CONTRACT BETWEEN

THE ALCOHOL, DRUG AND MENTAL HEALTH BOARD OF FRANKLIN COUNTY

AND

«COMPANY»

CONTRACT YEARS 2016–2017

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Article 1. Preliminary Recitals

1.1. Parties In accordance with O.R.C. §340.03(A)(8)(a), this agreement is by and between the Alcohol, Drug and Mental Health Board of Franklin County, 447 East Broad Street, Columbus, Ohio 43215–3822, (hereinafter "ADAMH Board") and «Company», «Address1», «Address2» (hereinafter "Provider").

1.2. Term Except for termination pursuant to Article 14 below, this Contract shall be effective on the first day of January, 2016 and shall terminate on the 31st day of December, 2016 in cases where the allocation is limited to one year. Otherwise the length of Contract will be two years and shall terminate on December 31, 2017.

1.3. Conditions Precedent Approval by the governing boards of the parties are independent conditions precedent to the formation, validity and enforceability of this Contract.

Article 2. Definitions

2.1. ACCO means an Agency Chief Clinical Officer who meets the requirements of O.R.C. §5122.01(K) or an equivalent position with a provider of alcohol and other drug abuse services.

2.2. Active Case Load means the number of clients assigned to a particular program or treatment modality who have been seen by the Provider in the past 120 days.

2.3. ADAMH Services means member services supported by non–Medicaid funding administered in whole or in part by the ADAMH Board. Previously known as non–Medicaid.

2.4. Adjudicated Claim means a bill for Mental Health and/or Alcohol and Other Drug Addictions Services submitted in an ANSI 837 electronic format which has been processed using the pricing and benefit rules in SHARES.

2.5. Agency Services Plan means the Provider's service plan as defined in O.A.C. §5122–26–09(A).

2.6. All–Hazards Coordinator means the person designated by the provider to be available for contact 24/7 in the event of a community disaster or agency–specific emergency.

2.7. Applicable Law means those federal, state and local laws and regulations which govern the conduct of the parties to this Contract.

2.8. Applicable Requirements includes all of the following to the extent that any of these requirements govern the conduct of the parties to this Contract:

2.8.1. Applicable law.

2.8.2. Protocols and guidelines from OhioMHAS which require compliance by providers.

2.8.3. Community Plan for the Provision of Alcohol, Drug Addiction and Mental Health Services ADAMH Board policies, procedures and guidelines referenced in Section 3.3

2.8.4. The requirements of this Contract.

2.9. Assessment (or Diagnostic/Assessment) means the Provider's encounter with a client for the purpose of determining the nature of the issue(s) to be addressed via clinical services. Definition shall be consistent with that used in the most recent Ohio administrative rules.

2.10. Calendar Year (CY) means the period January 1 through December 31**.** May also be referred to as Contract Year (KY).

2.11. Capacity means the total Active Case Load potentially available based on staffing, frequency and intensity of services, and other pertinent clinical issues. Where budget capacity equals Direct service FTEs times Case Load per FTE, include open positions as an FTE. Where functional capacity equals Direct Service FTEs times Case Load per FTE, include filled positions as an FTE.

2.12. **Case Plan** means plans of care prepared by the Case Worker for Franklin County Children Services Board or designee with input from Provider, member and member's family or guardians.

2.13. **CCO** means a chief clinical officer who meets the requirements of O.R.C. §5122.01(K).

2.14. **Claim** means a bill for Mental Health and/or Alcohol and Other Drug Addiction Services submitted in an ANSI837 electronic format in accordance with applicable requirements within this Contract.

2.15. **Community Disaster** A natural, technological, or man–made hazard that overwhelms local resources which results in the need to implement the Franklin County Emergency Operations Plan. The most likely hazards are flooding, tornadoes, hazardous material spills and terrorism.

2.16. **Continuity of Operations (COP)** means an agency's written plan describing contingencies for fiscal stability and service provision in the event of a catastrophic occurrence to the agency that may threaten the ability to conduct business (e.g. building fire, epidemic affecting many staff members).

2.17. **Contract** shall mean this agreement and any and all attachments hereto which are incorporated herein as if fully rewritten.

2.18. **CPST Rule** means the Community Psychiatric Support Treatment service rule set forth in O.A.C. §5122–29–17 as amended.

2.19. **Cultural Competency** means the integration and transformation of knowledge, information and data about groups of people into specific clinical standards, skills and service approaches.

2.20. **Encounter Data** means service activity (procedure codes, units of service and agreed-upon unit rates) submitted to ADAMH that represents the value of the services provided (fee-for-service equivalency). Providers are not reimbursed based on the value of encounter data but select programs are required to meet a defined percent threshold (generally 90% of the allocation amount) by year-end in order to substantiate program expense in the annual contract reconciliation.

2.21. **Ensure** means using reasonable professional skill and taking steps which are reasonably necessary to carry out the obligations set forth in this Contract.

2.22. **Group Member (SHARES)** formerly known as "Pseudo-UCI". A substitute for unique members used to submit claims in programs where it is not reasonable to enroll individual clients. Data elements of a group member include the Program Name, Location and address.

2.23. **HIPAA** means the Health Insurance Portability and Accountability Act of 1996

2.24. **Holistic Assessment** refers to the consideration of risk and protective factors within all life domains, including but not limited to psychological/emotional, medical, safety, legal, living situation, family and significant others, social and recreational, vocational and educational, cultural, and spiritual aspects.

2.23 **Home Board** means the ADAMH/CMH/ADAS Board contracting for services under O.R.C. Chapter 340 in the area in which a member resides and with which the member should be enrolled, when that member resides outside of the area served by the Network.

2.24. **Intake** refers to the Provider's initial encounter with a client for the purpose of obtaining demographic, financial and/or other information needed to initiate administrative and clinical processing.

2.25. **Interim Services** means activities which facilitate health promotion, reduction of adverse effects of substance abuse and reduction of the risk of transmitting disease. Interim services may include, but are not limited to: education and counseling regarding HIV, tuberculosis, needle sharing and transmission of disease. For pregnant women, interim services may also include counseling regarding the effects of alcohol and drug use on the fetus and prenatal care referral.

