Individual's Name: _____

OCHN CON ID: _____

Purchase of Services Agreement

This Agreement is made on _____ by and between_____ (an Individual Self-Directing Services) residing at _____ or _____ (Legal Representative on behalf of _____) (Individual), both separately and collectively herein after referred to as the Purchaser, and _____ ("Service Provider") located at _____. The purpose of this Agreement is to describe the general tasks and related duties of the Behavioral Health and Intellectual and Development Disability Supports and Services ("Supports and Services") being purchased from the Service Provider and how the Service Provider will be compensated for providing such services using Medicaid/Public Funding.

Article I SERVICE PROVIDER RESPONSIBILITIES INCLUDE

1. The Service Provider agrees to execute a Medicaid Provider Agreement for Self- Directed Services with the Oakland Community Health Network (OCHN) by signing **Attachment A**.
2. The Service Provider agrees to provide support to the Individual by performing duties outlined in this agreement, any attachments to it, and the Individual Plan of Service (IPOS).
3. The Service Provider acknowledges that this agreement is dependent on the Individual's participation in a Self-Directed arrangement through the OCHN.
4. The Service Provider is a Contractor of the person, and the Service Provider shall provide staff to perform the services described in the Individual Plan of Service (IPOS).
5. The Service Provider is the sole employer of the staff members and shall fulfill all federal and state employment obligations including but not limited to—maintaining workers compensation insurance, complying minimum wage standards and overtime regulations, withholding and payment of employment taxes, complying with occupational health and safety standards and all reasonable employer responsibilities.
6. The Service Provider has the legal responsibility to recruit, screen, hire, manage and supervise the staff in accordance with all applicable federal and state laws. The Service Provider shall comply with the credentialing and training requirements listed in **Attachment B**. The Service Provider is responsible for providing backup staffing.
7. The Service Provider (where/when applicable) will abide by all of the persons' house rules.
8. The Service Provider agrees to provide all services in compliance with the (a) Michigan Mental Health Code and Administrative Rules; (b) Applicable Federal, State, and Local laws, rules, regulations and policies including, without limitation, the Balanced Budget Act and MDHHS policies and procedures; (c) Medicaid Provider Manual; (d) Self-Determination

requirements; (e) applicable OCHN policies; and (f) the Individuals IPOS.

9. The Service Provider agrees to comply with 45 CFR Part 76 and certifies that it (and its staff):

   - Are not suspended or excluded from participation in the Medicaid or Medicare program;
   - Are not currently debarred, suspended, proposed for debarment, and declared ineligible or voluntarily excluded from covered transactions by any Federal, State, or local entity;
   - Have not within a three-year period preceding this agreement been convicted of or had a civil judgment rendered against them for (a) 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; (b) violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
   - Is not presently indicted or otherwise criminally or civilly charged by a government entity (Federal, State, or local) with commission of any of the offenses enumerated above; and
   - Have not within a three-year period, preceding this agreement had one or more public transactions (Federal, State, or local) terminated for cause or default.

10. The Service Provider must follow the Purchaser's instructions about how to document services provided according to the documentation standards of this agreement and how to organize the documentation.

11. All documentation must fully disclose the extent of the services provided as required by Medicaid rules and as outlined in the Individual's IPOS. Documentation must correspond with timesheets, be complete, concise, accurate, and include the face-to- face time spent providing services. Documentation must be legible (i.e. easy to read), signed, and dated.

12. Time spent providing Home Help or Independent Living Services funded by the Michigan Department of Health and Human Services (MDHHS) or an Integrated Care Organization (ICO) must be documented separately.

13. Documentation shall be maintained for a minimum of seven years from the date of service.

14. All individual personal records will be kept confidential and released only upon the written consent of the Purchaser. The Service Provider acknowledges that all records are the property of the Individual and shall be maintained or returned to him/her or OCHN at the time this agreement terminates.

15. The Service Provider agrees to:

    a. Submit to the jurisdiction of the OCHN ORR and any appropriate Federal or State entity (e.g. MDHHS); cooperate with Recipient Rights investigations; comply with ORR policies and procedures for reporting abuse and neglect and safeguarding Individuals; abide by determinations made by the OCHN ORR or any State or Federal entity regarding Recipient Rights, and promptly and diligently implement any remedial action required;

b. Assist the Individual/Legal Representative in filling out Recipient Rights complaints when requested and report actual or suspected Rights violations, including abuse or neglect in accordance with OCHN policy to:

Oakland Community Health Network
Office of Recipient Rights (OCHN ORR)
5505 Corporate Drive
Troy, MI 48098
Office (248) 858-1210 Fax (248) 509-9318

c. Ensure Incident Reports (IRs) are completed within 24 hours for any significant and/or unexpected events and forward the original to the OCHN ORR by mail or fax to the address above;

d. Immediately report serious or emergency situations (e.g. actual or suspected abuse, neglect, serious injuries, police involvement, deaths, missing persons, etc.) or any physical property or living condition that may pose a risk to the Individual's health or safety to the Individual's Legal Representative (if applicable), and the Clinically Responsible Supports Coordination Agency; and follow OCHN reporting requirements;

e. Act to safeguard the Individual and prevent additional injury; and

f. Not refuse the Individual admittance into his/her residence or otherwise exclude the Individual from his/her residence. This includes failing to return the Individual to his/her residence after hospitalizations or psychiatric assessments, when requested.

16. The Service Provider acknowledges and agrees that the Financial Management Service (FMS) agency is acting only as a financial administrator and shall in no way be considered the employer. OCHN is acting only as the Pre-paid Inpatient Health Plan (PIHP). OCHN pays for services to the Financial Management Services agency and is not the employer. OCHN may also contract with a provider organization to perform Self-Determination Administration. The Service Provider agrees that the Self-Determination Administrator is not the employer. The Service Provider agrees to hold the Financial Management Services entity, Self-Determination Administrator, and OCHN harmless for their roles in facilitating Self-Directed arrangements.

17. The Service Provider agrees to maintain, at its sole cost and expense, general liability, professional liability, motor vehicle liability (as applicable), and workers' compensation insurance coverage in full force and effect during the term of this agreement with limits that are industry standard for the activities arising out of this agreement. The Service Provider agrees to hold the Individual/Legal Representative, the Self-Determination Administrator, and the Financial Management Services entity harmless for any loss that is caused by the Service Provider's negligence or intentional misconduct in providing services under this agreement.

Article II PURCHASER RESPONSIBILITIES

1. Provide the Financial Management Service agency with the necessary documentation to timely give payment to the Service Provider.

2. Authorize payment for the delivery of Supports and Services as specified in this agreement and not to exceed authorizations as identified in the (IPOS) and Individual budget.

3. The Purchaser acknowledges and agrees that the Financial Management Service agency

is acting only as a financial administrator and shall in no way be considered the employer. The OCHN is acting only as the Pre-paid Inpatient Health Plan (PIHP) to pay the Financial Management Service agency and is not the employer. OCHN may also contract with a provider organization to perform Self-Determination Administration. The Purchaser agrees that the Self-Determination Administrator, if any, is not the employer of the Service Provider. The Purchaser agrees to hold the Financial Management Service agency, OCHN, and the Self-Determination Administrator harmless for their roles in facilitating Self-Directed arrangements.

4. The Purchaser acknowledges and agrees that OCHN or a delegated entity may suspend or terminate Medicaid/Public funding for the services provided by the Service Provider if it is determined that the Service Provider has failed to fulfill the terms outlined in the Purchase of Service Agreement, or if the Service Provider has jeopardized the individual's health or safety or has misused the individual's funds.

5. The Purchaser agrees to monitor the dollar amount spent in Medicaid/Public Funds in order to not exceed the Individual Budget and review the services provided and times worked by the Service Provider by reviewing the Service Provider's documentation of services such as progress notes, timesheets, etc.

6. Ensures the Service Provider documents services provided and organize the documentation, using the Person-Centered Planning process and ensure the documentation meets Medicaid rules: Documentation is complete, concise, and accurate; includes the face-to-face time spent providing services; and is legible, signed, and dated.

Article III SERVICE PROVIDER COMPENSATION

1. As authorized by the Individual/Legal Representative, the Financial Management Services Agency disburses ("makes") payment within the scope of the Individual's Individual Budget to an eligible Service Provider for covered Supports & Services.

   The Service Provider shall be compensated based on OCHN standardized rate sheet.
   CPT Code: _____ Type of Service: _____
   CPT Code: _____ Type of Service: _____
   CPT Code: _____ Type of Service: _____

2. The Service Provider shall ensure all health and safety needs are met as detailed in the IPOS and are expected to perform services listed according to the goals /objectives identified in the IPOS.

3. The Service Provider agrees to comply with and be bound by the laws and requirements (e.g. policies, procedures, etc.) for payments from Medicaid/Public funding resources. The Service Provider further agrees to be bound by and comply with the billing requirements for Self-Directed arrangements. Current Billing requirements are included as **Attachment C**, which may change from time to time.

4. If at any time after payment has been made to the Service Provider it is determined that the Service Provider did not perform Supports and Services, the costs of services billed/claimed were not medically necessary, the documentation does not substantiate medical necessity, the service was not delivered as claimed, the Service Provider was not credentialed or qualified, Medicaid was not being used as the payer of last resort, or the Service Provider

otherwise failed to demonstrate compliance with this agreement; the Service Provider shall promptly refund the full amount of the original payment to the FMS within 3-5 business days unless requested sooner. This provision shall survive termination of this agreement.

Article IV. DISPUTES AND TERMINATION

1. Invoice disputes concerning authorizations and invoices of payment should be sent to OCHN.
2. This Agreement will be in effect until such time as it is terminated or changed. Both parties agree to provide thirty (30) days written notice for termination without cause.

   The agreement may be terminated immediately if there has been substantiated cause of abuse, neglect, or fraud. The Service Provider agrees to participate in transition planning.

Service Provider's Business Name	Phone
Service Provider Representative (Print)	Title
Service Provider Representative's Signature	Date
Individual's Signature	Date
Legal Representative's Signature (if applicable)	Date
Legal Representative's Relationship to the Individual	

Attachment A
Medicaid Provider (42 CFR 431.107) Agreement

This Agreement is made on _____ between Oakland Community Health Network (OCHN)/the Pre-paid Inpatient Health Plan (PIHP) and _____ (Medicaid Provider). The purpose of this agreement is to define the roles and responsibilities of the above-named parties and to assure compliance with federal Medicaid requirements. This agreement shall remain in effect until such time it must be terminated or modified. Any party can initiate a termination or modification by providing written notice to the other of the desire to terminate or modify this agreement. This agreement should not be finalized until the provider has met any additional requirements to provide Medicaid Services (i.e. background check, training). Should the provider fail to meet Medicaid requirements, OCHN may suspend or terminate this agreement.

OCHN agrees to the following:

1) Upon receipt of this agreement, to certify the Medicaid Provider as available to provide Supports and Services to Individuals Self-Directing their Supports and Services that are financed through Michigan's Medicaid Specialty Pre-paid Mental Health Plan.

The Medicaid Provider agrees to the following:

1) To keep any records necessary to fully disclose the extent of services the provider furnishes to the individual who receives services.

2) On request, to furnish any information maintained under paragraph (1) of this section and any information regarding payments claimed for furnishing services under the person-centered plan to OCHN, the Financial Management Agency, the Self-Determination Administrator, the State Medicaid Agency, the Secretary of the Department of Health and Human Services, or the State Medicaid Fraud Control Unit.

3) To comply with the disclosure requirements specified in 42 CFR 455, Subpart B, as applicable which state that I must disclose if I own 5% of another provider entity.

4) To comply with the advance directive requirements specified in 42 CFR 489, Subpart I and 42 CFR 417.436 (d), as applicable. This regulation requires that the provider acknowledge the doctrine of informed consent whereby any and all forms of medical treatment, including life- sustaining treatment may be declined by the consumer as specified.

Both parties expressly acknowledge that the sole purpose of this agreement is to assure compliance with 42 USC 1902 (a) 27. (The Social Security Act, that requires an agreement with each provider.) Further both parties recognize and reaffirm that OCHN is not the employer of the Medicaid provider of services.

This agreement sets forth the entire understanding between parties with respect to the subject matters, and supersedes any and all other agreements, either oral or in writing between parties, pertaining to these matters. No change or modification of the terms of this agreement is valid unless it is in writing and signed by the parties. The parties agree to terms and conditions of this agreement as specified on the foregoing page, and so signify by affixing their signatures below.

Medicaid Provider's Signature	Printed Name	Date
OCHN Representative's Signature	Printed Name	Date

Internal Review Only

MCA Reviewer Name	Review Date

ATTACHMENT B

CREDENTIALING/IMPANELING REQUIREMENTS

The Service Provider guarantees and warrants that it complies with the Credentialing/Re-Credentialing policy of the Michigan Department of Health and Human Services (MDHHS), Oakland Community Health Network (OCHN) and the following standards:

IMPANELING/CREDENTIALING/ (RE-CREDENTIALING) STANDARDS

For the purposes of this Attachment references to:

a) " Staff (s)" or "All staff(s)" means staff with direct access to the Individual or who provide direct services to Individual(s) unless otherwise stated;

b) "Direct access" means access to the Individual's/(s)' property, financial information, medical records, treatment information, or any other identifying information.

I. Credentialing

(1) The Service Provider has in place written credentialing and re-credentialing policies and procedures for ensuring all staffs rendering services to Individuals are appropriately credentialed and qualified to perform such services. The Service Provider is also responsible for maintaining evidence of its Credentialing/re- credentialing activities and results (including evidence of background checks, trainings, etc.). The Service Provider shall not receive reimbursement/compensation for services performed by excluded staff persons or by staff persons whom the Service Provider cannot demonstrate satisfies credentialing requirements.

(2) The Service Provider maintains a readily available alphabetical roster of all staffs that includes:

- Staff name, position/title, staff classification (i.e. employee or independent/sub- contractor, etc.);
- The contingent/conditional offer of employment date, the official hire date[1];
- The date the staff person began providing services to Individual(s);
- The date of separation/termination (where applicable);
- Initial and annual criminal background check date or Michigan workforce background check fingerprint date, and type of criminal background check completed;
- Dates of Federal/State healthcare program exclusion checks and types of exclusion checks completed; and
- Dates of national sex offender's search.

[1] *The official hire date is the date that all contingencies related to the offer of employment have been satisfied.*

(3) The Service Provider's policies and procedures for the initial credentialing of applicants includes requirements for a written employment application to be completed, signed and dated by all applicants along with an attestation by the applicant of lack of present illegal drug use and the correctness and completeness of the application.

(4) The Service Provider conducts background checks on applicants prior to hire[2] and all staff annually thereafter. The Service Provider's background checks include, without limitation, the following checks:

- Criminal Background Checks;
- A national criminal history conducted for any staff person who has not been a Michigan resident at any time during the 12-month period prior to the background check being conducted;
- National Sex Offenders Search; and
- If working with children, a MDHHS Central Registry Clearance.

The Service Provider's background check results are screened in accordance with the standards set forth by OCHN and any applicable State and Federal laws, rules, regulations, or policies. The current OCHN Work Force and Provider Background Check policy[3] is available on OCHN's Provider Extranet.

The Service Provider ensures that only staff persons who are in good standing with the law (i.e., not: a fugitive from justice, a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, or an illegal alien) and who have had requisite background checks with eligible results are assigned to provide services to Individuals.

(5) The Service Provider adheres to the affirmative duty to prohibit employment, consulting contracts, or other arrangements with providers excluded from participation under either Medicare or Medicaid. The Service Provider complies with Federal and State requirements regarding Medicare/Medicaid Program Exclusion Status. *Please note: sanctioned provider information is available on the following websites: www.exclusions.oig.hhs.gov (OIG List), www.sam.gov (SAM), https://med.cms.gov (MED) and www.michigan.gov/mdhhs/0,1607,7-132-2945_42542_42543_42546_42551-16459--,00.html (MDHHS List)*.

a. At the time of initial credentialing, re-credentialing, on an annual basis, upon updates or changes in ownership, and upon request, the Service Provider obtains written disclosures in accordance with 42 CFR 455.104-106 and can provide said information upon request.

[2] Prior to hire means: *after making a conditional/contingent offer of employment to the candidate and prior to the candidate providing services to the Person.*

[3] The current OCHN Work Force and Provider Policy contains the effective date of 6/24/2024.

b. The Service Provider searches the Medicare/Medicaid Office of Inspector General (OIB) List of Excluded Individuals/Entities (LEIE) database, the System for Award Management (SAM), the Medicare Exclusion Database (MED), and the MDHHS list of Sanctioned Providers before hire, on a monthly basis, and at any time disclosure information is submitted to the Self- Determination Administrator in order to capture exclusions. The Service Provider maintains an immediate notification protocol of any exclusion, suspension, debarment or prosecution that may result in suspension, exclusion, or debarment to the Individual/Legal Representative, Self-Determination Administrator, and the Financial Management Services entity.

(6) The Service Provider has mechanisms for ensuring that a *paid* staff who will provide direct services to the Individual is not the:

- Spouse
- Guardian/Legal Representative (or spouse of Guardian/Legal Representative);
- Power of Attorney (POA) (or spouse of POA);
- Parent or Guardian of a minor child;
  or
- Other responsible relative.

(7) The Service Provider has mechanisms for ensuring that staff who will provide direct services to Individuals meet and maintain the following minimum qualifications:

- Be at least 18 years of age;
- Able to prevent transmission of communicable disease;
- Able to communicate effectively to follow IPOS requirements, beneficiary-specific emergency procedures, and to report on activities performed;
- Be in good standing with the law (i.e., not a fugitive from justice, a convicted felon who is either under jurisdiction or whose felony relates to the kind of duty to be performed, or an illegal alien);
- Has received training in the Individual Plan of Service (“IPOS”) before working alone with the Individual;
- Able to perform basic first aid procedures, as evidenced by completion of a first aid training course, self-test, or other method determined by Oakland Community Health Network;
- Has a valid driver’s license and insurance (as applicable) if providing transportation for the Individual;
- Eligible to work in the United States, as evidenced by a completed I-9 Form;
- Able to participate in Federal and State Health Care programs such as Medicare and Medicaid (i.e., not excluded or debarred from participation);
- Has completed any other training required by the IPOS.

(8) The Service Provider ensures that all staff meet applicable Medicaid and IPOS training requirements. The Service Provider has the sole responsibility for ensuring the provision of any additional staff training needed and recognizes that training requirements may change from time to time.

a. The Service Provider shall maintain evidence of completion of required trainings.
b. The Service Provider shall document the name, clock hours, and date of completion of required trainings.

II. Re-Credentialing

(1) The Service Provider conducts re-credentialing at least every two years, or sooner, as circumstances may require.

(2) The Service Provider's re-credentialing policies include requirements for:

a. An update of the information obtained during the initial credentialing; and
b. A review of:

- It and its staff's compliance with credentialing requirements;
- Quality issues; and
- Concerns which include grievances (complaints) and appeals information.

III. Credentialing/Re-Credentialing File

The Service Provider maintains a credentialing/re-credentialing file for each staff that contains at least the following:

a. The staff person's employment application;
b. The contingent/conditional offer of employment date, the official hire date, and the date the staff person started providing services to Individual(s); and
c. Any other pertinent information used in determining whether or not the staff person met credentialing standards/requirements (e.g. evidence of trainings, background checks, etc.).

IV. Reporting Requirements

The Service Provider shall report improper known organizational conduct or staff conduct that results in suspension or termination to the Purchaser of its services, OCHN, and the appropriate authorities (i.e. MDHHS, Attorney General, regulatory board or agency, licensing, etc. as applicable.) The Service Provider also agrees to *immediately* notify the purchaser of its services, OCHN, the Self-Determination Administrator, and the Financial Management Services entity of any felony or misdemeanor convictions or other events that could impact its ability to perform Behavioral Health and Intellectual and Developmental Disability Supports and Services.

V. Monitoring

(1) The Service Provider assesses the competency of all staff through supervision, observation, and performance evaluation at least annually.

(2) The Service Provider has a process for ongoing monitoring and auditing, and intervention, if appropriate, of sanctions, complaints and quality issues pertaining to it and/or its staff that includes, at a minimum, a review of:
   a. Medicare/Medicaid sanctions monthly;
   b. Substantiated Recipient Rights violations; and
   c. Concerns, grievances (complaints); and quality issues.

(3) The Service Provider agrees to fully cooperate with MDHHS, OCHN, the Financial Management Services entity, the Clinically Responsible Supports Coordination Agency, and the Self-Determination Administrator's monitoring and auditing practices and/or investigations. The Service Provider shall provide upon request documentation/information related to this agreement and copies of any audits and investigative findings. The Service Provider shall remain liable for all assembly and copying costs.

Attachment C

Billing Requirements:

1. The parties understand and agree that to use Medicaid/Public funds as payment to the Service Provider:

- **Medicaid/Public funds must be available** (The Individual Budget gives the estimated costs of services and gives the amount of Medicaid/Public Funding available to the Individual to purchase the Supports and Services needed to implement his/her IPOS)*;*
- **The** Service Provider **must be eligible to receive payment from the Financial Management Services entity BEFORE providing Supports and Services.** This is called provider eligibility. In other words, the Service Provider must:
  - Be credentialed (a process that is used to obtain and assess the qualifications of professionals interested in providing Supports and Services to Individuals) and have a satisfactory credentialing status;
  - Be qualified (for example, fully trained, undergone required background checks, all training up- to-date, not debarred or excluded from service provision, etc.);
  - Have entered into Medicaid Provider Agreement, etc.); and
  - Have entered into a Purchase of Services Agreement with the Individual/Legal Representative;
  - Have used qualified staff.
- **The services provided by the** Service Provider **must be covered.** This is called Covered Services. Services are covered when they are Supports and Services that were:
  - Authorized in the Individual Plan of Service (IPOS) and provided face-to-face;
  - Provided in a manner that meets Medicaid requirements;
  - Provided in keeping with the Individual's IPOS and Individual Budget for the purpose of reasonably achieving the goals in the Individual's IPOS;
  - Provided in keeping with this agreement (including attachments); and
  - Documented appropriately.

Please note: Payment rates in excess of the Individual Budget are not covered. Additionally, Medicaid/Public funding does not cover:

- Services excluded by Medicaid;
- Services that are not in keeping with the IPOS or Individual Budget;
- Other non-Supports and Services (such as caring for pets or other family members);
- Payments made directly or indirectly to responsible relatives or the legal guardian; or
- Actual or suspected fraud or abuse, billing errors, false claims/statements or documents, or any concealment of a material fact. ***(Fraud and/or Abuse may be prosecuted under Federal/State laws)***.

2. **Requesting Medicaid/Public Funding Reimbursement:**

To request payment of Medicaid/Public Funding from the Financial Management Services entity for covered Supports and Services provided by an eligible Service Provider, the Service Provider must submit a claim ("bill for service") made up of an invoice and supporting documents (e.g. timesheets). **Claims must be submitted no later than 4:30 pm of the third (3rd) BUSINESS day of the month following the month of service. Late submission of claims MAY result in a delay of payment, and any claims submitted to the Financial Management Services Entity later than forty-five (45) days from the date the service was**

provided will not be paid. The Service Provider acknowledges and agrees these claims will be returned unprocessed and payment will be denied.

3. **The Denial, Termination, or Suspension of Claims:**
The disbursement of Medicaid/Public Funding from the Financial Services Management entity may be denied, suspended, or ended for any of the following reasons:

   a. Claims for services were not submitted on time;
   b. The Individual's health, safety, or welfare is put at risk by the Service Provider;
   c. The Service Provider fails to maintain a current, executed Medicaid Provider Agreement or Purchase of Services Agreement;
   d. The Individual/Legal Representative revokes authorization ("consent") for payment;
   e. There are actual or suspected fraud, abuse, waste, billing errors; false statements, claims, or documents; or any concealment of a material fact;
   f. Delivery of Supports and Services cannot be substantiated;
   g. The Service Provider is excluded from Medicaid/Medicare participation;
   h. The Service Provider fails to fulfill its duties under this agreement, or the service is not in line with this agreement;
   i. The service is not supported by adequate documentation;
   j. The service is not covered under the Individual's benefit plan; *or*
   k. The Service Provider was otherwise ineligible for payment.