**PROVIDER AGREEMENT FOR SUBSTANCE USE DISORDER TREATMENT SERVICES**

**FOR FISCAL YEAR 2023 BETWEEN**

**NORTHERN MICHIGAN REGIONAL ENTITY**

**AND**

**Provider name**

**THIS AGREEMENT** is made and entered into this1st day of October, 2022**,** by and between **NORTHERN MICHIGAN REGIONAL ENTITY** (the “Payor”), whose administrative offices are located at 1999 Walden Drive, Gaylord, MI 49735, and PROVIDER NAME (the “Provider”), whose administrative offices are located at Provider Address, Provider City, Provider State, Provider Zip.

Locations:

**WHEREAS,** the Payor is a community mental health regional entity formed under 1974 P.A. 258, MCL 330.1001 et seq., (the “Mental Health Code”), specifically MCL 330.1204b, by five (5) community mental health services programs (“Participating CMHSPs”) for the region designated by the Michigan Department of Community Health (“MDHHS”) as Region 2;

**WHEREAS,** the Payor, pursuant to an agreement with MDHHS, serves as the prepaid inpatient health plan (“PIHP”) under 42 C.F.R. Part 438 that manages: the 1915(b) Specialty Supports and Services Program Waiver in conjunction with the 1915(c) Habilitation Supports Waiver Program (the “Concurrent 1915(b)/(c) Programs”); the Healthy Michigan Plan under Section 1902(2)(10)(a)(i)(viii) of the Social Security Act; and the SUD Community Grant Programs by serving as the coordinating agency for the treatment and prevention of substance use disorder services, under 2014 P.A. 500 (the “MDHHS/PIHP Master Contract”);

**WHEREAS,** pursuant to the MDHHS/PIHP Master Contract, the Payor receives funding to provide and/or arrange for the provision of substance use disorder (“SUD”) prevention and/or treatment services (“SUD Services”);

**WHEREAS,** the Provider is qualified to provide and has experience providing SUD Services; and

**WHEREAS, the Payor desires to engage the Provider and the Provider desires to be so engaged to provide SUD services pursuant to the terms and conditions set forth herein.**

**NOW, THEREFORE,** in consideration of the above and in consideration of the mutual covenants and conditions hereinafter contained, the Payor and the Provider agree as follows:

1. **DEFINITIONS**

The terms used in this contract shall be construed and interpreted as defined below, unless this Agreement otherwise expressly requires a different construction and interpretation.

**Clean Claim**: A clean claim is one that can be processed without obtaining additional information from the provider of the service or a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

**Customer**: In this contract, Customer includes all Medicaid Beneficiaries, Healthy Michigan Plan Beneficiaries and SUD Community Grant Beneficiaries located in the Payor’s service area who are receiving or may potentially receive SUD Services. The following terms may be used within this definition: clients, recipients, enrollees, beneficiaries, customers, individuals, persons served, Medicaid eligible.

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

**Health Care Professional**: A physician or any of the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), registered/certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

**Health Insurance Portability and Accountability Act of 1996**: Public Law 104-191, 1996 to improve the Medicare program under Title XVIII of the Social Security Act, the Medicaid program under Title XIX of the Social Security Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.

The Act provides for improved portability of health benefits and enables better defense against abuse and fraud, reduces administrative costs by standardizing format of specific healthcare information to facilitate electronic claims, directly addresses confidentiality and security of patient information - electronic and paper. HIPAA was amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act), as set forth in Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009. The United States Department of Health and Human Services (DHHS) promulgated administrative rules to implement HIPAA and HITECH, which are found at 45 C.F.R. Part 160 and Subpart E of Part 164 (the “Privacy Rule”), 45 C.F.R. Part 162 (the “Transaction Rule”), 45 C.F.R. Part 160 and Subpart C of Part 164 (the “Security Rule”), 45 C.F.R. Part 160 and Subpart D of Part 164 (the “Breach Notification Rule”) and 45 C.F.R. Part 160, subpart C (the “enforcement Rule”). DHHS also issued guidance pursuant to HITECH and intends to issue additional guidance on various aspects of HIPAA and HITECH compliance. Throughout this contract, the term “HIPAA” includes HITECH and all DHHS implementing regulations and guidance.

**Healthy Michigan Plan**: The Healthy Michigan Plan is a new category of eligibility criteria under the Patient Protection and Affordable Care Act and Michigan Public Act 107 of 2013 that began April 1, 2014.

**Healthy Michigan Plan Beneficiary**: An individual who has met the eligibility criteria for enrollment in the Healthy Michigan Plan and has been issued a Medicaid card.

**Medicaid Beneficiaries**: An individual who has been determined to be entitled to Medicaid and who has been issued a Medicaid card.

**Michigan Medicaid Provider Manual-Mental Health/Substance Abuse Chapter**: The Michigan Department of Community Health periodically issues notices of proposed policy for the Medicaid program. Once a policy is final, MDHHS issues policy bulletins that explain the new policy and give its effective date. These documents represent official Medicaid policy and are included in the Michigan Medicaid Provider Manual: Mental Health Substance Abuse section.

**Payor’s Service Area**: Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon and Wexford Counties.

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

**Potential Customer**: An individual who is a Customer residing in the Payor’s Service Area, but is not receiving SUD Services under this Agreement.

**Practice Guideline**: MDHHS-developed guidelines for PIHPs and CMHSPs for specific service, support or systems models of practice that are derived from empirical research and sound theoretical construction and are applied to the implementation of public policy.

**Prepaid Inpatient Health Plan (PIHP)**: In Michigan and for the purposes of this Agreement, a PIHP is defined as an organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR Part 438 that are responsible for inpatient services as part of a benefit package. The Payor is a PIHP that also manages the Autism iSPA, Healthy Michigan, Substance Use Disorder and Prevention SUD Community Grant and PA2 funds.

**Public Health Code**: Means Act 368 of the Public Acts of 1978, as amended.

**Public Officer**: A person appointed by the governor or another executive department official. For the purpose of section 2b of MCL § 15.341, public officer shall include an elected or appointed official of this State or a political subdivision of this State.

**ROSC**: Recovery Oriented Systems of Care

**Sentinel Event**: Is an “unexpected occurrence” involving death (not due to the natural course of a health condition) or serious physical or psychological injury or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase “or risk thereof” includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome. (JCAHO, 1998) Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

**Substance Use Disorder (SUD)**: The taking of alcohol or other drugs as dosages that place an individual’s social, economic, psychological, and physical welfare in potential hazard or to the extent that an individual loses the power of self-control as a result of the use of alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.

**SUD Community Grant**: A combination of the federal grant received by the State from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the general fund dollars appropriated by the legislature for the prevention and treatment of SUD.

**SUD Community Grant Beneficiary**: An individual eligible to receive SUD Services under the SUD Community Grant Program.

**Technical Advisory**: MDHHS-developed document with recommended parameters for PIHPs regarding administrative practice and derived from public policy and legal requirements.

**Technical Requirement**: MDHHS/PIHP contractual requirements providing parameters for the Payor regarding administrative practice related to specific administrative functions, and that are derived from public policy and legal requirements.

1. **CONTRACT AUTHORITY**

This Agreement is entered into pursuant to the authority granted to both parties under the Mental Health Code; 42 C.F.R. Part 438, 2012 P.A. 500 and the MDHHS/PIHP Master Contract.

1. **AGREEMENT CONTINGENT UPON FUNDING**
2. **MDHHS/PIHP Master Contract**

This Agreement is contingent upon receipt by the Payor of funding under the MDHHS/PIHP Master Contract, including without limitation Medicaid capitation funds, upon the terms of such funding as appropriated, authorized and amended, and upon the continuation of such funding.

1. **Funding**

This Agreement is contingent upon receipt by the Provider of Medicaid sub-capitation funds and fee-for-service payments, as earned contract revenue, from the Payor.

1. **Notice**

The Payor shall provide immediate notice to the Provider of any material reduction or loss of the funding upon which this Agreement is contingent.

1. **COMPLIANCE WITH MDHHS/PIHP MASTER CONTRACT/PIHP POLICIES, PROCEDURES, PLANS AND STANDARDS**
2. **MDHHS/PIHP Master Contract**

In addition to general compliance requirements set forth in this contract, it is expressly understood and agreed by the parties that this Agreement is subject to the applicable terms and conditions of the MDHHS/PIHP Master Contract together with attachments all of which are incorporated herein by reference. The Provider shall comply with all such applicable provisions and requirements of the MDHHS/PIHP Master Contract, including attachments thereto. Copies of the current MDHHS/PIHP Master Contract together with all attachments have been provided to the Provider in the URL in section IV. B of this agreement.

The provisions of this Agreement shall take precedence over said MDHHS/PIHP Master Contract unless a conflict exists. In the event that any provision of this Agreement is in conflict with the terms and conditions of the MDHHS/PIHP Master Contract, the provisions of MDHHS/PIHP Master Contract shall control. 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 the MDHHS/PIHP Master Contract;

**2.** Restates provisions of the MDHHS/PIHP Master Contract to afford the Payor the same or substantially the same rights and privileges as MDHHS; or

**3.** Requires the Provider to perform duties and/or services in less time than required of the Payor in the MDHHS/PIHP Master Contract.

1. **MDHHS/PIHP Master Contract Attachments**

Attachments to the MDHHS/PIHP Contract can be found at the following URL:

https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines

1. **Compliance Plan**

The Provider and all its principals, officers, employees, servants, contracted and subcontracted providers and agents are subject to and shall comply with all applicable requirements of the Payor’s Compliance Plan, as annually approved by the Payor’s Board. Failure to do so will result in remedial action and/or termination of this Agreement for material breach, as provided in Section VII of this Agreement.

1. **Standards**

The Provider shall comply with all standards developed by the Payor that may apply to the Provider’s performance under this Agreement. Prior to or during the term of this Agreement, the Payor shall develop specific standards.

1. **Policies/Procedures.**

The Provider and its employees and Subcontractors shall comply with all the Payor’s Policies and Procedures, as applicable under this Agreement; copies of which will be provided to the Provider as the same may change from time to time.

1. **PROOF OF PROVIDER’S BUSINESS STATUS; REQUIREMENTS OF PROVIDER SOLVENCY; AND, CERTIFICATION REGARDING DEBARMENT OR SUSPENSION**
2. **Conduct of Business**

The Provider shall furnish the Payor with notice of proof of the Provider’s authority to conduct business in the State of Michigan and in what business capacity (corporation, etc.), prior to commencing the provision of 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.

1. **Financial Solvency**

The Provider shall furnish the Payor with notice of proof of financial solvency, prior to commencing the provision of services hereunder, and with immediate notice of any change in financial position material to the Provider’s solvency and to its continuing in operation as a going concern, at any time during the term of this Agreement.

1. **Certification**

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 it and its principals, officers, employees and Subcontractors:

**1.** 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.** 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 anti-trust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

**3.** 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;

**4.** 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; and

**5.** Are not currently excluded from participation in any federal or State health care program.

1. **Independent Fiscal Audit**

Provider shall obtain an annual financial audit within ninety (90) days of the close of its fiscal year unless an “Annual Audit Waiver” is granted by Payor. The Provider is eligible for Annual Audit Waiver approval if Provider receives $100,000 or less from Payer to provide substance use disorder services to clients during the term of this agreement. The fiscal audit shall include, but is not limited to, the following areas of compliance:

* Generally Accepted Accounting Principles
* Fiscal solvency illustrated in Payer’s balance sheet and income statement
* Adherence to the terms of this Contract including documentation of claims submitted to Payer
* Applicable federal and state laws relative to this contract

The financial audit must include a list of revenues and expenses, by funder. Failure to submit this audit may result in imposition of a financial penalty.

1. The Provider will comply with the provisions of 2 CFR 200 and will comply with generally accepted accounting principles (GAAP) when preparing financial statements. Providers must apply the provisions of OMB Circular A-133 to determine if it is subject to an organization-wide “single-audit” based on the level of federal funding expended. If an organization-wide “single-audit” is required, programs financed by NMRE with $750,000 or more in federal funds should be included in the scope of the auditor’s risk-based approach used to determine which programs are to be tested and reported on as major programs, as specified in the 2 CFR 200, Subpart F. Providers that fall below the single audit threshold are exempt from the single audit requirements; however, for providers receiving $750,000 or more of total federal grant funding, a copy of the financial audit prepared in accordance with generally accepted auditing standards must be submitted by **June 30, 2023** as a minimum requirement of the Department.
2. **TERM OF THIS AGREEMENT**

The term of this Agreement shall be from October 1, 2022 through September 30, 2023. This Agreement may be extended, in increments no longer than twelve (12) months, with the mutual written consent of the Payor and the Provider through an amendment to this Agreement pursuant to Section XXXII of this Agreement.

1. **TERMINATION**
2. **Immediate**

This Agreement may be terminated by the Payor immediately upon the revocation, restriction, suspension, discontinuation or loss of any certification, accreditation, authorization or license which is required by any federal or State local law, ordinance, rule or regulation for the Provider to operate and/or provide services under this Agreement within the State of Michigan, including, without limitation, upon receipt of notice and/or discovery by the Payor that the Provider is:

**1.** Listed by the U.S. Office of Inspector General in its “Excluded Provider List,” as being excluded from participating in a federal or State health care program;

**2.** Listed by the State of Michigan as being suspended from participation in Medicare, Michigan Medicaid Program or any other Michigan health care program;

**3.** 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.;

**4.** Determined by the Payor to potentially jeopardize the health, safety, or welfare of an individual by continuation of this Agreement;

**5.** Found to have committed fraud or misrepresentation relating to the SUD Services performed under this Agreement; or

**6.** Determined by the Payor to havefailed to meet the requirements of solvency and of continuing as a going business concern or if the Provider generally fails to pay its debts as they become due.

1. **Notice**

Notwithstanding any other provisions in this Agreement to the contrary, either party hereto may terminate this Agreement for any reason by providing the other party with sixty (60) business calendar days prior written notification.

1. **MDHHS/PIHP Master Contract**

This Agreement shall terminate immediately upon the termination of the Payor’s MDHHS/PIHP Master Contract.

1. **Breach**

Any material breach of this Agreement, which has not been cured within thirty (30) business days of receipt of written notice of the breach shall result in the non-breaching party's right to terminate this Agreement upon the thirty-first (31) calendar day following the written notice of the breach. Consistent with Part I, Section 15.0 of the MDHHS/PIHP Master Contract, the Payor may terminate this Agreement for material breach of the Provider. Material breach is defined as the substantial failure of the Provider to fulfill its obligations under this Agreement or the standards promulgated by MDHHS pursuant to P.A. 597 of the Public Acts of 2002 (MCL 330.1232b).

1. **Sanctions**

This Agreement may be terminated in adherence to the Payor’s Sanctions Policy.

1. **Obligations After Termination**

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

1. **Payment**

Upon any termination of this Agreement, the Provider shall promptly supply the Payor with all information necessary for the payment of any outstanding claims and for the provision of SUD Services.

1. **Orderly Transfer**

The Provider agrees, in the event of termination of this Agreement and non-renewal, to cooperate with the Payor in the orderly transfer of the Customers’ records, property, programs and services, and other material items to the Payor and/or other contractors of the Payor, as applicable.

1. **Record Retention**

Following termination, any clinical or financial records pertaining to this Agreement that have not been transferred to the Payor, shall be retained in accordance with the retention standards.

1. **SERVICE AREA**
2. The counties of Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon and Wexford shall constitute the Payor’s service area (“Service Area”).
3. Any waiver of the service access/admittance and service payment restrictions hereunder may only be granted, with prior authorization, by the Payor’s Executive Officer or designee.
4. **TARGET POPULATION**

The Customer population and eligibility criteria for individuals served under this Agreement are specified in the attached Exhibit A.

1. **LICENSES/ACCREDITATION/CERTIFICATION/CREDENTIALING/PRIVILEGING**
2. **Licensure**

The Provider shall maintain and provide Payor with appropriate licenses for substance use disorder prevention, treatment, and recovery services for the services provided as required by Section 6234 of P.A. 501 of 2012, as amended.

Prior to commencing the provision of SUD Services under this Agreement, the Provider, as applicable, shall furnish the Payor with notice of primary verification that its staff and contracted professionals 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 render SUD Services under this Agreement.

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

1. **Credentialing/Privileges**

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’s staff professionals meet the Payor’s credentialing and privileging requirements, including biennial recredentialing/reprivileging and competency standards that comply with the MDHHS/PIHP Master contract policies, necessary to perform the services required under this Agreement.

1. **Accreditation**

The Provider shall be accredited by one of the following accrediting bodies: The Joint Commission (TJC formerly JCAHO); Commission on Accreditation of Rehabilitation Facilities (CARF); the American Osteopathic Association (AOA); Council on Accreditation of Services for Families and Children (COA); National Committee on Quality Assurance (NCQA), or Accreditation Association for Ambulatory Health Care (AAAHC). The Provider shall provide original correspondence from the accreditation bodies to the Payor. The Payor must determine compliance through review of said original correspondence. Accreditation is not required for peer recovery and recovery support services.

1. **Recovery Residences**

If providing recovery housing, provider shall be certified by the Michigan Association of Recovery Residences (MARR). The provider shall meet levels II, III, or IV.

1. **GENERAL RESPONSIBILITES**

The general SUD responsibilities of the Provider under this Agreement, are to:

1. Provide SUD services as described in Exhibit B, Exhibit C and Exhibit D at Payor-authorized sites during the term of this Agreement.
2. Utilize research-based or evidence-based practices from the National Registry of Evidenced-based Programs and Practices (www.nrepp.samhsa.gov) in outpatient treatment services. The Provider shall maintain a record of the types and dates of research-based or evidence-based practices provided for audit purposes. Progress notes for Customers shall indicate the treatment modalities being used.
3. Complete the SUD Services, documentation and records that meet the Payor’s requirements for reimbursement by the Payor. The Provider’s SUD Services and documentation/records shall comply with the standards of the Payor, MDHHS, any applicable licensing Department or Agency of the State of Michigan, the federal statutes and regulations governing the SUD Community Grant. The Provider shall maintain complete and accurate records of all SUD 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 designated representative(s).
4. The Provider’s designated representative(s) shall, from time to time, as may be required, meet with the designated representative(s) of the Payor’s EO to discuss the Customer(s) being served and/or the SUD Services required under this Agreement.
5. As applicable, submit an annual budget to the Payor for use of state administered funds for its substance use disorder treatment and rehabilitation services and substance use disorder prevention services in accordance with guidelines established by MDHHS.
6. The Provider agrees to comply with the reporting requirements found in Exhibit F. The reporting requirements may also be found in Section 3.1 Reporting, B.7 to the MDHHS/PIHP Master Contract and the requirements described in the SUD Services Policy Manual, which is part of this Agreement by reference. This includes submitting 100% complete, accurate and timely Treatment Episode Data Set (TEDS) records for persons served under this Agreement under treatment services.
7. The Provider will carry out its responsibilities under this Agreement consistent with the Payor’s most recent Strategic Plan as approved by MDHHS. The NMRE Strategic Plan is available as requested.
8. Comply with MDHHS OROSC priority areas as identified by the Payor. This may require development of work plans, monitoring, and follow up regarding priority areas progress by Payor EO or EO representative.
9. The Provider may not, without the Payor’s written consent, delegate to or with another party to carry out any of the functions or responsibilities of the Provider assigned to it under this Agreement.
10. The Provider will carry out its responsibilities under this Agreement consistent with the Payor’s Provider Manual, which is incorporated into this agreement by reference, for Substance Use Disorder services.
11. Where activities supported by this agreement produce books, films, or other such copy righted materials issued by the Provider, the provider may copyright but shall acknowledge that MDHHS reserves a royalty-free, non-exclusive and irrevocable license to reproduce, publish and use such materials and to authorize others to reproduce and use such materials. This cannot include service recipient information or personal identification data. Any copyrighted materials or modifications bearing acknowledgment or the MDHHS name must be approved by MDHHS prior to reproduction and use of such materials. The provider shall give recognition to MDHHS and NMRE in any and all publication papers and presentations arising from the program and service contract herein.
12. Providers will maintain adequate program, participant, and fiscal records and files including source documentation to support program activities and all expenditures made under the terms of this agreement, as required. Assure that all terms of the agreement will be appropriately adhered to and that records and detailed documentation for the services identified in this agreement will be maintained for a period of not less than ten (10) years from the date of termination, the date of submission of the final billing, or until litigation and audit findings have been resolved.
13. Providers will permit, upon reasonable notification and at reasonable times, access by authorized representatives of NMRE, MDHHS, Federal Grantor Agency, Comptroller General of the United States, or any of their duly authorized representatives, to the extent authorized by applicable state or federal law, rule or regulation, to records, files, and documentation related to this agreement.
14. Provider will ensure that all employees are not listed on the Office of Inspector General (OIG) Exclusions List and Michigan Excluded Provider list prior to hire. Per the NMRE credentialing policy, provider will ensure that all practitioners will be verified as unlisted on the National Provider Databank. Provider will provide Payor with documentation of the above exclusions verifications for the month(s) specified by the Payor.
15. **SERVICE ACCESS / PREAUTHORIZATIONS / DELIVERY/ UTILIZATION MANAGEMENT**
16. **Payor Responsibility**

The Payor is responsible under this Agreement for SUD Service access assurance, pre-authorizations, and utilization management as set forth in Exhibit C.

1. **Customer Placement**

The Payor and the Provider agree that placement of any Customer for SUD Services must be medically necessary and meet the criteria set forth herein and as may otherwise be established by the Payor and MDHHS.

* 1. **Treatment.** Referring to the Medicaid Manual using criteria for medical necessity, the Payor may:
		1. Deny services a) that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care: b) that are experimental or investigational in nature: or c) for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support, that otherwise satisfies the standards for medically-necessary services: and/or,
		2. Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.
		3. Not deny SUD Services solely based on PRESET limits of the cost, amount, scope, and duration of services: but instead determination of the need for services shall be conducted on an individualized basis. This does not preclude the establishment of quantitative benefit limits that are based on industry standards and consistent with this contract, and that are provisional and subject to modification based on individual clinical needs and clinical progress.
1. **Requirements/Standards**

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 MDHHS, including without limitation those set forth in Exhibit C**.**

1. **Prior Authorization**.

Any overall SUD Services rendered by the Provider under this Agreement for reimbursement by the Payor must be prior authorized by the Payor’s designated representative.

1. **Customer Removal**.

Upon the revocation, restriction, suspension, discontinuation, or loss of any certification, authorization, or license required by federal, State and local laws, ordinances, rules or regulations for the Provider to participate in any federal or Michigan health care program, including without limitation Medicare, Medicaid and SUD Community Grant Program, the Payor’s designated representative may remove the Customer(s) from the Provider’s services immediately, without prior notification to the Provider, and this Agreement shall terminate immediately upon receipt of notice thereof as provided in Section VII.

The Payor’s designated representative(s) may remove the Payor’s Customer(s) from the Provider’s services, upon notification to the Provider, for any violation or reasonable suspicion of a violation of recipient rights which in the judgment of the Payor’s designated representative has caused or may cause physical or emotional harm to the Customer(s) and/or, in the judgment of the Payor’s designated representative, there is a failure by the Provider to provide the services required by this Agreement. Such a violation, if substantiated by the Payor, may be regarded by the Payor as a material breach of this Agreement, which in addition to the Payor’s other legal remedies may result in immediate cancellation of this Agreement with said termination to be effective as of the date of delivery of written notice to the provider.

1. **Admission Preference and Interim Services**

The Code of Federal Regulations and the Michigan Public Health Code define priority population clients. The priority populations are identified as follows and in the order of importance:

1. Pregnant injecting drug user;
2. Pregnant;
3. Injecting drug user;
4. Parent at risk of losing their child(ren) due to substance use; and,
5. Individual under supervision of MDOC AND referred by MDOC OR individual being released directly from a MDOC facility without supervision AND referred by MDOC. Excludes individuals referred by court and services through local community corrections (PA 511 funded) systems.
6. All others. This includes individuals referred from the Angel Project, unless the individual referred meets a separate priority population.

Access timeliness standards and interim services requirements for these populations are provided in the next section. The Provider shall prioritize these populations to ensure that the timeliness standards in the following chart are met and, when necessary and applicable to the Provider’s approved service array as described in Exhibit C, shall make the suggested interim services are provided.

1. **Access/Admission/Interim Services Standards**

The following chart indicates the current admission priority standards for each population along with the current interim service requirements. If the Admission Requirements are not met, interim services are required to be given within the time indicated:

| **Population** | **Admission Requirement** | **Interim Service Requirement** | **Authority** |
| --- | --- | --- | --- |
|  |  |  |  |
| **Pregnant Injecting Drug User** | Screened & referred w/in 24 hrs.Detox, Methadone or Residential – Offer Admission w/in 24 business hoursOther Levels of Care –Offer Admission w/in 48 Business hours | **Begin w/in 48 hrs:**Counseling & education on:1. HIV & TB
2. Risks of needle sharing
3. Risks of transmission to sexual partners & infants Effects of alcohol & drug use on the fetus Referral for pre-natal care

*Early Intervention Clinical Svc* | CFR 96.121; CFR 96.131; Tx Policy #04Recommended |
|  |  |  |  |
| **Pregnant Substance User** | Screened & referred w/in 24 hoursDetox, Methadone or ResidentialOffer admission w/in 24 business hoursOther Levels of Care –Offer Admission w/in 48 Business hours | **Begin w/in 48 hrs**1. Counseling & education on:1. HIV & TB
2. Risks of transmission to sexual partners & infants
3. Effects of alcohol & drug use on the fetus

2. Referral for pre-natal care3. *Early Intervention Clinical Svc* | CFR 96.121; CFR 96.131;Recommended |
|  |  |  |  |
| **Injecting Drug User** | Screened & Referred w/in 24 hours;Offer Admission w/in 14 days | **Begin w/in 48 hrs – maximum waiting time 120 days**1. Counseling & education on:1. HIV & TB
2. Risks of needle sharing
3. Risks of transmission to sexual partners & infants

2. *Early Intervention Clinical Svc* | CFR 96.121; CFR 96.126Recommended |
|  |  |  |  |
| **Parent at Risk of Losing Children** | Screened & referred w/in 24 hoursOffer Admission w/in 14 days | **Begin w/in 48 business hrs***Early Intervention Clinical Services* | Michigan Public Health Code Section 6232 **Recommended** |
|  |  |  |  |
| ***Individual Under Supervision of MDOC and referred by MDOC or Individual Being Releases Directly From and MDOC Without Supervision and Referred by MDOC***  | *Screened & referred w/in 24 hours**Offer Admission w/in 14 days* | ***Begin w/in 48 business hrs****Early Intervention Clinical Services**Recovery Coach Services* | *MDHHS & PIHP contract Recommended* |
|  |  |  |  |
| **All Others** | Screened & referred w/in seven (7) calendar days.Capacity to offer Admission w/in 14 days | **Not Required** | CFR 96.131(a) – sets the order of priority;MDHHS & PIHP contract |

1. **MDHHS SERVICE REQUIREMENTS**
2. **National Outcome Measures (NOMS)**

Complete, accurate, and timely reporting of treatment and prevention data is necessary for MDHHS to meet its federal reporting requirements. For the SUD Treatment NOMS, it is the Provider's responsibility to ensure that the client information reported on these records accurately describes each client's status at admission first date of service (admission) and on the last day of service (discharge).

1. **Customer Services**

Customer Services is an identifiable function that operates to enhance the relationship between the individual and the Provider. This includes orienting new individuals to the services and benefits available including how to access them, and helping individuals with problems and questions regarding benefits. Standards for customer services are in 1.General Requirements; B. Customer Services Standards to the MDHHS/PIHP Master Contract. The Provider shall distribute the Payor customer services handbook to all customers at initiation of services and at least annually thereafter in their preferred format.

The Provider shall ensure that beneficiaries are notified that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services. The Provider shall also ensure all beneficiaries are notified how to access alternative formats.

1. **Recovery Policy**

All SUD Services provided to individuals with mental illness, including those with co-occurring conditions, shall be based in the principles and practices of recovery outlined in the Michigan Recovery Council document “Recovery Policy and Practice Advisory” included as 1.General Requirements; E. Access and Availability; 15to the MDHHS/PIHP Master Contract**.**

1. **Persons Associated with the Corrections System**

When the Provider receives referrals from the Michigan Department of Corrections (MDOC), the Provider shall handle such referrals as per all applicable requirements in this agreement. MDOC referrals may come from probation or parole agents, or from MDOC Central Office staff. In situations where persons have been referred from MDOC and are under their supervision, state-administered funds should be used as the payment of last resort.

When persons who are on parole or probation seek treatment on a voluntary basis from the Provider’s AMS services or from a panel provider, these self-referrals must be handled like any other self-referral to the MDHHS-funded network. AMS or provider staff may seek to obtain releases to communicate with a person’s probation or parole agent but in no instance may this be demanded as a condition for admission or continued stay.

1. **REFERRALS, SCREENING AND ASSESSMENT**

Individuals under MDOC supervision are considered a priority population for assessment and admission for substance use disorder treatment services due to the public safety needs related to their MDOC involvement. The PIHP shall ensure timely access to supports and services in accordance with Section 26 and the Access Standards in 1.General Requirements; E. Access and Availability; 8 of this contract.

PIHPs shall designate a point of contact within each PIHP catchment area for referral, screening and assessment problem identification and resolution. The position title and contact information will be provided to MDHHS, which will provide the information to the MDOC Central Office Personnel. PIHP will provide this contact information to MDOC Supervising Agents in their regions.

The MDOC Supervising Agent will refer individuals in need of substance use disorder treatment through the established referral process at each PIHP. The MDOC Supervising Agent will make best efforts to obtain from the individual a signed Michigan Behavioral Health Standard Consent Form (MDHHS 5515) and provide it to the PIHP and/or Provider along with any pertinent background information and the most recent MDOC Risk Assessment summary.

The MDOC Supervising Agent will assist the individual in calling the PIHP or Provider for a substance abuse telephonic screening for services. Individuals that are subsequently referred for substance use disorder treatment as a result of a positive screening must receive an in-person assessment. If the individual referred is incarcerated, the MDOC Supervising Agent will make best efforts to facilitate service initiation and appropriate contact with the PIHP/Provider. Provided that it is possible to do so the PIHP shall make best efforts to ensure the individual receives a telephonic, video or in-person screening for services at the designated location as arranged by MDOC Supervising Agent. The PIHP/Provider may not deny an individual an in-person assessment via phone screening.

Assessments must be conducted in accordance with MDHHS-approved assessment instruments (if any) and admissions decisions based on MDHHS-approved medical necessity criteria included in this contract. In the case of MDOC supervised individuals, these assessments should include consideration of the individual’s presenting symptoms and substance use/abuse history prior to and during incarceration and consideration of their SUD treatment history while incarcerated. To the extent consistent with HIPAA, the Michigan Mental Health Code and 42 CFR Part 2, and with the written consent of the individual, the PIHP/Provider will provide notice of an admission decision to the MDOC Supervising Agent within one business day, and if accepted, the name and contact information of the individual’s treatment provider. If the individual is not referred for treatment services, the PIHP/Provider will provide information regarding community resources such as AA/NA or other support groups to the individual.

PIHP/Providers will not honor MDOC Supervising Agent requests or proscriptions for level or duration of care, services or supports and will base admission and treatment decisions only on medical necessity criteria and professional assessment factors.

1. **PLAN OF SERVICE**

The individual’s individualized master treatment plan shall be developed in a manner consistent with the principles of person-centered planning as applicable to individuals receiving treatment for substance use disorders as defined in this contract and applicable portions of contract 1.General Requirements; E. Access and Availability; 9

The PIHP/Provider agrees to inform the MDOC Supervising Agent when Medication Assisted Treatment (MAT) is being used, including medication type. If the medication type changes, the PIHP/Provider must inform the MDOC Supervising Agent.

1. **RESIDENTIAL SERVICES**

If an individual referred for residential treatment does not appear for or is determined not to meet medical necessity criteria for that level of care, the MDOC Supervising Agent will be notified with one business day. If an individual is participating in residential treatment, the individual may not be given unsupervised day passes, furloughs, etc. without consultation with the MDOC Supervising Agent. Leaves for any non-emergent medical procedure should be reviewed/coordinated with the MDOC Supervising Agent. If an individual leaves an off-site supervised therapeutic activity without proper leave to do so, the PIHP/Provider must notify the MDOC Supervising Agent by the end of the day on which the event occurred.

The PIHP/Provider may require individuals participating in residential treatment to submit to drug testing when returning from off property activities and any other time there is a suspicion of use. Positive drug test results and drug test refusals must be reported to the MDOC Supervising Agent.

Additional reporting notifications for individuals receiving residential care include:

• Death of an individual under supervision.

• Relocation of an individual’s placement for more than 24 hours.

• The PIHP/Provider must immediately and no more than one hour from awareness of the occurrence, notify the MDOC Supervising Agent any serious sentinel event by or upon an individual under MDOC supervision while on the treatment premises or while on authorized leaves.

• The PIHP/Provider must notify the MDOC Supervising Agent of any criminal activity involving an MDOC supervised individual within one hour of learning of the activity.

1. **SERVICE PARTICIPATION:**

Provider must complete a monthly progress report on each individual on a template supplied by the MDOC and will send securely to the MDOC Supervising Agent by the 5th day of the following month.

The PIHP/Provider must not terminate any referred individual from treatment for violation of the program rules and regulations without prior notification to the individual’s MDOC Supervising Agent, except in extreme circumstances. The PIHP/Provider must collaborate with the MDOC for any non-emergency removal of the referred individual and allow the MDOC time to develop a transportation plan and a supervision plan prior to removal.

PIHP will ensure a recovery plan is completed and sent to the MDOC Supervising Agent within five business days of discharge. Recovery planning must include a customer’s acknowledgment of the plan and the Contractor’s referral of the customer to the prescribed aftercare services.

1. **Primary Care Coordination**

Provider must take all appropriate steps to assure that substance use disorder treatment services are coordinated with primary health care. Treatment case files must include, at minimum, the primary care physician’s name and address, a signed release of information for purposes of coordination, or a statement that the client has refused to sign a release. If no primary care physician exists, treatment case files shall include documentation of a referral to a primary care physician with follow-up documentation.

Care coordination agreements or joint referral agreements, by themselves, are not sufficient to show that the Provider has taken all appropriate steps related to coordination of care. Client case file documentation is also necessary.

1. **Satisfaction Surveys**

Provider shall cooperate with annual satisfaction surveys conducted by Payor. Surveys may be conducted by individual providers or may be conducted centrally by Payor. Clients may be active clients or clients discharged up to 12 months prior to their participation in the survey. Surveys may be conducted by mail, telephone, or face-to-face. Provider shall assist Payor in satisfying survey requirements, as required by Payor. Client Satisfaction Surveys will be completed as scheduled.

1. **Services for Pregnant Women, Primary Caregiver with Dependent Children, Caregiver Attempting to Regain Custody of Their Children**

The Provider must assure that it and its providers screen and/or assess pregnant women, primary caregivers with dependent children, and primary Caregivers attempting to regain custody of their children to determine whether these individuals need and request the defined federal services that are listed below. All federally mandated services must be made available.

1. **Federal Requirements.** Federal requirements are contained in 45 CFR (Part 96) section 96.124, and may be summarized as:

Providers receiving funding from the state-administered funds set aside for pregnant women and women with dependent children must provide or arrange for the 5 types of services, as listed below. Use of state administered funds to purchase primary medical care and primary pediatric care must be approved, in writing, in advance, by the Department contract manager.

* 1. Primary medical care for women, including referral for prenatal care if pregnant, and while the women are receiving such treatment, child care;
	2. Primary pediatric care for their children, including immunizations;
	3. Gender specific substance use disorders treatment and other therapeutic interventions for women, which may address issues of relationships, sexual and physical abuse, parenting, and childcare while the women are receiving these services;
	4. Therapeutic interventions for children in custody of women in treatment, which may, among other things, address their developmental needs, issues of sexual and physical abuse, and neglect; and
	5. Sufficient case management and transportation to ensure that women and their dependent children have access to the above mentioned services.

The above five types of services may be provided through this Agreement only when no other source of support is available and when no other source is financially responsible. MDHHS extends the federal requirements above to primary caregivers attempting to regain custody of their children or at risk of losing custody of their children due to a substance use disorder. These individuals are a priority service population in Michigan and; therefore, the five federal requirements listed above shall be made available to them.

1. **Requirements Regarding Providers**. Women’s Specialty Services may only be provided by providers that are designated as gender-responsive by the Department or as gender-competent by Payor and that meet standard panel eligibility requirements. Provider may be designated by the Department as Women’s Specialty providers, but such designation is not required. Payor must continue to provide choice from a list of providers who offer gender-competent treatment and identify providers that provide the additional services specified in the federal requirements.
2. **Treatment Episode Data Set (TEDS).** For TEDS reporting purposes, Payor must code ‘yes’ for all women eligible for and receiving qualified women’s specialty services. At admission, this can be coded based on eligibility. To qualify, the women must be either pregnant, have custody of a minor child, or be seeking to regain custody of a minor child. At minimum, the provider must be certified by the agency as gender competent. Provider shall submit reports to Payor as determined by Payor to satisfy these requirements.
3. **Cultural Competence**

The SUD Services provided by the Provider shall demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area. Such commitment includes acceptance and respect for the cultural values, beliefs and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services.

The Provider shall participate in the Payor’s efforts to promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

1. **Beneficiary Service Records**

The Provider shall ensure that it establishes and maintains a comprehensive individual service record system consistent with the provisions of MSA Policy Bulletins, and appropriate state and federal statutes. The Provider shall ensure that providers maintain in a legible manner, via hard copy or electronic storage/imaging, recipient service records necessary to fully disclose and document the quantity, quality, appropriateness, and timeliness of services provided. The records shall be retained according to the retention schedules in place by the Department of Management and Budget (DTMB) General Schedule #20 at: http://michigan.gov/dmb/0,4568,7150-9141\_21738\_31548-56101--,00.html. This requirement must be extended to all of the Provider's provider agencies.

1. **Other Service Requirements**

The Provider shall assure services are planned and delivered in a manner that reflects the values and expectations contained in the following guidelines attached to the MDHHS/PIHP Master Contract:

1. Inclusion Practice Guideline (1.General Requirements; K, Quality Improvement; 5)

In addition, the Provider must disseminate all practice guidelines it uses upon request to beneficiaries.

1. **Advance Directives**

The Provider shall provide adult Customers with written information on advance directive policies and a description of applicable state law and their rights under applicable laws. This information must be continuously updated to reflect any changes in state law as soon as possible but no later than 90 days after it becomes effective. The Provider must inform individuals that grievances concerning noncompliance with the advance directive requirements may be filed with Payor’s Customer Services department.

1. **Communicable Diseases**

The Provider is required to ensure the confidentiality of identified HIV-positive consumers, and must have procedures and/or policies to ensure protection of the consumer’s HIV status. The Provider must adhere to the Department’s Prevention Policy #02, Addressing Communicable Disease Issues in the Substance Abuse Service Network. The provider must assure that all provider staff have knowledge of the content areas as indicated in MDHHS/OROSC - Prevention Policy #02, Addressing Communicable Diseases Issues in the Substance Abuse Service Network, effective January 1, 2012. All staff with direct consumer contact must have a minimum of Level 1 Minimum Knowledge training. Training can be found on the Improving Practices website (https://www.improvingmipractices.org)

* + 1. Treatment providers must make available for persons receiving substance abuse services, either directly or through referral, tuberculosis (TB) treatment. If referred, responsibility extends to ensuring that the agency to which the consumer is referred has the capacity to provide these services.
1. Treatment providers must have in place and demonstrate compliance with procedures for the appropriate screening of all substance abuse consumers entering treatment for risk of HIV/AIDS, Sexually Transmitted Disease (STD), TB and Hepatitis. Provider assures that all consumers reimbursed with state funds have been provided with basic information on HIV/AIDS, Tuberculosis, Hepatitis and STD’s. In addition, treatment providers are required to provide basic information on risk. Consumers identified with high-risk behaviors must be provided additional information on resources available, health education and risk reduction activities and referral to testing and treatment (with follow-up).
2. Treatment providers must provide appropriate referral to Hepatitis C testing for all consumers with a history of injecting drug use. Treatment providers must provide appropriate referral for STD and HIV testing for all pregnant women.
3. Residential treatment providers must assure all consumers entering residential treatment are tested for TB upon admission, and that test results be known within five days of a residential treatment admission. Sub-acute detoxification treatment providers must complete a TB risk assessment as soon as practicable after admission and make a referral for TB testing for those consumers at high risk for TB. In the case of consumers who are at high risk for TB, the residential and sub-acute detoxification treatment provider must assure that universal precautions are followed. Consumers who exhibit symptoms of active TB need to be given a surgical mask to wear and placed in respiratory isolation immediately. If facility does not have the capability to place people in respiratory isolation, the consumer should be moved to a hospital or other location where they will not be a danger to those around them, until test.
4. The Payor prohibits the utilization of block grant funds for the distribution of sterile needles for injection of any illegal drug.
5. **Use of the Payor Clinical Assessment**

Provider shall complete the clinical assessment by utilizing Payor’s software.

1. **Regulatory Management**

The Provider shall have an established process for carrying out corporate compliance activities, to include Fraud, Waste, and Abuse. The process shall include promulgation of policy that specifies procedures and standards of conduct that articulate the Provider’s commitment to comply with all applicable Federal and State standards.

1. **Fetal Alcohol Spectrum Disorders**

SUD treatment programs are in a unique position to have an impact on the fetal alcohol spectrum disorder (FASD) problem in two ways. First, it is required that these programs include FASD prevention within their treatment regimen for those women that are included in the selective or indicated group based on Institute of Medicine (IOM) prevention categories. Second, for those treatment programs that have contact with the children born to women who have used alcohol it is required that the program screen these children for FASD and, if appropriate, refer for further diagnostics services.

1. **FASD Prevention Activities**

FASD prevention should be a part of all SUD treatment programs that serve women. Providing education on the risks of drinking during pregnancy and FASD detection and services are easily incorporated into the treatment regimes.

The IOM Committee to Study Fetal Alcohol Syndrome has recommended three prevention approaches. The universal approach involves educating the public and influencing public policies. The selective approach is targeting interventions to groups that have increased risk for FASD problems such as women of childbearing age that drink. The indicated approach looks at groups who have already exhibited risk behaviors, such as, pregnant women who are drinking or who gave birth to a child who has been diagnosed with FASD. This policy recommends using one of the FASD prevention curriculums for women in the selected or indicated group

1. **FASD Screening**

For any treatment program that serves women, it is required that the program complete the FASD prescreen for children that they interact with during their mother’s treatment episode. SUD clinicians do not need to be able to diagnose a child with any disorder in the spectrum of FASD, but do need to be able to screen for the conditions of FASD and make the proper referrals for diagnosis and treatment. The decision to make a referral can be difficult. When dealing with the biological family, issues of social stigma, denial, guilt and shame may surface. For adoptive families, knowledge of alcohol use during pregnancy maybe limited. The following guidelines were developed to assist clinicians in making the decision as to whether a referral is needed. Each case should be evaluated individually. However, if there is any doubt, a referral to a FAS diagnostic clinic should be made.

The following circumstances should prompt a clinician to complete a screen to determine if there is a need for a diagnostic referral:

1. When prenatal alcohol exposure is known and other FAS characteristics are present, a child should be referred for a full FASD evaluation when substantial prenatal alcohol use by the mother (i.e., seven or more drinks per week, three or more drinks on multiple occasions, or both) has been confirmed.
2. When substantial prenatal alcohol exposure is known, in the absence of any other positive criteria (i.e., small size, facial abnormalities, or central nervous system problems), the primary care physician should document exposure and monitor the child for developmental problems.
3. When information regarding prenatal exposure is unknown, a child should be referred for a full FASD evaluation for any one of the following:
4. Any report of concern by a parent or caregiver that a child has or might have FASD
5. Presence of all three facial features
6. Presence of one or more facial features with growth deficits in weight, height or both
7. Presence of one or more facial features with one or more central nervous system problems
8. Presence of one or more facial features with growth deficits and one or more central nervous system problems
9. There are family situations or histories that also may indicate the need for a referral for a diagnostic evaluation. The possibility of prenatal exposure should be considered for children in families who have experienced one or more of the following:
10. Premature maternal death related to alcohol use (either disease or trauma)
11. Living with an alcoholic parent
12. Current or history of abuse or neglect
13. Current or history of involvement with Child’s Protective Services
14. A history of transient care giving institutions
15. Foster or adoptive placements (including kinship care)

The Fetal Alcohol Syndrome (FAS) Pre-Screen Form can be used to complete the screening process. It also lists the fetal alcohol diagnostic clinics located in Michigan with telephone numbers for easy referral. These clinics complete FASD evaluations and diagnostic services. The clinics also identify and facilitate appropriate health care, education and community services needed by persons diagnosed with FAS.

1. **Intensive Outpatient Treatment – Weekly Format**

Provider may provide Intensive outpatient treatment (IOP) only if the treatment consists of regularly scheduled treatment, usually group therapy, within a structured program, for at least three days and at least nine hours per week. Intensive outpatient treatment must be authorized in accordance with the SUD Provider Manual.

1. **Outpatient Treatment**

Determination of treatment pathway shall be individualized and based on the individual determination of needs, per the BHI-MV. Outpatient treatment services must be authorized and provided in accordance with the SUD Provider Manual.

1. **Early Intervention**

Determination of treatment pathway shall be individualized and based on the individual determination of needs. Early Intervention services must be authorized and provided in accordance with the SUD Provider Manual.

1. **Residential Treatment**

Determination of treatment pathway shall be individualized and based on the individual determination of needs. Residential treatment services must be authorized and provided in accordance with the SUD Provider Manual.

1. **Opioid Treatment Services**.
2. **Determination of Needs/Individualized Treatment**

Determination of treatment pathway shall be individualized and based on the current clinical status of a patient in conjunction with current research/best practice protocols for their need. There shall be no “automatic” determination of whether a client is served in a drug free or medication-assisted setting.

SUD Services to persons who are opioid dependent shall be provided in accordance with one of the three current FDA approved medication assisted treatments for opioid dependence unless medically contraindicated. Medications shall be initiated, adjusted and/or discontinued as medically warranted, but there shall be no arbitrary termination of medication treatment simply because a client has been in care for a specified amount of time. Nor shall dosage be limited or imposed on the basis of policy requirements if they are at odds with current medical practice standards. Treatment of opioid dependence shall combine identified counseling/behavioral health therapies in conjunction with the FDA approved medication. Opioid treatment services must be authorized in accordance with the SUD Provider Manual.

1. **Standards for the Provision of Medication Assisted Treatment**

The National Institute on Drug Addiction (NIDA), the American Society of Addiction Medicine (ASAM) and the American Medical Association (AMA) have all identified addiction as a chronic and often relapsing brain disease.

All Medication Assisted Treatment (MAT) services provided to individuals identified as opioid dependent/addicted shall:

1. Be based on current research related to opioid dependence/ addiction.
2. Consist of treatment services that are a combination of outpatient therapy utilizing DBT, CBT, Contingency Therapy, and one of the three FDA approved medications as an adjunct therapy (Buprenorphine, Naltrexone). Counseling and medication therapies are to be offered within the same facility.
3. Not use urine drug screens as the sole determination for discharge, or as a predictor of current or future treatment success.
4. Acknowledge that relapse is a natural part of the disease of addiction.
5. Not consider abstinence as a requirement or the only required goal for treatment. Treatment goals shall address recovery markers such as: employment, participation in school, stable housing, sustained periods using only the MAT medication and other prescribed medication as instructed, taper/reduction in OTP medication, reunification/sustained unification of family, and involvement in the community.
6. Comply with the requirements in R 325.14418.
7. Comply with all application Medication Assisted Treatment Guidelines and/or Treatment Policies
8. **Detoxification Services**

Detoxification is identified as the stabilization of the medical effects of withdrawal from alcohol or other drugs and to the referral to the ongoing treatment and/or support services.

1. **Definition of Service**
2. A Covered Person must be admitted to the detoxification facility and be “in residence” for not less than twelve (12) hours.
3. NMRE will reimburse services if the client is a resident within the NMRE region. Residency requirements may be waived by NMRE in certain circumstances such as if the individual meets a priority population definition, lives in a contiguous county or is homeless. Requests for a waiver must be made in writing to the NMRE.

In addition to stabilization, services should include support and referral to ongoing treatment and/or support services.

1. **Other Requirements**
2. Sub-acute detoxification programs may not deny service to persons on the basis of drug of choice or the drug that is involved in the sub-acute detoxification request. This provision is subordinate to other admission criteria including the list of DSM V Diagnosis noted in Sub acute detoxification services are restricted to the treatment of withdrawal diagnosis.
3. Detoxification programs are not required to seek prior authorization for detoxification services except as otherwise may be required in this contract.
4. Detoxification services must be authorized in accordance with the NMRE SUD Provider Manual.
5. **STATE DISABILITY ASSISTANCE (SDA) REQUIREMENTS**

The Provider shall not refuse treatment services to an individual solely on the basis of the individual’s current or past involvement with the criminal justice system. To be eligible for funding through the SDA Room and Board Services in a Substance Use Disorder Treatment program, a person must meet the following criteria:

1. Meet Department of Human Services (DHS) cash asset limit of $15,000 and show proof of U.S. citizenship or have an acceptable alien status. In addition the client must be determined to be eligible for an incidental allowance through DHS. The DHS approval letter must be maintained in the client file.
2. Assessed by the regional Access Center to be in need of residential treatment services and authorized by NMRE for residential treatment
3. In residence in a residential treatment program each day that SDA payments are made.
4. Be at least 18 years of age.

Since the Department’s allocation of SDA funding to the region is not adequate to meet utilization throughout the fiscal year, if the client resides within the NMRE region, the Provider should continue to seek authorization from NMRE and submit service claims to the NMRE in a separate claims batch. SDA funding must be authorized in accordance with the NMRE SUD Provider Manual.

SDA funds shall be used for residential services only.

1. **STAFFING AND TRAINING REQUIREMENTS**
2. **Coverage**

The Provider shall provide the staff necessary to provide the SUD Services required under this Agreement and ensure SUD Services are in compliance with applicable requirements set forth herein, including without limitation Section XXII. The Provider shall notify the Payor’s EO or the EO’s designated representative immediately whenever:

1. The Provider’s staffing for SUD Services required under this Agreement has not been or cannot be provided; or,
2. The need for SUD Services to the Customer(s) is otherwise less than or greater than the Provider’s staffing level(s) agreed upon by the parties.
3. **Consistency/Cultural Competency**

The Provider shall maintain staffing consistency and programming continuity in the provision of SUD Services to Customers under this Agreement. The Provider shall ensure that all SUD Services are provided by staff in a manner that demonstrates cultural competency.

1. **Staff Development**

The Provider shall ensure continuous staff development of its employees and Subcontracted staff, if any, to maintain quality SUD Services as required by the Payor for the purposes of this Agreement. If the Provider determines that additional professional training is required in order for its staff to perform SUD Services or to maintain professional licenses, certifications, and authorizations required under this Agreement, the Provider shall be solely responsible for obtaining such training and for any related costs.

1. **MDHHS Training**

The Provider shall ensure compliance with MDHHS and Payor training requirements. The Provider shall submit documentation to the Payor for attendance and participation in training activities.

1. All staff with direct client contact shall have a minimum of Level I Minimum Knowledge training.
2. Annual continuing education
3. **BILLINGS / PAYMENTS**
4. **SUD Community Grant and Medicaid Fee-for-Service Payments**

Billing codes and rates for SUD Community Grant and Medicaid fee-for-service services, are set forth in Exhibit D and Attachment 1.

1. **Coordination of Benefits**

For the purposes of this Agreement, the Provider shall be responsible for the coordination of public and private benefits of each Customer under this Agreement. The Provider acknowledges that the Payor shall be the payor of last resort for Payor-authorized SUD Services to Payor-authorized Customers under this Agreement. The payments from the Payor to the Provider are intended only to cover the allowable costs of the SUD Services net of and not otherwise covered by payments provided by other funding sources.

1. **First and Third Party Liability Requirements**

The Provider shall identify and seek recovery from all liable parties, and report such efforts and recoveries to the Payor as outlined by the Payor, pursuant to federal and State requirements. If a liable party exists, the Provider must seek reimbursement from that party prior to requesting payment from Payor or coordinate the transfer or referral.

1. **Clean Claims**

All billings or requirements for fee-for-service reimbursement by the Provider shall be supported by source documentation on costs and services acceptable to the Payor. The Provider shall submit Clean Claims for SUD services rendered within sixty days (60) after the date of service. The Payor shall conduct verification reviews to substantiate claims received by the Provider. Only those services in which appropriate authorizations were obtained and appropriate documentation completed and submitted shall be reimbursed by the Payor. The Payor shall ensure payment to the Provider of Clean Claims within thirty (30) days of receipt of a complete and accurate invoice statement.

Reimbursement shall be contingent upon obtaining appropriate authorizations and completing/submitting required intervention documentation for billing purposes. The Provider shall only be reimbursed for SUD Services if the Provider meets the Payor’s credentialing and competency requirements.

1. **Payment in Full**

Payments from the Payor to the Provider for SUD Services rendered by the Provider to Customers under this Agreement shall constitute payment in full. The Provider shall be solely responsible for its payment obligations and payments to its employees and subcontracted staff, if any, for performing SUD Services required of the Provider under this Agreement. Such payments shall be made on a timely basis and on a valid clean claim basis.

The Provider and/or its employees and subcontracted staff shall not seek or collect any SUD Service fee payments directly from Customers, 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 employees and any subcontracted staff shall not require any co-payments, recipient pay amounts, or other cost sharing arrangements for the Provider’s SUD Services required under this Agreement and/or for SUD Services of its employees or any Subcontracted staff, unless specifically authorized by the Payor or the State or federal regulations and/or policies.
2. The Provider and/or its employees and any subcontracted staff shall not bill individuals for any difference between a service charge of the Provider or its employees or any subcontracted staff and the Payor’s payment for the Provider’s services required under this Agreement.
3. The Provider and/or employees and any subcontracted staff shall not seek nor accept additional supplemental payments from the individual, his/her family, or representative, for the Provider’s SUD Services and/or for the SUD Services of its employees or subcontracted staff.
4. Providers will abide by the Medicaid Manual stating that the provider is not to charge the beneficiary of Medicaid services.
5. **Sliding Fee Scale and Ability to Pay**

As required in the MDHHS/PIHP Master Contract, Part II(B) Section 5.5, the Provider shall adhere to the Payor’s sliding fee scale as identified in Exhibit B. All treatment and prevention providers shall utilize the Payor’s sliding fee scale. The sliding fee scale is established according to the most recent year’s Federal Poverty Guidelines at the time of contract generation as listed in Exhibit B.

The Provider must adhere to the Payor’s written policies and implement procedures to be used in determining an individual’s ability or inability to pay, when payment liability is to be waived, and in identifying all other liable third parties. The Provider must also adhere to the Payor’s policies and procedures for monitoring providers and for sanctioning noncompliance.

Financial information needed to determine ability to pay (financial responsibility) must be reviewed annually or at a change in an individual’s financial status, whichever occurs sooner, by the Payor.

The sliding fee scale must be applied to all persons (except Medicaid and MIChild) seeking SUD Services funded in whole or in part by the Payor.

Services may not be denied because of inability to pay. If a person’s income falls within the Provider’s regional sliding fee scale, clinical need must be determined through the standard assessment and patient placement process. If a financially and clinically eligible person has third party insurance, that insurance must be utilized to its full extent. Then, if benefits are exhausted, or if the person needs a service not fully covered by that third-party insurance, or if the co-pay or deductible amount is greater than the person’s ability to pay, SUD Community Grant funds may be applied. SUD Community Grant funds may not be denied solely on the basis of a person having third party insurance.

1. **Account Reconciliation**

Upon completion of 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 the 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 the Provider have not exceeded the Payor’s obligations under this Agreement. Said contract reconciliation shall be completed in full compliance with the MDHHS/PIHP Master Contract 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.

1. **Billings / Payments**

All billings or requirements for reimbursement by the Provider shall be supported by source documentation on costs and services acceptable to the Payor. The Payor shall conduct verification reviews to substantiate claims received by the Provider. Only those services in which appropriate authorizations were obtained and appropriate documentation completed and submitted shall be reimbursed by the Payor. The Payor shall ensure payment to the Provider of Clean Claims within thirty (30) days of receipt of a complete and accurate invoice statement.

Reimbursement shall be contingent upon obtaining appropriate authorizations and completing/submitting required intervention documentation for billing purposes. The Provider shall only be reimbursed for SUD Services if the Provider meets the Payor’s credentialing and competency requirements.

Any SUD Services rendered by the Provider under this Agreement shall be authorized according to Payor policy.

1. **Refunding of Payments**

The Provider shall not bill the Payor for SUD Services rendered under this Agreement in any instances in which the Provider received monies directly for SUD 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. If at any time it is determined, after SUD Services claims reimbursement to the Provider have been paid by the Payor, that the Provider received monies directly for the SUD 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. The Provider shall notify the Payor immediately of any such payments.

1. **Disallowed Expenditures and Financial Repayments**

In the event that 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 under this Agreement for fees, services claims and/or cost claims which are later disallowed, the Provider shall fully repay the Payor for such disallowed payments within sixty (60) days of the Payor’s final disposition notification of the disallowances, unless the Payor authorizes, in writing, additional time for repayment.

1. **QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT / PERFORMANCE INDICATORS / CUSTOMER ASSESSMENTS AND OUTCOMES / MANAGEMENT STUDIES.**
2. **Program**

The Provider, pursuant to this Agreement, shall meet the Quality Assessment / Performance Improvement Program (QAPIP) SUD requirements and standards of the Payor in accordance with the MDHHS/PIHP Master Contract.

1. **Performance**

The Provider shall meet the performance indicators set forth in the attached Exhibit E which is incorporated herein by reference and made a part hereof.

1. **The Payor’s Program**

The Provider agrees, pursuant to this Agreement, to cooperate fully in the Payor’s implementation of:

1. Performance improvement projects;
2. Quantitative and qualitative Customer assessments periodically, including Customer surveys, focus groups and other Customer 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.
6. **Material Breach**

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.

1. **NOTICE OF MATERIAL CHANGE IN FINANCIAL POSITION.**
2. **Notice**

The Providershall furnish the Payor with immediate notice of any change in financial position material to its ability to pay debts when due per federal and State requirements, regardless of whether its assets exceed liabilities and it continues as a going concern at any time during the term of this Agreement.

1. **RECORD ACCESS/INVESTIGATION/SITE REVIEW**
2. **Access**

The Payor, the federal government, the State of Michigan, or 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. All financial, administrative and clinical records pertaining to this Agreement must be retained according to the retention schedules in place by DTMB’s General Schedule #, unless these records are transferred to a successor organization or as otherwise directed in writing by MDHHS.

1. **Other Access**

The Omnibus Reconciliation Act of 1980 (Public Law 96-499) provides for access to the books and records of subcontractors of Medicare providers by the Secretary of Health and Human Services and the Comptroller General. Specifically, Section 952 of the Act prohibits payments under Medicare for services furnished for a provider by any of its subcontractors, where the cost or value of the contract over twelve (12) months is Ten Thousand and No/100 Dollars ($10,000.00) or more, unless such contract contains a provision allowing the Secretary of Health and Human Services and Comptroller General access to the contract, as well as books, documents, and records of the subcontractors which are necessary to verify the costs of the services under the contract. Access must be provided for ten (10) years after the provision of services. The Parties therefore agree to provide such access, as applicable. All books and records related to this Agreement shall be subject to audit and inspection by agents and representatives of the State of Michigan and the federal government, when appropriate. The provisions of Section XXI shall survive termination of this Agreement.

1. **Compliance**

The Provider agrees to provide access to the Provider’s Executive Officer or his designated representative(s) to evaluate, through survey, inspection or other means on a retrospective or current basis, the appropriateness, quality, and timeliness of services performed and compliance with program/service standards required hereunder.

1. **Evaluation**

The parties hereto agree that the State Medicaid Agency 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.