2.26. **Lead Provider** means a Mental Health provider who desires and agrees to contract with the ADAMH Board of Franklin County to assure the continuity of care for mental health or alcohol or other drug services for the

severely mentally disabled residents of Franklin County. Each lead provider signs a Continuity of Care Agreement with ADAMH and the Twin Valley Behavioral Healthcare Hospital.

2.27. Level of Care means a set of criteria, procedures, and methods for the assessment of and treatment for member's mental health and alcohol and other drug needs.

2.28. Linguistic Competence refers to compliance with the ADAMH Cultural Competency Plan Standards, based on the U.S. Department of Justice Policy Guidance Document "Enforcement of Title VI of the Civil Rights Act of 1964—National Origin Discrimination Against Persons with Limited English Proficiency" (LEP Guidance). This LEP Guidance sets forth the compliance standards to ensure that programs and activities normally provided in English are accessible to LEP persons and thus do not discriminate on the basis of national origin in violation of Title VI's prohibition against national origin discrimination:

2.28.1. Demonstrating in written organizational statements (policy, procedure, guidelines, etc.) that the organization provides interpretation and translation services, including ASL, TTY/TDD services.

2.28.2. Demonstrating that agency's administrative and clinical staff members are aware of LEP (Limited English Proficiency) clients' rights (Title VI of the Civil Rights Act of 1964).

2.28.3. Demonstrating in written procedural statements the process for handling incoming LEP consumers phone calls and walk–ins, demonstrating that staff is trained and capable to utilize such services as needed.

2.28.4. Demonstrating that main agency Forms/Information/Directions are provided in client's primary language. This standard is implemented in coordination with the state departments and ADAMH, which take leadership in translation of essential materials into non–English languages, in response to documented consumer need.

2.28.5. Demonstrating in written procedural statements the process for linking persons served to translators and interpreters. Demonstrating that staff is trained and capable to utilize interpreter services, as needed.

2.28.6. Demonstrating with financial data that the organization pays for interpretation and translation services.

2.28.7. Demonstrating with QA/QI data that persons served are satisfied with interpretation and translation services.

2.29. Material means a substantial change in any of the following:

2.29.1. *Quality* Any change in the quality of services required to be provided under this Contract. Quality is measured as the effectiveness of treatment or prevention for the client as cited in Sections 7.6 and 7.7 in this contract.

2.29.2. *Services/Programs Defined in the Provider's Agency Services Plan* Any change in the amount, scope or duration of services/programs for clients or any change in the ability of priority populations to access services/programs. The characteristics of service/program are described in the Provider's Agency Services Plan and the change is measured by a 10% or greater impact in amount, scope, duration, and/or access.

2.29.3. *Funding* Any changes in funding that constitute 10% or greater of the Provider's total behavioral healthcare funding.

2.29.4. *Business Structure/Administration* Any change in the corporate business structure or administration which significantly affects the Provider's ability to carry out its duties under this Contract or applicable requirements.

2.30. Medical Emergency means a situation in which a Member presents with a physical condition requiring a medical professional to ascertain the necessity for immediate medical care.

2.31. Medically Necessary Services means those services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.

2.32. Member means a person required to be served under this Contract and who is eligible for services reimbursed in whole or in part by public funds. The use of the term "member" shall not be interpreted in a manner which will deny any person services if such person is entitled to services under Applicable Requirements.

2.33. Minimum Necessary the minimum amount of Protected Health Information (PHI) necessary to achieve the purpose of the use or disclosure.

2.34. National Provider Identification Number means the 10 digit unique identification number issued to Provider by the Centers Medicare & Medicaid Services.

2.35. Netcare Access means the coordinated, integrated system in Franklin County for crisis, assessment and referral services.

2.36. Nepotism means favoritism or tolerance shown by those in positions of control to relatives, significant others or friends that could lead to conflicts of interest and/or the appearance of impropriety.

2.37. Network means the providers which have a contract with the ADAMH Board of Franklin County, and are providing services and have offices within Franklin County.

2.38. O.A.C. refers to the Ohio Administrative Code and any amendment made effective during the term of this Contract.

2.39. O.R.C. refers to the Ohio Revised Code and any amendment effective during the term of this Contract.

2.40. ODJFS refers to the Ohio Department of Job and Family Services.

2.41. OhioMHAS refers to the Ohio Department of Mental Health and Addiction Services

2.42. Proprietary Information shall be defined in accordance with applicable law, except that the designation of information as "proprietary" shall not alter any requirement in this Contract for disclosure of such information.

2.43. Protected Health Information (PHI) means individually–identifiable health information transmitted by electronic media; maintained in any electronic media such as magnetic tape, disk, optical file; or transmitted or maintained in any other form or medium, i.e. paper, voice, fax, Internet, etc. PHI generally includes such individually identifiable health information as name, address, phone number, fax number, date of birth, social security number, or other unique identifying number(s), and other information as identified in 45 CFR 164.514(b)(2)(i)A–R.

2.44. Providers are any entity that is certified to provide behavioral healthcare treatment, support or prevention services by the State of Ohio and have an executed contract with the ADAMH Board of Franklin County.

2.45. Psychiatric Emergency shall be defined as a situation in which a Member is in imminent risk of harm to self and/or others requiring a mental health professional to ascertain the necessity for immediate psychiatric care.

2.46. Publicly–Funded means funded in whole or in part by any funds administered by the ADAMH Board from Federal, State or local governmental sources or from local levy or match reimbursed to ADAMH by another public entity.

2.47. Recovery means a personal process of overcoming the negative impact of a behavioral health care related illness despite its continued presence.

2.48. Recovery–Orientated Care is what psychiatric and addiction treatment and rehabilitation practitioners offer in support of the person’s recovery.

2.49. Regular Contact means contact with members for the purpose of assisting the member becoming engaged in a treatment program or service when it becomes available. Regular contact may include, but is not limited to: telephone or face–to–face contact, distribution of literature or interim services.

2.50. Resident of Franklin County means a person who is physically present in Franklin County, with a documented intent to remain here, except that:

2.50.1. If a person is a client of and/or receiving the mental health, alcohol and other drug addiction treatment, supervision, support or other assistance in a specialized residential facility or program that includes nighttime sleeping accommodations, then the person is a resident of that county in which the person maintained his or her primary place of residence at the time the person entered the facility;

2.50.2. If a person is committed pursuant to O.R.C. §2945.38, 2945.39, 2945.40, 2945.401, or 2945.402, the person is a resident of the county where the criminal charges were filed.

2.51. Resiliency means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses–and to go on with life with a sense of mastery, competence and hope.

2.52. Routine Care means care for members who are not pregnant or IV Drug Users, not in medical or psychiatric emergencies and not in need of urgent care as defined by the provider.

2.53. SCCO means the System Chief Clinical Officer appointed by the ADAMH Board

2.54. SHARES means the Shared Healthcare and Recovery Enterprise System, a health care information system supporting client enrollment, benefit management, provider contracting, claims processing and payment, and utilization and outcomes management. Administrative oversight of SHARES is managed by the Three C Recovery and Health Care Network Council of Government.

2.55. SPMI Lead Providers include Columbus Area Inc., Concord Counseling Services, North Central Mental Health Services, North Community Counseling Centers Inc., Southeast Inc. and Twin Valley Behavioral Healthcare–CSN.

2.56. State Fiscal Year (SFY) means the period of July 1 of one year through June 30 of the following year.

2.57. Subcontract shall mean any agreement, other than an employment agreement, between the Provider and any other person, corporation or other entity under which such person, corporation or other entity is obligated to perform member services which are required to be performed by the Provider under this Contract.

2.58. Three C Recovery and Health Care Network Council of Government, hereinafter referred to as COG, means the entity formed pursuant to Chapter 167 of the Ohio Revised Code by the Alcohol, Drug Addiction, and Mental Health Services Board of Cuyahoga County; the Alcohol, Drug and Mental Health Board of Franklin County and the Hamilton County Mental Health and Recovery Services Board. The **COG** provides a forum for the planning and development of an integrated system of behavioral health care and primary health care in a manner which is cost–effective and efficient and which promotes and protects the best interest of persons being served by its member Boards.

2.59.

2.60. Turnover means separation of an employee from an establishment (voluntary, involuntary or other). Monthly turnover is measured by the number of total separations during the month divided by the number of employees who worked during or received pay for the pay period that includes the 12th of the month. Annual turnover is measured by the number of total separations for the year divided by average monthly employment for the year.

2.61. Waiting List means a list of individuals who have requested services, but have not yet been linked to those services. This list shall include the information necessary for the provider to contact the individual should a treatment slot become available, the date the service was originally requested and other information as required by OhioMHAS, ODJFS or federal/state law and in accordance with the ADAMH Guidelines in Attachment 3.

Article 3. Requirements Applicable to the Parties

3.1. General Requirements

3.1.1. The Parties shall perform their respective duties under this Contract in accordance with applicable requirements. The Provider shall also comply with its Articles of Incorporation, Code of Regulation and/or By–Laws.

3.2. Applicability The requirements of this Contract shall apply only to programs and services funded or administered wholly or in part by the ADAMH Board as approved in the Provider's Agency Service Plan and Budget.

3.3. Policies of the ADAMH Board The policies, procedures and guidelines of the ADAMH Board which are applicable to the services which the Provider renders under this Contract are identified in Attachment 2. In the event there is a conflict between any policy, procedure, or guideline of the ADAMH Board and the terms of this Contract, then the terms of this Contract shall govern. Upon request of the Provider, the ADAMH Board shall provide the Provider with all policies, procedures and guidelines in effect at the time of the signing of the Contract unless such documents have already been provided by the ADAMH Board. The ADAMH Board shall provide copies of policies, procedures or guidelines which have been changed.

3.4. Community Plans Providers shall provide timely information requested by the ADAMH Board which is necessary for community planning and to qualify for federal, state and local funding.

3.5. Alternative Funding Sources The Provider shall make reasonable efforts to diversify its funding base. The ADAMH Board shall provide reasonably necessary technical assistance at the request of the Provider.

3.6. Medicaid Eligibility Verification Provider hereby appoints ADAMH as its representative for purposes of verifying whether persons seeking and/or being referred for ADAMH services are eligible for Medicaid. In order to permit ADAMH to provide these services, Provider agrees to provide to ADAMH its National Provider Identification Number. ADAMH shall verify the Medicaid eligibility of each person submitted by Provider. ADAMH may subcontract with a third party to perform such eligibility verification. ADAMH or its subcontractor shall forward to Provider documentation of each person's eligibility for Medicaid so Provider can perform its obligations under Section 4.5 of this Agreement.

3.7. System Information The ADAMH Board shall prepare summaries of information, upon request of the Provider, which are reasonably required for the Provider to carry out its duties under this Contract. In making requests for information under this section, the Provider shall specify the information being requested with reasonable particularity and the reasons for the request. Information exchanged between the Board and Providers shall adhere to all HIPAA requirements and 42 CFR 164.514(b)(2)(i)A–R (if applicable).

3.8. HIPAA & Code of Federal Regulations Privacy Compliance The parties will be compliant with Code of Federal Regulations (42 CFR 164.514(b)(2)(i)A–R) (if applicable) and Federal HIPAA requirements including but not limited to Privacy, EDI, Security, and NPI.

3.8.1. Providers receiving this contract are considered by ADAMH to be "covered entities" under HIPAA regulations. Providers are required to indicate their declared status using Attachment 17 of this contract. Providers who do not declare status as a covered entity under HIPAA provisions may be subject to entering into a Business Associate Agreement (BAA) with ADAMH as a requirement of fulfilling this contract.

3.8.2. Electronic Data Interchange: Providers are required to follow COG-SHARES EDI guidelines.

3.8.3. Providers will post the ADAMH Notice of Privacy Practices in a visible location at all sites at which ADAMH funded services are delivered.

3.8.4. Providers will ensure each ADAMH–funded client served by its agency during the contract period will receive the ADAMH Notice of Privacy Practices.

a. ADAMH will email a pdf file of its Notice of Privacy Practices to the Providers for distribution. Versions will be available in English, Spanish, and Somali languages.

b. The Provider may direct any client questions, concerns, or requests to exercise their rights to the ADAMH Privacy Officer at 614–224–1075, as noted in the Notice of Privacy Practices.

Article 4. General Service Requirements

4.1. Services and Staff

4.1.1. The Provider shall provide the services for populations identified in the Providers ASP in accordance with applicable requirements.

4.1.2. The ADAMH Board, Provider Leadership Association and the Consumer and Family Advocacy Council shall collaboratively implement strategies to further the involvement of consumers and families in providing recommendations and advice on the delivery of mental health, alcohol and other drug addiction services. This will include, but not be limited to a survey of consumer and family membership that is presented to the Providers' Boards of Trustees. Every Provider shall have a documented mechanism for consumer and family member input to the Provider's Board of Trustees at least annually.

4.2. General Assurances of the Provider Required by ADAMH

4.2.1. The Provider shall maintain compliance with applicable certifications and licensure standards.

4.2.2. The Provider shall develop and implement reasonable policies in accordance with current ADAMH Board policies which require that services are not denied to a member solely because of behavior which is symptomatic of the illness or condition causing the member to need services under this Contract.

4.2.3. No member shall be denied OhioMHAS–certified services solely because of refusal to accept other OhioMHAS–certified services offered by the Provider.

4.2.4. Services shall be provided in the least restrictive, most natural setting which is available and appropriate to the needs of the member.

4.2.5. Providers shall deliver recovery/resiliency–oriented services and supports that are identified by members and their families as effective in managing their behavioral health care disorder(s) and fulfilling valued roles in the community. Such services and supports shall address components including but not limited to clinical care, family support, peer support and relationships, work and other meaningful activity, community involvement, education and learning, access to resources, overcoming the effects of stigma and increasing personal responsibility and decision making.

a. The ADAMH Board, Provider Leadership Association and the Consumer and Family Advocacy Council shall develop mutually agreed–upon principles and practices for ADAMH system recovery/resiliency based care, which shall provide as a basis for the services performed under this section.

4.2.6. Services shall be culturally and linguistically competent and shall respond effectively to:

a. The member's needs and values present in all cultures, including, but not limited to, the African–American, Appalachian, Asian, Latin, Hispanic, Native American, and Somali cultures,

b. The needs of members with disabilities, including, but not limited to members who are Deaf/Hearing Impaired,

c. The needs based on each member's gender and sexual orientation,

d. The needs based on each member's age

e. The member's changing level of needs

4.2.7. The Provider shall work with the ADAMH Board to identify and eliminate disparities in access to and quality of care, including but not limited to implementing guidelines for providing culturally and linguistically competent services.

4.2.8. Services provided under this Contract shall be coordinated with the provision of other services and systems appropriate to the needs of the member and family being served, including but not limited to Child and Adult Protective Services, Justice Systems, Vocational Rehabilitation, Homeless Shelters, Developmental Disabilities and Schools.

4.2.9. The Provider shall respond to the member's physical health care needs and coordinate care with primary health care provider(s). The Provider shall also coordinate with health care payors, including but not limited to Medicaid Managed Care Entities.

4.2.10. The Provider shall operate facilities and programs in accordance with applicable requirements relating to member safety.

4.2.11. The Provider shall provide services in a manner which minimizes barriers to access and care in accordance with applicable requirements.

4.2.12. The Provider shall provide such other assurances as may be required by ADAMH, OhioMHAS or other funding source.

4.3. Assurances for OhioMHAS The Provider shall conform to the assurances set forth in Attachment 19, regardless of the source of funding constituting Provider Allocations. ADAMH reserves the right to modify the mix of funds (local, state, federal) that support programs to maintain effective resource management.

4.4. Continuation of Services and Reimbursement Services and reimbursement shall be provided without interruption until modification or termination of the Contract in accordance with Article 14 except as provided in this Contract.

4.5. General Eligibility for Services

4.5.1. If the Provider is certified to provide emergency/crisis intervention services, such services shall be provided based on need without regard to the county of residence of the member. If the Provider is not so authorized, a suitable referral must be provided to the member.

4.5.2. Resident of Franklin County

a. Any resident of Franklin County as defined in Section 2.50 of this Contract may be eligible for services of the Provider.

b. ADAMH reserves the right to limit the amount, scope and duration of services provided to those consumers who are deemed eligible under paragraph c.viii. of this section. Members enrolled in SHARES using the Residency Verification Form will be enrolled in the Franklin County Temporary (90-Day) Benefit Plan.

c. The Provider shall review and maintain a record of documentation verifying that a person seeking and/or being referred for ADAMH Services is a resident of Franklin County prior to enrolling the individual with the ADAMH Board. Documentation will be attached to the Member's SHARES enrollment form or member update enrollment form. Acceptable documentation includes:

i. valid driver's license or state ID

ii. Copy of MITS Medicaid Eligibility summary page

iii. voter registration

iv. vehicle registration

v. officially filed federal, state or local tax form or payment

vi. public benefits, utility, school, employment, military, real estate or other record confirming a Franklin County permanent mailing address

vii. record from Franklin County homeless shelter or street outreach worker if the client does not use a homeless shelter

viii. signed Residency Verification Form, if the person has no other available documentation

4.5.3. Financial Eligibility and Financial Responsibility

a. The Provider shall review and maintain a record of documentation verifying if the person seeking and/or being referred for ADAMH Services is eligible for Medicaid and other third party payors, prior to enrolling the individual with the ADAMH Board. The ADAMH Board may request documentation of Medicaid and other third party payor eligibility at the time of enrollment and/or perform periodic record reviews at the Provider's location.

b. The Provider shall ensure members potentially eligible for Medicaid and other insurance receive reasonable assistance in applying for, securing, and maintaining coverage.

c. The Provider shall verify the person's financial eligibility for the ADAMH Public Subsidy for ADAMH Services and responsibility for cost sharing, in accordance with Attachment 14 of this Contract, prior to enrolling the individual with the ADAMH Board. The ADAMH Board will request documentation of financial eligibility or fee waivers attached to the Member's SHARES enrollment form or member update enrollment form.

4.5.4. Establishing Medicaid Consumers' Eligibility for ADAMH Services

a. Providers seeking reimbursement for ADAMH services on behalf of an enrolled Medicaid consumer shall submit behavioral healthcare Medicaid claims directly to the State of Ohio's Medicaid claim system (MITS).

b. Payment of ADAMH services on behalf of an enrolled Medicaid consumer are subject to section 4.5 of this contract.

4.6. Members' Access to Care

4.6.1. Except as otherwise provided herein, the Provider shall ensure timely and appropriate access to services consistent with the member's assessed needs and level of care, making reasonable efforts to reduce the number of days between a person's initial contact with the agency, and the initial assessment, and then to the subsequent service, if ongoing treatment is indicated.

4.6.2. ***Required Access to Care for Referral Priorities:*** Consistent with the mutually agreed upon principle of providing services in the least restrictive, most natural setting, ADAMH identifies its highest "access to care" priority as persons with behavioral health care needs who are stepping down from more restrictive crisis levels of care and those who the probate court has determined are subject to court ordered outpatient treatment. The Provider shall plan through the Agency Services Plan and Budget; adapt to changing community conditions; and must provide capacity for rapid linkage, clinical assessment, and community stabilization supports for the following categories of individuals who are stepping down:

a. Currently linked, re–linked and newly linked adults hospitalized at Twin Valley Behavioral Healthcare (TVBH) and other Ohio Department of Mental Health Regional Psychiatric Hospitals (RPH).

i. Post–Discharge Response Timeframe: The Provider shall provide an outpatient service in the community within seven (7) days of discharge and an appointment with the Provider psychiatrist within fourteen (14) days of discharge.

ii. Pre–Discharge Response Timeframe: For currently linked clients, the client will be served at the hospital by his or her primary clinician/treatment team the first business day after admission and at least weekly during the stay. For re–linked or newly linked clients, the Provider shall conduct an assessment and coordinate with the hospital treatment team to determine the level of CPST and/or support needed, will provide the hospital the name of the primary clinician assigned for the client within three (3) business days of the linkage and will serve the client at least weekly during the stay. Telephone and video conferencing may be used in the case of out–of–county hospitals.

b. Currently linked, re–linked and newly linked adults hospitalized at The Ohio State University, Mount Carmel Hospital, and Riverside Methodist Hospital or requiring a stay on the Netcare Crisis Stabilization Unit (CSU) or other ADAMH crisis stabilization beds.

i. Post–Discharge Response Timeframe: The Provider shall provide an outpatient service in the community within seven (7) days of discharge and an appointment with the Provider psychiatrist within fourteen (14) days of discharge.

ii. Pre–Discharge Response Timeframe: Columbus Area, Inc., Concord Counseling Services, North Central Mental Health Services, North Community Counseling Services and Southeast, Inc. shall provide an on–unit assessment or other linkage service within three (3) business days of receiving a referral from the unit, if the unit makes the referral at least two (2) business days prior to discharge. If the unit refers to other Providers, if the referral from the unit is delayed, or if discharge occurs prior to on–unit assessment or other linkage service, the Provider shall make all reasonable efforts to have telephone contact with the client on the unit and offer the outpatient services within the timeframe identified in this Section. The Provider shall give notification to the unit of treatment assignment, time, date and location of follow up appointment prior to discharge.

c. Currently linked, re–linked and newly linked adults requiring a multi–day physician–ordered Netcare Holdover stay.

i. Post–Discharge Response Timeframe: In accordance with ADAMH System Quality Indicators, the Provider shall provide currently linked clients a treatment service within three (3) business days of a Netcare Crisis Episode. For re–linked or newly linked clients requiring a multi–day physician–ordered Holdover, the Provider shall provide an outpatient service in the community within seven (7) days of discharge, and if clinically indicated, an appointment with the Provider psychiatrist within fourteen (14) days of discharge.

ii. Pre–Discharge Response Timeframe: The Provider shall make all reasonable efforts to have telephone contact with the client on the unit and offer the outpatient services within the timeframe identified in this Section. The Provider shall give notification to the unit of treatment assignment, time, date and location of follow up appointment prior to discharge.

d. Currently linked, re–linked and newly linked children and adolescents who are referred from in–county or out–of–county private/community psychiatric hospitals and ADAMH–funded Crisis Stabilization Beds.

i. Post–Discharge Response Timeframe: The Provider shall provide an outpatient service in the community within seven (7) days of discharge, and if psychiatrically medicated at discharge, will facilitate an appointment with a physician in the community within thirty (30) days of discharge.

ii. Pre–Discharge Response Timeframe: The Provider shall provide an on–unit assessment or other linkage service within three (3) business days of receiving a referral from that unit, if the unit makes that referral at least two (2) business days prior to discharge. If the referral from the unit is delayed, or if discharge occurs prior to on–unit assessment or other linkage service, then that Provider shall make all reasonable efforts to have telephone contact with the client on the unit and offer the outpatient services within the timeframe identified in this Section. The Provider shall give notification to the unit of treatment assignment, time, date

and location of follow up appointment prior to discharge. Telephone and video conferencing may be used in the case of out–of–county Hospitals.

e. Currently linked, re–linked and newly linked adults referred from Maryhaven, Inc. from its Engagement Center, Sub–Acute Detoxification and Ambulatory Detoxification programs for AoD services only.

i. Post–Discharge Response Timeframe: The Provider shall provide services within seven (7) days of discharge from the designated Maryhaven programs.

f. Currently linked, re–linked and newly linked adults placed on outpatient commitment by order of the probate court.

i. Post–Probate Court Determination Response Timeframe: The Provider shall provide an outpatient service in the community within seven (7) days of discharge and an appointment with the Provider psychiatrist within fourteen (14) days of discharge.

4.6.3. ***Access to Care Based on Clinical Acuity, Risk and Protective Factors:*** The Provider shall holistically evaluate and effectively respond to members' clinical acuity, factors which exacerbate risk or pose immediate threats to safety and the protective factors which might mitigate the risk.

a. Each provider will have clear educational materials available to disseminate to each consumer and their family that provides a consistent message regarding expectations of ongoing care (e.g., average length of stay, discharge criteria, alternative resources available).

b. In addition to the highest priority referral categories of persons stepping down from more restrictive crisis levels of care or on outpatient commitment per Section 4.8.2, and commensurate with the size and scope of each program, the Provider shall plan for and serve new clients with urgent needs.

c. The Provider shall anticipate and effectively respond to the emergent and urgent clinical needs of current clients, to prevent the escalation of crises and promote resolution in the least restrictive manner in the member's natural environment, and with respect for member's treatment preferences.

d. The terms "urgent" and "emergent" are descriptors of dynamic episode–specific clinical acuity rather than static person–specific descriptors. Due to the nature of mental and addictive disorders, persons' intensity of clinical need may fluctuate, necessitating different provider response times and intensity.

e. The Provider shall meet the following access to care timeframes for persons assessed to have emergent, urgent or routine needs, as follows:

i. Persons with Emergent Treatment Needs:

a) Response Timeframe: Persons with emergent needs shall be assisted within three (3) hours by the Provider or the Provider will take appropriate measures to obtain assistance for the person by another provider.

b) Clinical Presentation: Indicates a need for immediate intervention due to the presence of factors that may place the person at imminent risk of harm to self, harm to others, or serious and acute deterioration in functioning. A person with emergent needs, if clinically indicated following the intervention, may require a prioritized referral into a more restrictive treatment environment.

ii. Persons with Urgent Needs:

a) Response Timeframe: Persons with urgent needs shall be served within two (2) days (48 hours) where appropriate OhioMHAS–certified services can be made available.

b) Clinical Presentation: Indicates a need for expedited treatment due to the presence of factors that could place the person at risk of harm to self, harm to others, or serious and acute deterioration in functioning. The person is not exhibiting such symptoms at present; however these risks could increase without expedited access to treatment.

iii. Persons with Routine Needs:

a) Response Timeframe: Providers shall make every effort to provide timely access to services for persons with routine treatment needs within 72 hours. Persons who are not identified as having emergent or urgent needs may be placed on waiting lists. Persons on wait lists will be made aware of the potential length of time they may have to wait for treatment, an agency contact name and number, what to do if needs become urgent, and alternative services or supports that may be available.

b) Clinical Presentation: No identified factors that would suggest the person is currently exhibiting or at risk of exhibiting harm to self, harm to others, or serious and acute deterioration in functioning, such that more immediate access to treatment would be warranted.

iv. Notwithstanding the provisions of paragraphs i, ii, or iii above, Pregnant Women and Intravenous Drug Users shall be offered an assessment or clinical engagement appointment within 24 hours from initial contact or referral. Such members shall be offered admission to a clinically appropriate treatment program within 24 hours from completion of the assessment. If assessment, engagement and/or treatment services are not available within the time required by this Section 4.6.3.e.iv, then a clinically appropriate referral to another provider shall be made immediately. If no clinically appropriate treatment referral is available through a provider funded by the ADAMH Board, then the member may be placed on a waiting list and the Provider shall offer or arrange for appropriate interim services.

v. Child Welfare, Disability Development and/or Juvenile Justice Involved Children: Notwithstanding the provisions of paragraphs i, ii, or iii above, the Provider shall participate in the referral and linkage processes for children involved in multiple systems with behavioral health needs in particular, currently linked, re–linked and newly linked children and adolescents previously in Franklin County Children's Services custody who are transitioning from in–county or out–of–county long term residential treatment.

vi. Netcare Referrals (excluding Crisis Stabilization Unit and Holdover Priority Referrals as required above): providers shall accept referrals from Netcare Access, in accordance with the Board priorities, outlined in this contract and in a volume commensurate with the provider's ADAMH Board allocation and Agency Services Plan/Budget. A referral from Netcare based on crisis services or an assessment, shall have the same status as an initial request from the consumer directly. Urgent and routine protocols apply.

4.6.4. Consistent with Sections 4.6.1, 4.8.5, and 4.9, the Provider determines the appropriate level of care and maintains treatment as clinically appropriate and medically necessary.

4.6.5. If the Provider violates Section 4.6 and refuses referrals the ADAMH Board shall be notified immediately and take action accordingly. The ADAMH Board may review the pattern of referrals, providing communication of situations or concern, prior to taking appropriate action, including, but not limited to suspending future referrals and withholding ADAMH–service payments.

4.6.6. If there are disputes regarding Section 4.6, the Provider shall provide services to the member until the dispute is resolved. Reimbursement for services under dispute shall be made in accordance with applicable requirements.

4.7. Waiting Lists, Service Demand and Capacity

4.7.1. Waiting lists shall be available for all Publicly Funded Services in the event of capacity overflow unless otherwise prohibited by existing regulations.

4.7.2. Provider shall establish policies and procedures, including waiting list management; program–specific admission, exclusion, continued stay and discharge criteria; client prioritization processes; referral requirements; interim contact/service strategies and responses to "no shows". The provider shall make these policies and procedures available to consumers, family members on all waiting lists maintained by the Provider, and will submit a copy of the current waiting list roster when requested by the ADAMH Board.

4.7.3. The Provider agrees to work in partnership with the ADAMH Board to develop and implement a shared, HIPAA–compliant web–based waiting list function to monitor and track individuals waiting for treatment and housing services in the ADAMH system of care including but not limited to the requirements of section 5119.362 of the Ohio Revised Code.

4.8. Provision of Services

4.8.1. *ADAMH Services* Subject to available funding per Attachment 1, the Provider shall accept members who are eligible for ADAMH paid services who meet the Provider's admission criteria and who are otherwise eligible for care under this Contract.

4.8.2. Subject to available funding, the Provider will offer services from within the ADAMH service taxonomy to members enrolled, including face–to–face, telephone, and outreach services as clinically appropriate.

4.8.3. The Provider shall manage ADAMH service funding to provide consistent access for consumers throughout the contract year.

4.8.4. If the Provider anticipates that it will not have capacity to accept ADAMH services referrals for more than a 30–day period, the following procedure shall be followed:

a. The Provider shall notify the ADAMH Board thirty (30) days in advance of the discontinuation of referral acceptance and supply the following documentation to the ADAMH Board:

i. A narrative listing the affected programs and explanation of the circumstances, anticipated date when referrals shall be again accepted, actions to mitigate the circumstances and maximize efficiencies, AND

ii. Current agency financial statements and other fiscal data requested by ADAMH related to ADAMH financed capacity.

b. The ADAMH Board shall review all applicable supporting documentation.

c. If it is determined to be necessary after review of documentation, a special Provider–Stat session shall be conducted.

4.8.5. The Provider retains the clinical responsibility for the development of a recovery/resiliency oriented, individualized service plan with the member or legal guardian that addresses the medically necessary clinical needs of the member and the interventions that will be utilized to meet those needs. The member or legal guardian has the right to informed participation in the development, periodic review and revision of the individualized treatment plan, and to receive a copy of it. Nothing in this language will preclude a Provider from providing medically necessary services, to youth or adults, and being reimbursed for those services that are covered under this Contract.

4.9. Transfer and Termination of Services

4.9.1. The Provider shall not transfer or terminate services to any member until one of the following in 4.9.1.a–4.9.1.g has occurred:

a. Services have been voluntarily terminated by the member;

b. The treatment or crisis plan has been completed;

c. Member cannot be located within sixty (60) days of referral or last contact;

d. Appropriate referrals and linkages have been developed and put in place;

e. The member has moved out of Franklin County with the intent to establish residency in another county;

f. Death of the member; or

g. Involuntarily terminated by the court system.

4.9.2. Prior to transferring or terminating services to a member for the following in 4.9.2.a.–c., the Provider shall offer multiple explanations to the member and shall determine that transfer or termination is not likely to result in harm to self or others:

a. The member refuses to enroll for other third–party payers for which member is eligible, member refuses to utilize third–party benefits when possessed, and/or member refuses to pay fees when other third–party benefits were not sought or used,

b. No clinical progress is being made; or

c. When it is determined that termination is clinically appropriate.

4.9.3. Providers will have policies and procedures in place to address and review terminations and transfers. These policies and procedures will be consistent with existing OhioMHAS guidelines and standards.

4.10. Subcontracts Subcontracted services, including treatment and administrative services, shall operate in conformity with this Contract and other applicable requirements.

4.11. Crisis, Crisis, Assessment and Referral Procedures

4.11.1. The Provider shall enter into a mutually acceptable affiliation agreement with Netcare by the beginning of each contract period (January 1) for crisis services and shall do all of the following:

a. Mutual communication of appropriate clinical information to ensure continuity of care.

b. Mutual adherence to agreed–upon protocols for clinical continuity.

c. Mutual adherence to system–wide access to services and capacity plan to be developed by the ADAMH Board and Provider Leadership Association (PLA).

4.11.2. Policies, procedures and guidelines adopted by the Provider for crisis, assessment and referral shall be carried out in accordance with ADAMH Board policies, procedures and guidelines, the Contract, the ADAMH Board Community Plan for the Provision of Alcohol, Drug Addiction and Mental Health Services and the Agency Services Plan or equivalent.

4.11.3. The Provider shall ensure that emergency intervention services are provided in accordance with professional standards to members in need of such services.

4.12. Enrollment and Reporting

4.12.1. After verifying and documenting eligibility as defined in Section 4.5, the Provider shall enroll all eligible Franklin County residents who seek and/or are referred for ADAMH Services (as defined in Section 2.3) within 10 business days of their first date–of–service.

4.12.2. The Provider shall take all steps reasonably necessary to permit the ADAMH Board to collect name–identifying information for the purpose of enrolling clients in publicly–funded services, establishing eligibility of clients and processing their claims for payment.

4.12.3. The Provider shall provide the member with the required disclosures; and shall have the member sign all consent for treatment, authorization to bill, and/or release forms in accordance with applicable requirements.

4.12.4. After meeting the requirements of Section 4.12.3, the Provider shall enroll the client in accordance with SHARES Member Enrollment procedures. ADAMH will determine a new client's eligibility within 10 business days of the Provider's submission into SHARES IPC.

4.13. Member Management To ensure member information and claims adjudication accuracy the Provider shall submit changes to the member's enrollment information using the SHARES Member Update Form.

4.14. Disclosures and Releases of Information

4.14.1. Prior to enrollment and claim submission, the Provider shall make every reasonable effort to ensure that each member who is seeking publicly–funded services signs the release/consent for treatment, reviews the disclosure statement which conforms to applicable requirements of O.R.C. 1347, and which informs the member of required information including, but not limited to:

a. The purpose of the Personal Information System known as SHARES,

b. How information will be used by the State Departments, the ADAMH Board and other public funders,

c. The security provision to prevent re–disclosure,

4.14.2. The Provider shall ensure that members sign all releases which are necessary under applicable laws and rules, including, but not limited to, releases of information on drug and alcohol treatment which conform to requirements of Federal (42 CFR - §290dd-3. Confidentiality of [Alcohol Abuse] Patient Records or 42 CFR - §290ee-3. Confidentiality of [Drug Abuse] Patient Records) and State law(ORC 5119.27 Confidentiality of Records Pertaining to Identity, Diagnosis or Treatment).

4.14.3. Any uses or disclosures of PHI will be made in accordance with the HIPAA regulations and when applicable, any stricter or more stringent requirements of other federal or state law will be adhered to.

4.14.4. Requests for and disclosures of PHI will comply with the minimum necessary standard as required by HIPAA regulations, 42 CFR 164.514(b)(2)(i)A–R (as applicable) and consistent with ADAMH's policy.

Article 5. Administration

5.1. Acknowledgment

5.1.1. For those services funded by the ADAMH Board, the Provider's letterheads, advertisements, newsletters and brochures shall include the ADAMH Board logo or the statement that the Provider is a contract agency of the Alcohol, Drug and Mental Health Board of Franklin County.

5.1.2. The Provider's website shall include the ADAMH Board logo and link to www.adamhfranklin.org

5.1.3. The Provider shall work in partnership with the ADAMH Board to implement the Community Education Plan, and enhance community support for the publicly funded community safety network of care which addresses alcohol, drug and mental health needs of members in Franklin County.

5.1.4. The ADAMH Board shall provide the Provider with a sign which is appropriate for the Provider's location, and which identifies the ADAMH Board as a funder of the Provider. The Provider shall display such sign in a visible, publicly accessible and appropriate location in all facilities which are used by the Provider for services required under this Contract. The ADAMH Board shall display a sign at the ADAMH Board listing Board–funded providers.

5.1.5. The Provider shall notify and request representation from the ADAMH Board at any annual meeting or events where ADAMH Board–funded programs are highlighted. The ADAMH Board will provide advance notice to the Provider of any public meeting or event held by ADAMH where the Provider will knowingly in advance be discussed or highlighted.

5.2. Agency Services Plan/Budget and Disaster Mitigation/Recovery Plan

5.2.1. The provider must have an approved Agency Service Plan (ASP)/Budget prior to the execution of this Contract. The ASP/Budget is hereby incorporated as a deliverable to this contract.

5.2.2. The Provider agrees that the ASP/Budget will be used as a primary means for the ADAMH Board to manage system access, capacity, and outcomes.

a. The Provider agrees that the ADAMH Board has the right and responsibility to monitor whether ASP/Budget projections are on track in terms of numbers and capacities of people served, types of people served, and linkage to service for persons served.

b. The Provider further agrees that the Board will use projections and processes outlined in the ASP/Budget to determine, in part, whether expected outcomes are being met for persons served.

c. The Provider agrees that the Board may use scheduled Provider–Stat meetings, Board/PLA quality assurance processes, as well as other data collection methods to determine whether the expectations outlined in the ASP/Budget are being met with respect to system access, capacity, and outcome.

d. The Provider understands and agrees that the targets and projections outlined in the ASP/Budget are used by the Board to formulate and present a total system effort, individual provider effort, and that these data are presented to community regulatory authorities and others for system funding and support.

e. The Provider understands and agrees to the necessity to be forthcoming and accountable with respect to projections and targets set forth in the ASP/Budget.

f. The Provider agrees that projections made in the ASP/Budget and data collected throughout the year with respect to these projections may be used in quality improvement processes, system planning processes, and subsequently in system funding and planning decisions that might evolve from such processes.

g. If during a Contract Year, the anticipated number of unduplicated clients served or the number of new clients served for claim and/or block grant reimbursement changes materially (±10%), the Provider will be required to submit revised estimates to ADAMH for evaluation/approval.

5.2.3. The ADAMH Board shall allocate OhioMHAS Central Pharmacy Line of Credit, and may supplement this with ADAMH discretionary resources. The results of this allocation are, to meet the psychotropic medication needs of high risk/high priority indigent clients, thereby reducing unnecessary hospitalization because of the inability to afford required medications; to provide subsidized support for AoD Medically Assisted Treatment (MAT) costs; and to promote recovery.

a. *Central Pharmacy Management Plan*: The Provider shall have a Central Pharmacy Management Plan. The Plan shall be updated annually and submitted as a component of the Agency Services Plan and Budget as specified in Attachment 3 and approved by ADAMH as an attachment to this Contract. The Board and Provider shall routinely monitor the effectiveness of the Central Pharmacy Management Plan. The Plan shall identify the:

i. projected count of unduplicated clients and expenditures

ii. specific strategies and results of efforts to continually improve the clinical quality of care and cost–effective management

iii. role and impact of the Provider's Medical Director; and

iv. applicable program policies and procedures, including but not limited to a client cost–sharing and re–investment procedure.

b. *Regulatory Compliance*: The Provider shall comply with all federal and state laws and regulations, including the Ohio Pharmacy Service Center requirements; Ohio Department of Mental Health & Addiction Services Central Pharmacy Outpatient Manual and the ADAMH Board Provider Services Contract, or any other funding sources where requirements may be more stringent.

c. *Eligibility Determination*: Prior to utilizing this allocation for a client, the Provider shall determine financial and clinical eligibility. Eligibility re–determination shall be made quarterly thereafter, except as required for temporary assistance where financial eligibility shall be determined monthly.

d. *Financial Eligibility and Cost–Sharing*: The Provider shall determine financial eligibility in accordance with contract Section 11.9 Fees and Duty to Bill; Section 11.10 Duty to Appeal, and the Member Financial Eligibility, Fee Administration, and Public Subsidy Schedule specified in Attachment 14 to this Contract.

i. Central Pharmacy Line of Credit or ADAMH discretionary allocations shall not be used for clients with other payer or medication sources, including but not limited to medication samples; pharmaceutical assistance programs; Medicaid; managed care, third party insurance, and/or self–pay.

ii. If a client urgently needs medication, appears to be eligible for alternate payer or medication sources and the Provider has assisted him/her to apply for those sources, the Provider may use Central Pharmacy temporarily, and shall conduct financial eligibility review monthly until the alternate sources are available.

iii. Per Section 5.2.3.a.iv., the Provider shall develop, submit for approval and implement a client cost–sharing procedure for Central Pharmacy. The procedure shall ensure that:

a) the calculation of the client's cost–sharing liability is incurred consistent the income and family size framework of the ADAMH Public Subsidy Schedule, but will be managed by the Provider without the use of SHARES.

b) the cost–sharing is in the form of an administrative dispensing fee for routine medications, not to exceed a specified dollar level per month to cover all prescriptions.

c) the Provider shall collect and use the client administrative dispensing fee for clinical purposes, as the Provider deems appropriate.

e. *Clinical Eligibility:* The Provider shall determine clinical eligibility.

i. For psychiatric treatment, the Provider shall comply with the Ohio Pharmacy Service Center requirements and document the medical necessity for this pharmaceutical intervention. A client must be:

a) An adult with Severe Persistent Mental Illness or a youth with Severe Emotional Disturbance; or

b) At risk of psychiatric hospitalization if the medications were discontinues; or

c) