal Revenue Procedures) to the IRS and to other public authorities requiring payroll withholding and employee insurance payments if so allowed by the other public authorities.

**B.** The financial management services to be performed by the Provider, acting administratively on behalf of the Payor, for subsequent fee-for-service reimbursement from the Payor per valid claims pursuant to this Agreement also may include the following services, which are also defined and allowed by the MDHHS as “fiscal intermediary” services:

1. Designating a primary contact person, who will be readily available to the Payor, and have responsibility for monitoring and ensuring that the terms of this contract are fulfilled.
2. Safeguarding, managing and accounting for funds disbursed from the Payor on behalf of each Self Determination Participant and maintain complete and current financial records along with supporting documentation to demonstrate that funds have been expended in accordance with the individuals Person Centered Plan.
3. Disbursing funds to vendors and providers after obtaining
   1. provider contracts and employment agreements
   2. verification that a Medicaid Provider Agreement has been signed by each provider; and
   3. timesheets or invoices approved by Client-participant or his or her authorized representative.
4. Not issuing any payments directly to the Self Determination Participant(s).
5. Maintaining complete current financial records, copies of all agreements, and supporting documentation verifying expenditures paid by the Provider on behalf of each Client-participant for seven years.
6. Recording, maintaining and providing a monthly spending report for each Client-participant and provide a copy to the Payor and the Client-participant and maintain records for seven years.
7. Flagging for the Payor and the Client-participant any deviation in an individual budget of 10%, either under or over expenditures at any time.
8. Making records regarding Client-participants available to the Payor as requested for completion of compliance audits, or other required investigations.
9. Acting as Employer Agent and performing the financial administrative duties of employer, pursuant to IRS Section 3504 and IRS Revenue Procedure 70-6.
10. Issuing payroll payments to PAS workers hired directly by the Client participant.
11. Withholding income, Social Security, and Medicare taxes from payroll payments and make payments to the appropriate authorities for taxes withheld.
12. Issuing benefit payments.
13. Ensuring that Department of Justice I-9 form is completed (verification of citizenship or resident alien status).
14. Making payments for unemployment taxes and workers compensation insurance to the appropriate authorities.
15. Serving as payment agent for vendors of services and supports chosen and retained by the Client-participant.
16. Issuing W-2 forms and tax statements according to all applicable federal, state and locals laws and regulations.
17. Obtaining documentation from the Client-participant and file it with the IRS so that the Provider can serve as Employer Agent for Clients, and meet the requirements of state and local income tax authorities and unemployment insurance authorities.
18. Reconciling all accrued expenses/accounts payable no later than 60 days following the end of the fiscal year.

## C. FISCAL INTERMEDIARY DOCUMENTATION REQUIREMENTS:

### The Provider shall act as the agent of the Self Determination Participant in terms of performing the financial administrative duties of an employer. The Provider shall assist the Self Determination Participant in assuring all necessary documentation is in place and copies maintained, including but not limited to:

### 42 CFR 431.107 Agreement between the Provider and the Payor.

1. Employment Agreements between the Self Determination Participant and his/her employees.
2. Employment applications, criminal background check releases and reports, T.B. test results, completed trainings, driver’s license, automobile insurance and driving records.
3. Tax identification number (IRS SS-4 application for I.D. #’s).
4. Accurately maintain and report (when requested) employee benefits such as vacation, sick leave, personal leave, holidays and leaves of absence. These arrangements are individual and listed in each employee’s job description.
5. Proof of issuance of the following:
   1. Wage payments
   2. FICA payments
   3. Benefit payments
   4. Tax withholding and payments to the taxing authority
   5. W-2 forms and tax statements
   6. IRS form 2848 “Power of Attorney and Declaration of Representative” or IRS Form 8821 Tax Information Authorization”
   7. IRS form 2678 “Employer Appointment of Agent”
   8. Verification of citizenship or resident alien status
   9. Unemployment insurance
   10. Other applicable wage deductions

**EXHIBIT C**

**BILLING OF AND PAYMENTS FOR VALID SERVICE FEE CLAIMS**

**(EXAMPLE)**

1. 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 financial management services rendered by the Provider under this Agreement shall be on a fee-for-service basis.
   1. \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ($\_\_\_\_) per unit (month) for payor-authorized fiscal intermediary services (CPT T2025) rendered by a qualified professional.
2. **Requirements for Billing of Claims and Payments of Claims**. The Provider shall submit monthly billing claims in to the designated Payor to the Payor with valid claims for each month in which Payor-authorized financial management services are rendered under this Agreement. All monthly billing statements of the Provider shall specify billable services to the Payor 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 said Provider hereunder.

The Payor shall authorize and process service claims payments to the Provider within thirty (30) days following receipt of a complete and accurate billing statement from said Provider. The Provider's submittal of a billing statement of claims for any service fees hereunder shall constitute said Provider's verification that the services have been completed, in compliance with the reimbursement requirements of the Payor.

**C.** Upon completion of the Payor’s fiscal year and/or upon 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 said Provider for the fiscal year shall be reviewed and reconciled in direct accordance with the service and financial provisions hereunder in order to assure that the Payor’s payments to said 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 reconciliation for each (Payor) fiscal year shall be paid within sixty (60) days after notification of the Payor’s final determination.

**EXHIBIT D**

**PERFORMANCE INDICATORS AND OBJECTIVES**

**(Example)**

1. The Provider shall maintain financial, service and Client data by Client in such a way as to allow the Payor or its representative to determine compliance with State and Federal laws, as well as Provider requirements.
2. The Provider shall provide an accounting for all expenditures by Client at least monthly.
3. The Provider shall issue properly authorized claims on behalf of the Client within 15 days of receipt 95% of the time.
4. The Provider shall ensure compliance with State and Federal (and IRS) guidelines for all transactions on behalf of the Payor or the Client.
5. The Provider shall file all necessary tax forms (941, W-2’s, etc.) timely 100% of the time.
6. The Provider will ensure that Client employees complete required trainings and documentation is sent to Payor within 90 days of hire.
7. The Provider will supply accurate monthly reports in Payor approved formats which include accrued expenses through month end in order to effectively monitor budget versus actual expenses.
8. The Provider will submit all claims for reimbursement through Payor’s electronic claims submission portal.

9. The Provider will be compliant with MDHHS/CMH Contract Attachment requirements regarding Fiscal Intermediary/CMH monitoring Requirements:

1. Contract and Procurements

2. Qualification Requirements

3. Fiscal Accountability

4. Employer Agent

5. Employment Support

6. Monitoring Performance

**EXHIBIT E**

**PAYOR-REQUIRED PROCESSES AND PRACTICES FOR THE**

**IMPLEMENTATION OF FINANCIAL MANAGEMENT SERVICES**

**(EXAMPLE)**

The Provider, acting as a fiscal agent on behalf of the Payor, agrees to adhere to Payor-required processes and practices for the implementation of the financial management services as a fiscal intermediary required under this Agreement, including, but not limited to, the following:

**A.** The Payor shall process sufficient funding advance(s) of Medicaid Funds and/or State General Funds to the Provider in order to provide the Provider, acting as a fiscal agent on behalf of the Payor, with sufficient cash flow for executing payment transactions required hereunder of a fiscal intermediary, and thereby expenditures of Medicaid Funds and/or State General Funds allowed pursuant to this Agreement.

The Provider shall not claim, retain, or report said funding, as advanced by the Payor, as income of said Provider. The Provider shall not claim, retain, or report interest earned on said funding, as advanced by the Payor, as interest income of said Provider. Upon termination of contract the Provider shall reimburse the Payor for the full amount of the funding advance(s).

**B.** In executing transactions required of a fiscal intermediary, the Provider, acting as a fiscal agent on behalf of the Payor, agrees to abide by Payor’s financial policies and procedures, including those for financial transactions, procurement, and employee/provider agreements. The Payor shall provide the Provider, acting as a fiscal agent on behalf of the Payor, with required forms and agreements approved for legal form and content.

The Payor and the Provider agree to the following process for transmission and verification of claims:

1. If there is a concern that the claims/files posted by the Provider do not match what is found by the Payor, the Payor shall notify the Provider immediately by email, and both parties shall work to resolve the discrepancy.
2. After verification of receipt of claims/files, the Payor shall review and process claims.  If the Payor has any questions about the claims that will affect the amount that the Provider will be paid (e.g., service is outside authorized amount or time frame), the Payor shall immediately email the Provider with the issue/question.
3. If the Payor is not paying the exact amount as on the Claims List, the Payor shall provide written description of what is different and the reason for such. This will be provided with the payment.
4. Should the Provider believe that any claims have been "missed" for payment (i.e., have not been paid and there is no explanation of why it hasn't been paid), the Provider shall notify the Payor-identified staff immediately.

**C.** The Provider, acting as a fiscal agent on behalf of the Payor, agrees to execute payment transactions and thereby expend Medicaid Funds and/or State General Funds, as advanced by the Payor, hereunder in accordance 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, tax, and employment regulations.

**D.** Upon conclusion of each fiscal year of this Agreement, a final reconciliation shall be completed on a net cost basis wherein the Medicaid Funds and/or State General Funds advanced by the Payor to the Provider, interest earned on said advanced funding, if any, and the total of the payment transactions by said Provider and thereby expenditures of Medicaid Funds and/or State General Funds pursuant to this Agreement shall be reviewed and reconciled in direct accordance with the service and financial provisions hereunder in order to assure that the Payor’s obligations have not been exceeded under this Agreement.

Said fiscal year reconciliation of this Agreement shall be completed annually in full compliance with MDHHS requirements and in accordance with the revenue and expenditure reconciliation process and requirements of the MDHHS/CMHSP Master Contract for General Funds and the MDHHS/PIHP Master Contract for Medicaid Funds, the Mental Health Code, the MDHHS Rules, and applicable State and federal laws, including Medicaid regulations. Any amount due to the Payor or to the Provider as a final fiscal year reconciliation for each (Payor) fiscal year shall be paid within sixty (60) days after notification of the Payor’s final determination.

**E.** Should the Provider fail to fulfill its obligations as required under this Agreement, thereby resulting in assessment(s) by the MDHHS, the State of Michigan and/or the federal government of financial penalties against the Payor, the Payor shall, in turn, exact assessment(s) of financial penalties of the same amount against the Provider for said Provider’s failure to fulfill its obligations as required hereunder and said Provider shall reimburse the Payor accordingly as the financial payback(s) therefore.

**F.** Should the Provider fail to fulfill its obligations as required under this Agreement, thereby resulting in unallowable Medicaid and/or State General Fund services and/or cost claims, the Provider shall not be reimbursed by the Payor hereunder for any such services and/or cost claims; thereto, the Provider shall repay to the Payor any such payments made by the Payor with Medicaid (federal share and/or State share) Funds and/or State General Funds to said Provider for such unallowable services and/or cost claims. This revenue reimbursement requirement shall survive the termination of this Agreement and repayment shall be made by the Provider to the Payor within sixty (60) days of the Payor’s final disposition notification to said Provider that the Payor has made unallowable payments with Medicaid (federal share and/or State share) Funds and/or State General Funds to said Provider for unallowable services and/or cost claims and, thereby, financial payback by the Provider is required.

**G.** In the event that the Payor hereby, the parties to the MDHHS/PIHP Master Contract for Medicaid funds and MDHHS/CMHSP Master Contract for General Funds therefore, the MDHHS and 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 failed to fulfill its obligations as required under this Agreement and, thereby expenditures of Medicaid (federal share and/or State share) Funds and/or State General Funds for services claims and/or cost claims are later disallowed, the Provider shall 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.

**EXHIBIT F**

**ENTITY DISCLOSURE/DISCLOSURE OF OWNERSHIP**

**EXAMPLE**

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

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

Payor/PIHP requires each applicable contractor to identify their “managing employee(s)” in policy or procedure. Managing Employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

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