1. **Site Reviews**

The Payor shall conduct or cause to be conducted annual on‑site reviews of the Provider to determine compliance with Payor’s provider network requirements including without limitation Provider’s compliance with recipient rights and confidentiality requirements under the Mental Health Code. In that regard, the Provider agrees to the following:

1. The Provider shall reasonably cooperate with all site reviews;
2. The Payor retains the right to conduct site visit reviews without prior notification, in which event the Provider shall cooperate with Payor to provided unimpeded access.
3. The Payor or its designee shall prepare a written report of its site review findings. Said report shall not contain any information prohibited from use or disclosure under the Mental Health Code, Public Health Code or HIPAA;
4. The Payor or its designee may share its site review findings and written report with other PIHPs or community mental health services programs, upon request and as determined by the Payor;
5. Notwithstanding anything to the contrary contained in this Agreement, the Payor may also obtain site review findings and reports regarding the Provider from other PIHPs or CMHSPs, and the Payor may utilize such information in the exercise of its rights under this Agreement.
6. The Payor retains the right to seek additional information or take further actions following the Provider site review, including without limitation conducting follow up site reviews;
7. All final determinations, management actions and network status decisions concerning the Provider that are based on or related to site review findings, shall be made exclusively by the Payor;
8. The Provider, its attorneys, assignees, transferors, transferees, principals, partners, officers, directors, employees, servants, subsidiaries, parent corporations, affiliates, successors, agents, and representatives, agree not to pursue any and all claims demands, damages, debts, liabilities, obligations, contracts, agreements, causes of action, suits and costs, of whatever nature, character or description, whether known or unknown, suspected or unsuspected, anticipated or unanticipated, which the Provider may claim to have against the Payor arising out of the site review, the site review report or the sharing of the site review findings or site review report, except for those claims directly related to payment from the Payor to the Provider.
9. **Provider Grievances**

The Provider agrees to adhere to the Payor’s policies and procedures governing provider grievances, disputes and appeals, including without limitation any grievance, dispute or appeal of changes in the Provider’s status as a provider in the Payor’s provider network.

1. **Material Breach**

Refusal by the Provider to allow the Payor, the federal government, the State of Michigan or their designated representatives access to the Provider records, programs 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.

1. **COMPLIANCE IN GENERAL**
2. **Laws**

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. Pursuant to MDHHS/PIHP Master Contract, Sections 13.0 and 18.0, the Provider, its principals, officers, employees, servants, and agents shall perform all their respective duties and obligations under this Agreement in compliance with all applicable: federal, State, and local laws, ordinances, rules and regulations, including but not limited to the following:

1. **Michigan’s State Plan under Title XIX of the Social Security Act** and Michigan’s Medicaid Provider Manual and Medicaid Policies and Guidelines;
2. **The Anti-Lobbying Act, 31 USC 1352** as revised by the Lobbying Disclosure Act of 1995, 2 USC 1601 et seq., and Section 503 of the Departments of Labor, Health and Human Services and Education
3. **The Balanced Budget Act of 1997** (“BBA”), as amended, and final rule 42 CFR Part 438;
4. **The Provider agrees to adhere to the Office of Civil Rights Policy Guidance on Title VI Prohibition Against Discrimination** as it affects persons with Limited English Proficiency;
5. In accordance with 42 CFR 422.128 and 42 CFR 438.6, the Payor shall maintain, and the Provider shall adhere to, written policies and procedures for advance directives. The Provider shall provide adult beneficiaries with written information on advance directive policies and a description of applicable state law and their rights under applicable laws. This information must be continuously updated to reflect any changes in state law as soon as possible but no later than 90 days after it becomes effective. The Provider must inform individuals that grievances concerning noncompliance with the advance directive requirements may be filed with Payor’s Customer Services;
6. The Payor’s policies and procedures governing provider grievances, disputes and appeals, including without limitation any grievance, dispute or appeal of changes in the Provider’s status as a provider in the Payor’s provider network.
7. 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.);

(Contracts in excess of $100,000). Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.), as amended -- Contracts and sub-grants of amounts in excess of $100,000 shall contain a provision that requires the recipient to agree to 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.). Violations shall be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

1. **The Hatch Political Activity Act**, 5 U.S.C.1501-1508, and Intergovernmental Personnel Act of 1970, as amended by Title VI of the Civil Service Reform Act, P.L. 95-454, 42 U.S.C. 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.
2. **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 by 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 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. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law 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. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity. The Provider also assures that this language will be included in any sub-awards that contain provisions for children's services.

The Provider also assures, in addition to compliance with Public Law 103-227, any service or activity funded in whole or in part through this agreement will be delivered in a smoke-free facility or environment. Smoking shall not permitted anywhere in the facility, or those parts of the facility under the control of the Provider. 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.

1. **Confidentiality.** To the extent that Payor and Provider are HIPAA Covered Entities and/or Programs under 42 CFR Part 2, each agrees that it will comply with HIPAA’s Privacy Rule, Security Rule, Transaction and Code Set Rule and Breach Notification Rule and 42 CFR Part 2 (as now existing and as may be later amended) with respect to all Protected Health Information and substance use disorder treatment information that it generates, receives, maintains, uses, discloses or transmits in the performance of its functions pursuant to this Agreement. To the extent that Provider determines that it is a HIPAA Business Associate of Payor and/or a Qualified Service Organization of Payor, then Payor and Provider shall enter into a HIPAA Business Associate Agreement and a Qualified Service Organization Agreement that complies with applicable laws and is in a form acceptable to both Payor and Provider.

Payor and the Provider shall maintain the confidentiality, security and integrity of beneficiary information that is used in connection with the performance of this contract to the extent and under the conditions specified in HIPAA, the Michigan Mental Health Code (PA 258 of 1974, as amended), the Michigan Public Health Code (PA 368 of 1978 as amended), and 42 C.F.R. Part 2.

1. **Byrd Anti-Lobbying Amendment**. 31 U.S.C. 1352 and 45 CFR Part 93. No appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
2. **Davis-Bacon Act**. (All contracts in excess of $2,000). (40 U.S.C. 276a to a-7) -- When required by Federal program legislation, all construction contracts awarded by the recipients and sub-recipients of more than $2,000 shall include a provision for compliance with the Davis-Bacon Act (40 U.S.C. 276a to a-7) and as supplemented by Department of Labor regulations (29 CFR part 5), "Labor Standards Provisions Applicable to Contracts Governing Federally Financed and Assisted Construction"). Under this act, contractors shall be required to pay wages to laborers and mechanics at a rate not less than the minimum wages specified in a wage determination made by the Secretary of Labor. In addition, contractors shall be required to pay wages not less than once a week. The recipient shall place a copy of the current prevailing wage determination issued by the Department of Labor in each solicitation and the award of a contract shall be conditioned upon the acceptance of the wage determination. The recipient shall report all suspected or reported violations to the federal awarding agency.
3. **Contract Work Hours and Safety Standards**. (All contracts in excess of $2,000 for construction and $2,500 employing mechanics or laborers). (40 U.S.C. 327 - 333) -- Where applicable, all contracts awarded by recipients in excess of $2,000 for construction contracts and in excess of $2,500 for other contracts that involve the employment of mechanics or laborers shall include a provision for compliance with Sections 102 and 107 of the Contract Work Hours and Safety Standards Act (40 U.S.C. 327 - 333), as supplemented by Department of Labor regulations (29 CFR part 5). Under Section 102 of the Act, each contractor shall be required to compute the wages of every mechanic and laborer on the basis of a standard workweek of 40 hours. Work in excess of the standard workweek is permissible provided that the worker is compensated at a rate of not less than 1 and 1/2 times the basic rate of pay for all hours worked in excess of 40 hours in the workweek. Section 107 of the Act is applicable to construction work and provides that no laborer or mechanic shall be required to work in surroundings or under working conditions that are unsanitary, hazardous or dangerous. These requirements do not apply to the purchases of supplies or materials or articles ordinarily available on the open market, or contracts for transportation or transmission of intelligence.
4. **Rights to Inventions Made Under a Contract or Agreement**. (All contracts containing experimental, developmental, or research work). Contracts or agreements for the performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and the recipient in any resulting invention in accordance with 37 CFR part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations issued by the awarding agency.
5. **Special Waiver Provisions for MSSSP**. Michigan’s Specialty Services and Supports Waiver Program authorized under 1915(b)(1), (3) and (4) of the Social Security Act is currently approved until September 30, 2014.

The 1915(b) Waiver is concurrent with a five-year 1915(c) waiver, referred to as the Home and Community-Based Habilitation Supports Waiver, serving people with a developmental disability, is currently approved until September 30, 2015. Under these waivers, beneficiaries are entitled to specified medically necessary specialty supports and services from the Provider.

1. **Conflict of Interest**. 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 MDHHS or any of its constituent institutions, an employee of the Payor, or 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. Breach of this covenant may be regarded as a material breach of the Agreement and may be a cause for termination thereof by the Payor.
2. **Human Subject Research**. Protection of Human Subjects Act, 45 CFR, Part 46, subpart A, sections 46.101-124 and HIPAA. The Provider agrees that prior to the initiation of the research, the Provider will submit institutional Review Board (IRB) application material for all research involving human subjects, which is conducted in programs sponsored by the Department or in programs which receive funding from or through the State of Michigan, to the Department’s IRB for review and approval, or the IRB application and approval materials for acceptance of the review of another IRB. All such research must be approved by a federally assured IRB, but the Department’s IRB can only accept the review and approval of another institution’s IRB under a formally-approved interdepartmental agreement. The manner of the review will be agreed upon between the Department’s IRB Chairperson and the Contractor’s IRB Chairperson or Executive Officer(s).
3. **SUD Administrative Rules**:
4. Program Match Requirements, R 325.4151 - 325.4156
5. Substance Use Disorders Service Program, R 325.14101 - 325.14125
6. Licensing of Substance Use Disorder Programs, R 325.14201 - 325.14214
7. Recipient Rights, R 325.14301 - 325.14306
8. Methadone Treatment and Other Chemotherapy, R 325.14401 - 325.14423
9. Case-finding, R 325.14601 - 325.14623
10. Outpatient Programs, R 325.14701 - 325.14712
11. Inpatient Programs, R 325.14801 - 325.14807
12. Residential Program, R 325.14901 - 325.14928.
13. **Michigan Mental Health Code and Administrative Rules.**
14. **Michigan Public Health Code and Administrative Rules.**
15. **Waivers.** Approved Medicaid Waivers and corresponding CMS conditions, including 1915(b), (c) and 1115 Demonstration Waivers.
16. **MDHHS Appropriations Acts** in effect during the contract period.
17. **Michigan Medicaid Provider Manual.**
18. **MSA Policy Bulletin Number: MSA 13-09.**
19. **SUD.** Provider’s Substance Use Disorder service delivery system shall comply with:
20. The **Drug Abuse Office and Treatment Act** of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse;
21. The **Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act** of 1970 (P.L. 91-616) as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism;
22. §§523 and 527 of the **Public Health Service Act** of 1912 (42 U.S.C. §§290 dd-3 and 290 ee 3), as amended, relating to confidentiality of alcohol and drug abuse patient records
23. Any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and,
24. The requirements of any other nondiscrimination statute(s) which may apply to the application.
25. **1978 PA 368, Public Health Code**, health reporting requirements. The Provider agrees to ensure compliance with all such reporting requirements through its provider contracts
26. Sections from PL 102-321, as amended, that apply to PIHPs and contractors include but are not limited to:
27. 1921(b)
28. 1922 (a)(1)(2)
29. 1922(b)(1)(2)
30. 1923
31. 1923(a)(1) and (2), and 1923(b
32. 1924(a)(1)(A) and (B
33. 1924(c)(2)(A) and (B)
34. 1927(a)(1) and (2), and 1927(b)(1)
35. 1927(b)(2): 1928(b) and (c)
36. 1929
37. 1931(a)(1)(A), (B), (C), (D), (E) and (F)
38. 1932(b)(1)
39. 1941
40. 1942(a)
41. 1943(b)
42. 1947(a)(1) and (2).
43. **Subsequent Rules or Regulations.** 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 hereto, but the parties hereto retain the right to exercise any remedies available to them by law or by any other provisions of this Agreement.
44. **Material Breach**. 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.
45. **NONDISCRIMINATION**
46. **Laws**

In performing their duties and responsibilities under this Agreement, the parties hereto shall comply with all applicable federal and State laws, rules and regulations prohibiting discrimination.

1. The parties hereto shall not discriminate against any employee or applicant for employment with respect to hire, tenure, terms, conditions, or privileges of employment or a matter directly or indirectly related to employment because of race, color, religion, national origin, age, sex, height, weight, marital status, physical or mental disability unrelated to the individual’s ability to perform the duties of the particular job or position, as required pursuant to the Elliott Larsen Civil Rights Act of 1976 PA 453, as amended and Section 504 of the Federal Rehabilitation Act 1973, PL 93‑112, 87 Stat. 394.
2. The parties hereto shall comply with the provisions of the Michigan Persons With Disabilities Civil Rights Act of 1976 PA 220, as amended, and Section 504 of the Federal Rehabilitation Act of 1973 P.L. 93-112, 87 Stat 394, as amended.
3. The Provider shall comply with MCL 15.342 Public Officer or Employee prohibited conduct, the Americans with Disabilities Act of 1990 (ADA), P.L. 101-336, 104 Stat 328 (42 USCA S 12101 et seq.), as amended; the Age Discrimination Act of 1973; the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964; and Title IX of the Education Amendments of 1972.
4. For purposes of this Section XXIII, Employee shall be defined as an individual classified or unclassified, of the executive branch of this state. For the purpose of section 2b of MCL 15.341, employee shall include an employee of this state or a political subdivision of this state. Public Officer shall be defined as a person appointed by the governor or another executive department official. For the purpose of section 2b of MCL 15.341, public officer shall include an elected or appointed official of this state or a political subdivision of this state.
5. Each of the parties hereto shall not refuse to treat nor will they discriminate in the treatment of any beneficiary or referral, under this Agreement, based on the individual's source of payment for services, or on the basis of age, sex, height, weight, marital status, arrest record, race, creed, handicap, color, national origin or ancestry, religion, political affiliation or beliefs, or involuntary patient status.
6. **Material Breach**

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.

1. **HEALTH AND SAFETY OF CUSTOMERS/ENROLLEE RIGHTS/ CUSTOMER GRIEVANCE PROCEDURES**
2. **Health and Safety**

The Provider shall monitor the health, safety and welfare of each beneficiary while he or she is under its service supervision pursuant to this Agreement. The Provider agrees to immediately notify the Payor of any event that meets the Payor’s standards for event reporting, including without limitation sentinel event, critical incident and risk event reports, all as defined by MDHHS. The deadlines for reporting these events are set forth in the Payor’s Critical Incident Policy. It is the responsibility of the Provider to monitor the health, safety and welfare of each recipient of SUD Services and to take appropriate action if there is an identified risk to a recipient’s health, safety or welfare.

1. **Mental Health Code**

Each party hereto shall strictly comply with all Recipient Rights provisions of the Mental Health Code and the MDHHS Rules. Customers shall be protected from violations of recipient rights while they are receiving services under this Agreement.

1. **Notice of Action Forms**

The Provider ensures that Notice of Action forms are in compliance with the Balanced Budget Act of 1997 and MDHHS requirements. Also, the Provider will ensure that all Notice of Action Requirements, as set forth in the MDHHS Technical Requirements (July, 2020) are met when services requested have been denied, suspended, terminated, reduced or unreasonably delayed. State mandated form will be utilized as directed.

1. **Sentinel Events**

The Provider agrees to furnish the Payor’s Executive Officer or designated representative with immediate notice of any Sentinel Event involving any recipient of SUD Services hereunder.

1. **Reporting Events**

The Provider shall report events to the Payor in accordance with federal and State laws, regulations and rules and the Payor’s contractual obligations under the MDHHS/PIHP Master Contract.

1. **Recipient Rights**

The provider shall strictly comply with all Recipient Rights provisions of the Mental Health Code, Public Health Code, and of the MDHHS Rules. The Provider agrees to post a copy of Payor-provided Summary of Rights, as guaranteed by the Mental Health Code and the MDHHS Rules, in a conspicuous place in each building where consumers are served. The Consumers shall be protected from rights violations while they are receiving supports/services under this Agreement. The Provider shall report all alleged rights violations regarding a Consumer hereunder to the Payor’s Office of Recipient Rights designated staff representative in writing on Payor-designated forms. Provider shall notify Payor of the number and nature of all recipient rights complaints in each month by no later than the 10th of the following month.

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 Office, policies, procedures, and process and agrees to implement appropriate remedial action for substantiated violations of 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.

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.

1. **Response to Complaints**

Each party hereto 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 recipients or potential Customers.

A beneficiary or an applicant for public substance use disorder services may access several options to pursue resolution of complaints regarding services and supports managed and/or delivered under this Agreement. The Provider will ensure that beneficiaries are given written information as to what their Appeal and Grievance Rights are and what procedural options exist to resolve service delivery disputes. The Provider must inform beneficiaries of their right to an administrative fair hearing following appeal of an Adverse Benefit Determination. Provider shall notify Payor’s Customer Service Specialist of the number and nature of Customer grievances and complaints each month prior to the 10th of following month.

1. **Access by Payor**

The Provider agrees that the Payor’s Recipient Rights Office representatives shall

have unimpeded access at any time to any Consumer and all applicable staff,

supports/services records, and supports/services of the Provider pursuant to this

Agreement, 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 complaints. Access to Provider’s training records also shall be provided to the Payor’s Recipient Rights Officer.

1. **Regulatory Agency**

The Provider’s Chief Executive Officer or Executive Director shall inform, in writing, the Payor’s Executive Officer 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 recipient of SUD Services under this Agreement. The Provider also shall inform, in writing, the Payor’s Executive Officer immediately of any subsequent findings, recommendations, and results of such notices, inquiries, or investigations.

1. **Beneficiary Transfer**

Each partyhereto agrees that if the health or safety of any beneficiary is in jeopardy, the Provider shall arrange for the immediate transfer of that individual to another provider.

1. **Health Care Practitioner Discretions**

Provider shall not prohibit any of its providers, acting within their lawful scope of practice, from advocating on behalf of a beneficiary in any grievance or utilization review process, or individual authorization process to obtain necessary health care services including:

1. For the beneficiary’s health status, medical care or treatment options, including any alternative treatment that may be self-administered;
2. For any information the beneficiary needs in order to decide among all relevant treatment options;
3. For the risks, benefits and consequences of treatment or non-treatment; and
4. For the beneficiary’s right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions.
5. **Material Breach**

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.

1. **CUSTOMER RECORDS/ESTABLISHMENT/RETENTION/ACCESS/RELEASE/ CONFIDENTIALITY**
2. **Customer Record**

The Providershall establish and maintain a comprehensive individual service record system consistent with the provisions of MSA Policy Bulletins, and appropriate State and federal statutes. Individual service record content shall comply with 42 CFR 456.111 and 456.211. The Provider shall maintain in a legible manner, recipient service records necessary to fully disclose and document the quantity, quality, appropriateness and timeliness of services provided. The records shall be retained according to the retention schedules in place by the DTMB’s General Schedule #20 at: http://michigan.gov/dmb/0,4568,7-150-9141\_21738\_31548-56101--,00.html. The Provider must comply with 45 CFR Part 164 requirements to allow beneficiaries to inspect and obtain a copy of protected health information.

The Provider shall serve as the holder of record for all Customer records maintained by the Provider under this Agreement for purposes of assuring that the Payor has full access to such records for services hereunder to beneficiaries.

1. **Confidentiality**

All Customer 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 laws and regulations. The Provider must provide safeguards that restrict the use or disclosure of information concerning beneficiaries as required by State and federal laws and regulations.

Because of the nature of the relationship between the parties hereto, there shall be an ongoing exchange of confidential information relating to beneficiaries served under this Agreement. Each party hereto, its officers, employees, servants, agents and its Subcontractors shall comply with all applicable federal and State laws, rules and regulations, including HIPAA, the Mental Health Code, P.A. 258 of 1974, the Public Health Code, PA 368 of 1978, 42 C.F.R. Part 2 and the MDHHS Rules on confidentiality.

1. **RELATIONSHIP OF THE PARTIES**
2. **Independent Contractor.**

In performing their duties and responsibilities under this Agreement, it is expressly understood and agreed that the relationship between the parties hereto is that of an independent contractor. This Agreement shall not be construed to establish any principal/agent or employer/employee relationship between the parties hereto.

1. **MDHHS**

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

1. **Employees of Parties**

It is expressly understood and agreed that the employees, servants and agents of any of the parties to this Agreement shall not be deemed to be and shall not hold themselves out as the employees, servants or agents of the other parties. Each of the parties to this Agreement shall be responsible for withholding and payment of all income and social security taxes to the proper federal, State, and local governments for its employees.

1. **Employee Benefits**

The employees of each of the parties hereto shall not be entitled to any fringe benefits otherwise provided by any of the other parties to its employees, such as, but not limited to, health and accident insurance, life insurance, paid vacation leave, paid sick leave, and longevity. Each of the parties hereto shall carry workers' compensation and unemployment compensation coverage for its employees, as required by law.

1. **LIABILITY**
2. **Payor**

All liability to third parties, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities to be carried out by the Payor in the performance of this Agreement shall be the sole and non-transferable responsibility of the Payor, and not the responsibility of the Provider, if the liability, loss, or damage is caused by, or arises out of, the actions or failure to act by the Payor, its board members, officers, employees or representatives; provided that nothing herein shall be construed as a waiver of any governmental immunity that has been provided to the Payor, its board members, officers, employees or representatives, by statute or court decisions.

1. **Provider**

All liability to third parties, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities to be carried out by the Provider in the performance of this Agreement shall be the sole and non-transferable responsibility of the Provider, and not the responsibility of Payor, if the liability, loss, or damage is caused by, or arises out of, the actions or failure to act by the Provider, its board members, officers, employees or representatives; provided that nothing herein shall be construed as a waiver of any governmental immunity that has been provided to the Provider, its board members, officers, employees or representatives, by statute or court decisions.

1. **Legal Representation**

Each party to this Agreement must seek its own legal representative and bear its own costs including judgments in any litigation which may arise out of its obligations under this Agreement. It is specifically understood and agreed that neither party will indemnify the other party in such litigation.

1. **Joint Liability**

In the event that liability to third parties, loss or damage arises as a result of activities conducted jointly by the parties hereto in fulfillment of their responsibilities under this Agreement, such liability, loss, or damage shall be borne by each party in relation to each party’s responsibilities under the joint activities, provided that nothing herein shall be construed as a waiver of any public or governmental immunity granted to any of the parties hereto as provided by applicable statutes and/or court decisions.

1. **Notice Legal Action**

The Provider and Payor agree that written notification shall take place immediately of pending legal action that may result in an action naming the other or that may result in a judgment that would limit the Provider's ability to continue service delivery at the current level. This includes actions filed in courts or by governmental regulatory agencies.

1. **LIABILITY INSURANCE**
2. **Insurance**

The Provider shall procure, pay the premium on, keep and maintain during the term of this Agreement, liability insurance coverage for all services to be performed 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 $1,000,000.00 per claim.
4. General Liability Insurance (occurrence basis only) with the following coverage inclusions:
5. Broad Form General Liability Endorsement or equivalent, if not in policy proper.
6. Independent Contractor Liability Insurance coverage.
7. Contractual Liability.
8. Limits of Liability for Item 4 above shall not be less than $1,000,000.00 per occurrence, and/or aggregate, combined single limit for Personal Injury, Bodily Injury and Property Damage.
9. **Certification**

The Provider shall submit certification of its insurance coverage to the Payor prior to the execution of this Agreement. The certificates of insurance for the Provider shall contain a provision stating that coverages afforded under the policies will not be changed or canceled until at least thirty (30) days prior written notice has been given to the Payor. The Provider shall provide the Payor with written notification at least thirty (30) days prior to any reduction or termination of the insurance coverage required herein.

1. **Other Insurance**

The Provider shall maintain such other insurance as it deems appropriate for its own protection.

1. **Breach**

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.

1. **MISCELLANEOUS PROVISIONS**
2. **Laws**

Federal requirements deriving from Public Law 102-321, as amended by Public Law 106-310, and federal regulations in 45 CFR Part 96 are pass-through requirements. Federal Substance Abuse Prevention and Treatment (SAPT) SUD Community Grant requirements that are applicable to states are passed on to PIHPs unless otherwise specified.

1. **Regulations**

42 CFR Parts 54 and 54a, and 45 CFR Parts 96, 260, and 1050, pertaining to the final rules for the Charitable Choice Provisions and Regulations.

1. **Program Operation**

The Provider shall provide the necessary administrative, professional, and technical staff for operation of the program.

1. **Notification of Modifications**

The Provider shall provide timely notification to the Payor, in writing, of any action by its governing board or any other funding source that would require or result in significant modification in the provision of services, funding or compliance with operational procedures.

1. **Notification of Provider Changes**

Provider shall notify Payor immediately of changes to the location or street address of services provided and applicable remittance or billing address changes.

1. **Software Compliance**

The Provider must ensure software compliance and compatibility with the PIHP’s data systems for services provided under this agreement for the production of work products and reports. All required data under this agreement shall be provided in an accurate and timely manner without interruption, failure or errors due to the inaccuracy of the Contractor’s business operations for processing date/time data.

1. **SAMHSA/DHHS License**

The federal awarding agency, Substance abuse and Mental Health Services Administration, Department of Health and Human Services (SAMHSA/DHHS), reserves a royalty-free, nonexclusive and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, for federal government purposes: (a) The copyright in any work developed under a grant, sub-grant, or contract under a grant or sub-grant; and (b) Any rights of copyright to which a grantee, sub-grantee or a contractor purchases ownership with grant support.

1. **Monitoring of Designated Women’s Subcontractors**

The Payor is required to monitor all Designated Women’s Programs (DWP) for the following:

1. Outreach activities to promote and advertise women’s programming and priority population status.
2. Gender-Responsive policy for treating the population.
3. Education/Training of staff identified as women’s specialty clinicians and supervisors. Required 12 semester hours equivalent to 64 workshop type training hours.
4. **Publication Rights**

Provider shall be subject to the terms and conditions imposed on Payor concerning publication rights under the MDHHS/PIHP Master Contract, Part I, Section 8.0.

1. **Notice**

Any and all notices, designations, consents, offers, acceptances or other communications herein shall be given to either party, in writing, by facsimile, electronic transmission, personal delivery or deposited in certified mail to the Executive Officer of the party at the address as shown in the introductory paragraph of this Agreement (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.

1. **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.

1. **Provider 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 and the Provider’s Subcontractors, in performing services required hereunder, shall fully cooperate with the other contractors of the Payor. The requirements of such cooperation shall not interfere with the Provider in the performing of the services required under this Agreement.

1. **Time of the Essence**

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

1. **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.

1. **Return of Property**

Upon the termination of this Agreement, each party hereto shall return immediately all documents, correspondence, files, records, papers or other property of any kind of the other party.

1. **Disclosure**

All information in this Agreement is subject to the provisions of the Freedom of Information Act, 1976 PA 442, as amended, MCL 15.231, et seq.

1. **MONITORING THE AGREEMENT**
2. **Oversight**

The Payor retains full oversight and monitoring responsibility and authority for all activities under this Agreement, and all activities must be carried out in accordance with applicable State and federal laws and regulations, MDHHS/PIHP Master Contract and the Payor policies and standards. The Payor shall have access to the Provider’s records, as permitted by law, which the Payor deems necessary to carry out the Payor’s oversight and monitoring functions. The performance of the terms of this Agreement shall be monitored on an ongoing basis by both of the designated representatives of the Payor and of the Provider.

1. **Liaison**

The Executive Officer of the Payor and the Chief Executive Officer or Executive Director of the Provider shall appoint administrative liaisons to be available to communicate with the liaisons of the other party in the performance of this Agreement.

1. **Provider Inability to Provide Services**

In the event that circumstances occur that reduces or otherwise interfere with the ability of the Provider to provide or maintain the specified services or operational procedures delegated to and/or required of the Provider under this Agreement, the Provider shall immediately notify the Payor. A meeting between the designated representatives of the Payor and of the Provider shall be convened as soon as possible in order to determine the immediate course of action and possible resolution of the situation.

1. **SANCTIONS**
2. **General**

The Payor may utilize a variety of means; such as formal written notice of contract violation, plan of correction, or referral moratorium, to assure the Provider’s compliance with the requirements set forth in this Agreement. The Payor may pursue remedial actions and possible sanctions as needed to resolve outstanding contract violations and performance concerns.

The following are examples of compliance or performance problems for which remedial actions including sanctions can be applied to address repeated or substantial breaches, or reflect a pattern of non-compliance or substantial poor performance. This listing is not meant to be exhaustive, but only representative.

1. Reporting timeliness, quality and accuracy
2. Performance Indicator Standards
3. Repeated Site-Review non-compliance (repeated failure on same item)
4. Substantial or repeated health and/or safety violations.
5. Lack of service documentation to meet Medicaid and/or other payor requirements

The Provider may utilize the dispute resolution process set forth in this Agreement to dispute a contract compliance notice issued by the Payor.

1. **Uncured Deficiencies**

Substantial failure by the Provider to fulfill its obligations hereunder, which is not cured within the time period specified in Section VII may result in the termination of this Agreement for material breach or sanctions.

1. **RESOLUTION OF CONTRACT ISSUES AND DISPUTES**
2. **Disputes**

Disputes that fall outside of section VII of this agreements that cannot be resolved through amiable discussion will be resolved as follows:

1. The Payor’s designee and the Provider’s CEO/Executive Director or designee will attempt to resolve the dispute through discussion with each other.
2. If the dispute continues to be unresolved to the satisfaction of the Payor and/or the Provider, both parties to the dispute will provide written descriptions of the issue in dispute and propose a solution to the Payor’s CEO within 15 (fifteen) calendar days or within agreed upon timeframe by involved parties. The Payor’s CEO will have thirty (30) calendar days or a mutually agreed upon timeframe to provide a written decision.
3. If the Payor and/or the Provider remain dissatisfied, mediation, arbitration or legal recourse as provided by law may be sought.
4. **Other Recourse**

Each party hereto maintains the right to seek recourse, at its option, through legal remedies in a court of competent jurisdiction after exhausting its rights and obligations under the Payor’s policies and procedures governing provider grievances as set forth in Section XIX, paragraph F.

1. **Uninterrupted Payments**

Notwithstanding any other provision in this Agreement, the parties hereto agree that the payments of funds due and payable from the Payor to the Provider under this Agreement shall not be stopped, interrupted, reduced, or otherwise delayed as a consequence of the pendent status of any dispute arising under this Agreement.

1. **WAIVERS**
2. **No Waiver**

No failure or delay on the part of any of the parties to this Agreement in exercising any right, power or privilege hereunder shall operate as a waiver, thereof, nor shall a single or partial exercise of any right, power or privilege preclude any other further exercise of any other right, power or privilege. In no event shall the making by the 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.

1. **Amendment**

Modifications, amendments, or waivers of any provision of this Agreement may be made only by the written consent of all the parties to this Agreement.

1. **ASSIGNMENT**
2. **Consent**

The Provider shall not assign this Agreement nor any of its rights or obligations hereunder, without the prior written consent of the Payor, nor shall the duties imposed upon the Provider herein, including without limitation any managed care function, be delegated by the Provider without the prior written consent of the Payor. The provision of substance use disorder services may not be subcontracted or delegated, with the exception of contracting with the Provider’s staff to provide such services. Any such attempted assignment, delegation or subcontracting in violation of this Section shall be void at initiation.

1. **Successors and Permitted Assigns**

This Agreement shall be binding upon the parties hereto and their respective successors and permitted assigns.

1. **DISREGARDING TITLES**

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

1. **COMPLETENESS OF THE AGREEMENT**

This Agreement, the attached Exhibits, and the additional and supplementary documents incorporated herein by specific reference contain all the terms and conditions agreed upon by the Payor and the Provider, and no other agreements, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind either the Payor or the Provider, except for that certain Memorandum of Understanding between the parties hereto having the same term as this Agreement and the Operating Agreement by and between the Payor and the Participating CMHSPs.

1. **SEVERABILITY AND INTENT**
2. **Invalid Provision**

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.

1. **Removal of Provision**

If 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.

1. **No Third Party Beneficiary**

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

1. **CERTIFICATION OF AUTHORITY TO SIGN THIS 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. This Agreement shall be deemed executed, valid, enforceable and binding upon the parties once signed in handwriting or by any electronic means, and may be delivered by facsimile or electronic transmission.

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

**NORTHERN MICHIGAN REGIONAL ENTITY**

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

Eric Kurtz Date

Chief Executive Officer

**Provider name**

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

Provider Authorized Representative Signature Date

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

Provider Authorized Representative Printed Name, Title

**EXHIBIT A: CUSTOMER POPULATION**

The Customer population and eligibility criteria for Medicaid SUD Services and SUD Community Grant Services under this Agreement shall be those required of Payor in the MDHHS/PIHP Master Contract, and in Chapter III of the MDHHS Medical Services Administrative Policy Manual, as revised, as well as **Exhibit B**.

**EXHIBIT B: CUSTOMER POPULATION AND ELIGIBILITY
CRITERIA FOR SUD SERVICES**

Customers for SUD Services under this Agreement are those individuals identified in **Exhibit A** and are receiving SUD treatment, prevention or early intervention services under this Agreement.

For treatment services, the Provider must ensure that SUD Services authorization and reauthorization are consistent with the following:

**Medical Necessity Criteria for SUD Services:**

* Necessary for screening and assessing the presence of a substance use disorder; and/or
* Required to identify and evaluate a SUD; and/or
* Intended to treat, ameliorate, diminish or stabilize the symptoms of substance use disorder;
* Expected to arrest or delay the progression of a SUD; and/or
* Designed to assist the individual to attain or maintain a sufficient level of function in order to achieve his/her goals of community inclusion and participation, independence, recovery or productivity.
* The determination of a medically necessary SUD Service must be:
	+ Based on information provided by the individual, individual’s family, and/or other individuals (e.g., friends, personal assistants/aide) who know the individual; and
	+ Based on clinical information from the individual’s primary care physician or clinicians with relevant qualifications who have evaluated the individual; and
	+ Based on individualized treatment planning; and
	+ Made by appropriately trained SUD professionals with sufficient clinical experience; and
	+ Made within federal and State standards for timeliness; and
	+ Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
* SUD services authorized by the Payormust be:
	+ Delivered in accordance with federal and State standards for timeliness in a location that is accessible to the individual; and
	+ Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
	+ Provided in the least restrictive, most integrated setting. Residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
	+ Delivered consistent with, where they exist, available research findings, health care practice guidelines and standards of practice issued by professionally recognized organizations or government agencies.
* Using criteria for medical necessity, a Provider and/or Payor may:
	+ Deny services a) that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care; b) that are experimental or investigational in nature; or c) for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support, that otherwise satisfies the standards for medically-necessary services; and/or
	+ Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.
	+ May not deny services solely based on PRESET limits of the cost, amount, scope, and duration of services; but instead determination of the need for services shall be conducted on an individualized basis. This does not preclude the establishment of quantitative benefit limits that are based on industry standards and consistent with the above, and that are provisional and subject to modification based on individual clinical needs and clinical progress.
	+ Services may not be denied because of inability to pay. If a person’s income falls within the Payor’s regional sliding fee scale, clinical need must be determined through the standard assessment and patient placement process. If a financially and clinically eligible person has third party insurance, that insurance must be utilized to its full extent. Then, if benefits are exhausted, or if the person needs a SUD Service not fully covered by that third-party insurance, or if the co-pay or deductible amount is greater than the person’s ability to pay, Community Grant funds may be applied. SUD Community Grant funds may not be denied solely on the basis of a person having third party insurance.

**Clinical Eligibility: DSM – Diagnosis.** In order to be eligible for SUD Treatment Services purchased in whole or part by state-administered funds under this Agreement, an individual must be found to meet the criteria for a primary diagnosis for one or more selected substance use disorders found in the Diagnostic and Statistical Manual of Mental Disorders (DSM 5). These disorders are listed below. This requirement is not intended to prohibit use of these funds for family therapy. It is recognized that persons receiving family therapy do not necessarily have substance use disorders.

Cannabis Related Disorders:

Cannabis Use Disorder – Mild/Moderate/Severe/Intoxication/Withdrawal

Unspecified Cannabis-Related Disorder

Hallucinogen Related Disorders:

Phencyclidine Use Disorder – Mild/Moderate/Severe/Intoxication

Unspecified Phencyclidine Related Disorder

Other Hallucinogen Use Disorder – Mild/Moderate/Severe/Intoxication

Hallucinogen Persisting Perception Disorder

Unspecified Hallucinogen Related Disorder

Inhalant Related Disorders:

Inhalant Use Disorder – Mild/Moderate/Severe/Intoxication

Unspecified Inhalant Related Disorder

Opioid Related Disorder:

Opioid Use Disorder – Mild/Moderate/Severe/Intoxication

Opioid Withdrawal

Unspecified Opioid Related Disorder

Sedative, Hypnotic, or Anxiolytic (SHA) Related Disorders

SHA – Mild/Moderate/Severe/Intoxication

SHA – Withdrawal delirium/withdrawal with perceptual disturbances

SHA – Without perceptual disturbances

Unspecified SHA Related Disorder

Stimulant Related Disorders:

Stimulant Use Disorder

Amphetamine-type substance use disorder, Mild/Moderate/Severe

Other or Unspecified Stimulant – Mild/Moderate/Severe

Cocaine – Mild/Moderate/Severe/Withdrawal

Stimulant Intoxication

Amphetamine or other stimulant, without perceptual disturbances

Amphetamine or other stimulant, with perceptual disturbances

Cocaine, without perceptual disturbances/with perceptual disturbances

Stimulant Withdrawal

Unspecified Stimulant Related Disorder

Alcohol Use Disorders

Alcohol Use Disorder – Mild/Moderate/Severe

Alcohol Intoxication

Alcohol Withdrawal delirium

Alcohol Withdrawal, with perceptual disturbances/without perceptual disturbances

Unspecified Alcohol-Related Disorder

Other (unknown) Substance Related Disorders:

Other (unknown) Substance Use Disorder – Mild/Moderate/Severe/Intoxication

Other (unknown) Substance Withdrawal

Unspecified Other (unknown) Substance Related Disorder

**Block Grant Financial Eligibility:** In order to be eligible for Substance Use Treatment Services through the Community Block Grant, an individual must meet the household income listed below.

**General Information**:

**Other Insurance**: The collection and reporting of third party fees earned by the provider must be the first source of funding for clients as NMRE is the payer of last resort. Community Block Grant funding may be utilized for clients in which the third-party benefits have been exhausted or the service the individual meets criteria for is not covered by the third party benefit. It is the provider’s responsibility to develop and maintain policies and procedures regarding the collection and reporting of client fees and payments received.

**Client Income Eligibility**: The fee scale set forth in this policy outlines the total household income allowable by family size. Clients whose current projected household income falls within the guidelines identified in the current year’s contractual agreement are eligible for Community Block Grant funding. Financial information needed to determine financial responsibility must be reviewed every six months or at a change in financial situation. Annual income eligibility guidelines are based on a percentage of the most recent poverty guidelines at the time of contract generation as listed in **Exhibit B** below.

**Income Verification**: An income verification form is to be completed for each NMRE client utilizing Community Block Grant funding except for Room and Board services. The form must be signed by the client. Proof of income must also be documented within the client file. If proof of income does not exist, a statement written and signed by the client documenting why no proof of income exists must be included within the client file. If utilizing an electronic record, statements typed into the record are allowable as long as a client signature is included.

**Co-Payments**: The rates NMRE will pay are subject to a co-payment for services funded by Community Block Grant. Co-payments may be waived or reduced by the Program Director or designee; this waiver must be based upon individual circumstances. It is the provider’s responsibility to develop and maintain policies and procedures regarding guidelines for waiving co-payments.

**Sliding Fee Scale:**

**Northern Michigan Regional Entity**

**FY 2023 Income Eligibility**

|  |  |  |  |
| --- | --- | --- | --- |
| **Minimum Family Size** | **Maximum Family Size** | **Minimum Income** | **Maximum Income** |
| 1 | 1 | $0 | $25,760 |
| 1 | 2 | $0 | $34,840  |
| 1 | 3 | $0 | $43,920 |
| 1 | 4 | $0 | $53,000 |
| 1 | 5 | $0 | $62,080 |
| 1 | 6 | $0 | $71,160 |
| 1 | 7 | $0 | $80,240 |
| 1 | 8\* | $0 | $89,320 |

 \*For each additional family member, add $4,540

Sliding fee scale based upon 2022 poverty guidelines Effective: 1/13/2022

Services are subject to applicable co-payment benefit limitations for Community Block Grant funding and other contractual requirements. Medicaid, Healthy Michigan and MIChild funding are not subject to co-payment benefit limitations and may not include any form of client payment.

**Income Verification/Fee Agreement**

**Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family Size:**

|  |  |
| --- | --- |
| Client | 1 |
|  |  |
| Number of people, other than the client, living in the household |  |
|  |  |
| **Total Household** |  |

**Income:**

 **Please use annual income information (projecting forward).**

Gross Salaries, Wages Etc. $\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Income:

 Alimony $\_\_\_\_\_\_\_\_\_\_\_\_\_

 Child Support $\_\_\_\_\_\_\_\_\_\_\_\_\_

 Social Security $\_\_\_\_\_\_\_\_\_\_\_\_\_

 Unemployment $\_\_\_\_\_\_\_\_\_\_\_\_\_

 Workers Compensation $\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other (Describe):

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_

 Total Income $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

+++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++

*I hereby certify that the income/dependent information shown above is a true and correct statement. Based upon this information it has been determined that I will be responsible for a fee of $ \_\_\_\_\_\_\_ per individual session or $\_\_\_\_\_\_\_\_\_\_ per group session.*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ / \_\_\_\_ / \_\_\_\_*

 *Client Signature Date*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ / \_\_\_\_ / \_\_\_\_*

 *Witnessed by Date*

(Note: if the fee is reduced or waived the Program Director or designee must be the witness signature)

**This form should be reviewed annually or at any change in financial status.**

**EXHIBIT C: SERVICE ACCESS / PREAUTHORIZATIONS / DELIVERY /
UTILIZATION MANAGEMENT PROCEDURES**

* + - 1. Customer eligibility and appropriateness must be clearly documented prior to the provision of SUD Services.
			2. Any SUD Services to be provided by the Provider for a Customer must be included in an individualized written plan of service which is signed by the Customer.
			3. Any SUD Services from the Provider under this Agreement for reimbursement by the Payor must follow established authorization protocols and the Payor’s policies. Prior authorization prospectively addresses the eligibility of services for payment under the Payor’s policies. Decisions are made based on the medical necessity criteria. Level of care determination is based upon ASAM Patient Placement Criteria.
			4. The Provider will ensure that SUD Services provided to a Customer will be medically necessary and meet applicable criteria. Documentation must clearly demonstrate which SUD Service was provided and that the SUD Service was medically necessary. Notes will accurately reflect the therapeutic techniques, skills, and progress made in session.

**EXHIBIT D: BILLING OF AND PAYMENTS FOR VALID SERVICE
REIMBURSEMENT CLAIMS**

* + - 1. Payor shall make contract payments to Provider in accordance with requirements of the MDHHS/PIHP Master Contract, applicable State and federal laws, and Medicaid regulations. Medicaid cannot and will not be utilized to pay for room and board while a Customer is receiving services at a residential substance use disorder treatment facility. Payment for residential services is solely for treatment provided while at residential facilities.

The methodology for reimbursement from the Payor to the Provider for valid claims for authorized covered services rendered by the Provider under this Agreement shall be on a per unit rate(s). The per unit rate(s) to be paid by the Payor to the Provider as reimbursement for valid claims for Payor-authorized covered services rendered by the Provider during the term of this Agreement shall be as listed on Attachment 5: SUD Service Rates and Modifiers.. The Provider shall only be eligible for payment for codes listed on Attachment 1 under ASAM Levels of Care for which Provider is approved by the MDHHS.

* + - 1. The Provider shall be solely responsible for transportation of its staff 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’s staff 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.
			2. The Provider shall submit claims no less than monthly for each month in which Payor-authorized services are rendered under this Agreement. In order to be considered valid claims for which payments from the Payor may be made, the Provider’s billing of covered services claims must be received by the Payor within sixty (60) days following the completion of the month in which the services were rendered by the Provider hereunder with the exception of consumers with first and third party insurance. The Payor shall authorize and 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, MDHHS, Medicaid, and/or third party reimbursers and is on file currently. If the Provider’s services and service documentation are not in compliance with the reimbursement requirements of MDHHS, the Payor, Medicaid, and/or third party reimbursers, the Provider shall not be paid and/or shall return payments received from the Payor in such instances.

* + - 1. Upon completion of 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 the 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 the Provider have not exceeded the Payor’s obligations under this Agreement. Said contract reconciliation shall be completed in full compliance with the MDHHS/PIHP Master Contract, 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 E: PERFORMANCE INDICATORS AND OBJECTIVES**

* 1. The Provider shall support and coordinate as needed with the NMRE Quality Improvement Program.
	2. The Provider shall comply with the Payor’s Clinical Protocols as set forth in the SUD Services Provider Policy Manual, which is incorporated by reference into this Agreement and made a part hereof.
	3. The Provider agrees to cooperate fully in the Payor’s implementation of: (1.) quantitative and qualitative member assessments periodically, including Customer satisfaction surveys and other Customer feedback methodologies; and, (2.) studies to regularly review outcomes for service recipients as a result of programs, treatment, and community services rendered to individuals in community settings and (3.) the Payor’s comprehensive, continuous, integrated system of care for persons with co-occurring mental illness and SUD. (4.) the Payor’s contract monitoring performed annually (minimally). Contract monitoring may be completed by an appointed representative.
	4. The Provider will be responsible to be aware of performance indicators mandated by MDHHS that apply to services provided as well as the appropriate utilization of exclusionary criteria. It is the expectation that services will be offered/provided within the timelines established by MDHHS.
1. The percentage of discharges from a SUD Detox unit who are seen for follow-up care within seven (7) days of discharge.
2. The percentage of new persons with substance use disorder receiving service within fourteen (14) days.
	1. Service Expectation
3. A current assessment is available for each Customer served.
4. Current Person Centered Treatment Plan is available. The treatment plan must be signed by the Customer.
5. The Treatment Plan must indicate the evidence based service(s) to be provided.
6. Treatment Plan reviews are available, as required by set MDHHS/OROSC Treatment Policies.
7. Evidence exists that each service provided corresponds to what is supported in the person-centered plan.
8. Each service that has been provided is supported by documentation meeting all requirements.
9. Services that are outlined in the plan are being provided.
10. Services that are outlined in the plan are provided at the intensity that is specified.
11. Services that are being provided are reviewed for progress towards the goals of the plan.
12. Claims submitted for services provided are consistent with the service that was provided and reflect the staff that provided the service.
13. Applicable licensing, certification and/or accreditation are up to date.

**EXHIBIT F: REPORTS**

The NMRE is required to submit reports to MDHHS per contractual requirements. The reports listed below are just the reports not able to be obtained elsewhere or in any other manner.

Report templates are each found on the NMRE Knowledge Base at the following URL: https://support.nmre.org/helpdesk/KB/View/32967430-sud-provider-reports-for-fy21.

Required Reports:

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| **Report** | **Timeframe** | **Due Date** |
| 90% Capacity Management Report | Monthly | Needed when a SUD Service program reaches capacity |
| Children’s Referral Report | Quarterly | The 15th of the month following the previous quarter |
| Residential Sentinel Events Summary Report | October – MarchApril - September | April 15thOctober 15th |
| Women’s Specialty Services Report | Annual | November 15th of contract year |

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**ATTACHMENT 1: Service Rates and Modifiers**

**RATES EFFECTIVE OCTOBER 1, 2022 THROUGH SEPTEMBER 30, 2023**

Provider specific services and codes will be authorized by NMRE and uploaded to the RECON System. The Provider shall only be eligible for payment for codes under ASAM Levels of Care for which it is MDHHS approved, at locations that have been approved for panel participation by the NMRE. Provider shall provide copies of current MDHHS ASAM Level approval letters upon Payor request, renewal, and initial approval. Modifier descriptions follow fee schedule.

FY2023 SUD CPT & HCPC Code Rates

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| --- | --- | --- |
| **Code** | **Description of Code** | **Rate** |
| **90832** | Individual Psychotherapy (must be masters level licensed clinician and MCBAP certified), 30 Minutes: ASAM Level(s): 1, 2 | **$64.07** |
| **90832 with HH/HG/BN/HA/HD** | Individual Psychotherapy (must be masters level licensed clinician and MCBAP certified), High-rate service modifiers, 30 Minutes: ASAM Level(s): 1, 2 | **$69.50** |
| **90832 DB** | Individual Psychotherapy as part of a DBT Specialized Program (must be masters level licensed clinician and MCBAP certified), 30 Minutes: ASAM Level(s): 1, 2 | **$78.65** |
| **90834** | Individual Psychotherapy (must be masters level licensed clinician and MCBAP certified), 45 Minutes: ASAM Level(s): 1, 2 | **$98.28** |
| **90834 with HH/HG/BN/HA/HD** | Individual Psychotherapy (must be masters level licensed clinician and MCBAP certified), High-rate service modifiers, 45 Minutes: ASAM Level(s): 1, 2 | **$104.26** |
| **90834 DB** | Individual Psychotherapy as part of a DBT Specialized Program (must be masters level licensed clinician and MCBAP certified), 45 Minutes: ASAM Level(s): 1, 2 | **$117.94** |
| **90837** | Individual Psychotherapy (must be masters level licensed clinician and MCBAP certified), 60 Minutes: ASAM Level(s): 1, 2 | **$127.06** |
| **90837 with HH/HG/BN/HA/HD** | Individual Psychotherapy (must be masters level licensed clinician and MCBAP certified) High-rate Service modifiers, 60 Minutes: ASAM Level(s): 1, 2 | **$138.47** |
| **90837 DB** | Individual Psychotherapy as part of a DBT Specialized Program (must be masters level licensed clinician and MCBAP certified), 60 Minutes: ASAM Level(s): 1, 2 | **$157.30** |
| **90846** | Family psychotherapy (without the patient present; must be masters level licensed clinician and MCBAP certified), 50 Minutes: ASAM Level(s): 1, 2 | $97.74 |
| **90847** | Family psychotherapy (with the patient present; must be masters level licensed clinician and MCBAP certified), 60 Minutes: ASAM Level(s): 1, 2 | $130.32 |
| **90849** | Family psychotherapy (must be masters level licensed clinician and MCBAP certified); multiple family group psychotherapy, Encounter: ASAM Level(s): 1, 2 | $65.16 |
| **90853** | Group psychotherapy (must be masters level licensed clinician and MCBAP certified), 60, 90, 120 minutes. Minutes: ASAM Level(s): 1, 2 | $70.59 |
| **90853 with HH/HG/BN/HA/HD** | Group psychotherapy (must be masters level licensed clinician and MCBAP certified), High-rate service modifiers, Encounter: ASAM Level(s): 1, 2 | $77.65 |
| **90853 DB** | Group psychotherapy as part of a DBT Specialized Program, (must be masters level licensed clinician and MCBAP certified), 60, 90, 120 minutes. Minutes: ASAM Level(s): 1, 2 | $108.60 |
| **97810** | Acupuncture - 1 or more needles, Initial 15 Minutes: ASAM Level(s): 1,2,3,WM | $10.86 |
| **97811** | Acupuncture - 1 or more needles, Additional 15 Minutes: ASAM Level(s): 1,2,3,WM | $5.43 |
| **A0100** | Transportation, encounter. Taxi/Uber one way fare. Pays at cost (Block Grant only) | 1 encounter per $1 cost |
| **A0110** | Transportation, encounter. Bus Pass, one way fare. Pays at cost (Block Grant only) | 1 encounter per $1 cost |
| **H0001**  | Alcohol and/or drug assessment (completed by provider) ASAM Continuum, Encounter (Minimum 60 minutes): ASAM Level(s): 1,2 | $288.33 |
| **H0001 GA** | GAIN - 1 Core Assessment, Encounter: ASAM Level(s): 1,2 | $288.33 |
| **H0004**  | Individual Therapy/Counseling (must be MCBAP certified), 15 Minutes: ASAM Level(s): 1, 2 | $26.06 |
| **H0004 with HH/HG/BN/HA/HD** | Individual Therapy/Counseling (must be MCBAP certified), High-rate service modifiers, 15 Minutes: ASAM Level(s): 1, 2 | **$**29.32 |
| **H0004DB** | Individual Therapy/Counseling as part of a DBT Specialized Program, 15 Minutes: ASAM Level(s): 1, 2 | $39.32 |
| **H0005** | Group counseling by a clinician (must be MCBAP certified), 60, 90, 120 Minutes: ASAM Level(s): 1, 2 | $65.16 |
| **H0005 with HH/HG/BN/HA/HD** | Group counseling by a clinician (must be MCBAP certified), High-rate service modifiers, Encounter: ASAM Level(s): 1, 2 | $71.68 |
| **H0005DB** | Group Counseling by a clinician as part of a DBT Specialized Program, Encounter: ASAM Level(s): 1, 2 | $108.60 |
| **H0006** | Case Management, Encounter (minimum 15 minutes): ASAM Level(s): 1, 2 | **$27.15** |
| **H0010**  | Sub-acute detoxification (residential - medical monitored detox), Day: ASAM Level(s): 3.7WM | **$428.97** |
| **H0010 with HH/HG/BN/HA/HD** | Sub-acute detoxification (residential - medical monitored detox), High-rate service modifiers Day: ASAM Level(s): 3.7WM | **$434.40** |
| **H0012**  | Sub-acute detoxification (residential - clinical detox), Day: ASAM Level(s): 3.2WM | **$347.52** |
| **H0012 with HH/HG/BN/HA/HD** | Sub-acute detoxification (residential - clinical detox), High-rate service modifiers, Day: ASAM Level(s): 3.2WM | **$352.95** |
| **H0015** | Intensive outpatient (from 9 to 19 hours of structured programming per week based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education, Day: ASAM Level(s): 2 | $162.90 |
| **H0015 with HH/HG/BN/HA/HD** | Intensive outpatient (from 9 to 19 hours of structured programming per week based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education, High-rate Service Modifiers, Day: ASAM Level(s): 2 | $179.19 |
| **H0018 W1** | Clinical low-intensity residential services, Day (30 days or less): ASAM Level(s): 3.1 | **$143.35** |
| **H0018 W1 with HH/HG/BN/HD** | Clinical low-intensity residential services, High-rate service modifiers, Day: ASAM Level(s): 3.1 | **$157.69** |
| **H0018 W1 HA** | Clinical low-intensity residential services - adolescent, Day: ASAM Level(s): 3.1 | $358.38 |
| **H0018 W3** | Clinical specific population residential services, Day (30 days or less): ASAM Level(s): 3.3 | **$209.06** |
| **H0018 W3 with HH/HG/BN/HD** | Clinical specific population residential services, High-rate service modifiers, Day (30 days or less): ASAM Level(s): 3.3 | **$229.96** |
| **H0018 W3 HA** | Clinical specific population residential services, Day (30 days or less): ASAM Level(s): 3.3 | $358.38 |
| **H0018 W5** | Clinical high-intensity residential services, Day (30 days or less): ASAM Level(s): 3.5 | **$209.06** |
| **H0018 W5 with HH/HG/BN/HD** | Clinical high-intensity residential services, High-rate service modifiers, Day (30 days or less): ASAM Level(s): 3.5 | **$229.96** |
| **H0018 W5 HA** | Clinical high-intensity residential services, Day (30 days or less): ASAM Level(s): 3.5 | $358.38 |
| **H0019 W1** | Clinical low-intensity residential services, Day (more than 30 days): ASAM Level(s): 3.1 | **$143.35** |
| **H0019 W1 with HH/HG/BN/HD** | Clinical high-intensity residential services, High-rate Service Modifiers, Day: ASAM Level(s): 3.1 | **$157.69** |
| **H0019 W1 HA** | Clinical high-intensity residential services - adolescent, Day: ASAM Level(s): 3.1 | $358.38 |
| **H0019 W3** | Clinical specific population residential services, Day (more than 30 days): ASAM Level(s): 3.3 | **$209.06** |
| **H0019 W3 with HH/HG/BN/HD** | Clinical specific population residential services, High-rate service modifiers, Day (more than 30 days): ASAM Level(s): 3.3 | **$229.96** |
| **H0019 W3 HA** | Clinical specific population residential services, Day (more than 30 days): ASAM Level(s): 3.3 | $358.38 |
| **H0019 W5** | Clinical high-intensity residential services, Day (more than 30 days): ASAM Level(s): 3.5 | **$209.06** |
| **H0019 W5 with HH/HG/BN/HD** | Clinical high-intensity residential services, High-rate service modifiers, Day (more than 30 days): ASAM Level(s): 3.5 | **$229.96** |
| **H0019 W5 HA** | Clinical high-intensity residential services, Day (more than 30 days): ASAM Level(s): 3.5 | $358.38 |
| **H0020** | Methadone administration and/or service (provision of the drug by a licensed program - combined rate of medical doctor's visits, drug testing and medication), Encounter: ASAM Level(s): 1 | **$15.20** |
| **H0022** | Early Intervention services, Encounter: ASAM Level(s): .5 | $48.87 |
| **H0038** | Self Help/Peer Services. These non-clinical services may be provided by trained staff working under the supervision of a SATS. Required staff training includes MDHHS training, or CCAR training if completed prior to 1-1-18. Documentation requirement is satisfied with a progress note. , 15 Minutes: ASAM Level(s): 1,2 | **$22.81** |
| **H0050** | Brief intervention (clinical), 15 Minutes: ASAM Level(s): .5, 1, 2 | $21.72 |
| **H2011 HF** |  Crisis Intervention, 15 Minutes: ASAM Level(s): 1 | **$35.30** |
| **H2027 HF** | Didactics (can be non-clinical), 15 Minutes: ASAM Level(s): 1 | $8.69 |
| **H2034** | Recovery Housing, Day: ASAM Level(s): 1 | **$18.46** |
| **H2036**  | Intensive outpatient (more than 20 hours of structured programming per week based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education not including overnight stays, Day: ASAM Level(s): 2 | $184.62 |
| **H2036 with HH/HG/BN/HA/HD** | Intensive outpatient (more than 20 hours of structured programming per week based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education not including overnight stays, Day: ASAM Level(s): 2 | $203.08 |
| **S0215** | Transportation, encounter. Pays per mile at the current IRS rate (Block Grant only) | IRS Mileage rate |
| **S9976** | Room and Board, Day: ASAM Level(s): 3.1, 3.2, 3.3, 3.5 3.7WM | $30.41 |
| **S9976SD** | State Disability Funded Room and Board, Day: ASAM Level(s): 3.1, 3.3, 3.5 | $30.41 |
| **T1009** | Child Care for Women's Specialty Service clients, Day: ASAM Level(s): 1,2,3 | $54.30 |
| **T1007** | Treatment Plan Development. Initial Treatment plan only. These non-clinical services may be provided by trained staff working under the supervision or an SATS. Documentation requires a dated treatment plan signed by both clinician and client., Encounter: ASAM Level(s): 1 | $97.74 |
| **T1012** | Self Help/Peer Services. These non-clinical services may be provided by trained staff working under the supervision of a SATS. Required staff training includes CCAR training. Documentation requirement is satisfied with a progress note. 15 Minutes: ASAM Level(s): 1,2 | $22.81 |
| **T2003** | Transportation, encounter. Gas Card. Pays at cost (Healthy Michigan Plan only) | $1.09 |

\*Co-Pays apply for Community Block Grant Outpatient Services ($10 for assessment services, $10 for intensive outpatient services, $2.50 per unit of individual services and $5 for group services)

\*\*Provider shall remove Food Stamp amounts received from room and board cost

FY2023 SUD CPT & HCPC Code Modifiers

|  |  |
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| **Modifier** | **Description** |
| **HD** | Women's Specialty Service |
| **HG** | OTP services for Methadone |
| **BN** | Medication Assisted Treatment for Opioid DO Services non-Methadone Services |
| **HH** | Co-Occurring Specialty Services |
| **HA** | Adolescent |
| **DB** | DBT Specialized Program |
| **GA** | GAIN Assessment |
| **W1** | Clinically Managed Low-Intensity Residential Services, adolescent and adult level of care (ASAM Level 3.1) |
| **W3** | Clinically Managed Population-Specific High-Intensity Residential Services, adult only level of care modifier used with H0018HF or H0019 with (ASAM Level 3.3) |
| **W5** | Medically Managed Medium-Intensity Residential Services for adolescents and Clinically Managed High-Intensity Residential Services for adults intermediate level of care (ASAM Level 3.5) |
| **W7** | Medically Monitored High-Intensity Inpatient Services for adolescents and Medically Monitored Intensive Inpatient Services Withdrawal Management for adults, Complex/high tech level of care (ASAM Level 3.7) |
| **SD** | State Disability Funded Room and Board  |
| **UN** | Two patients served |
| **UP** | Three patients served |
| **UQ** | Four patients served |
| **UR** | Five patients served |
| **S** | Six or more patients served |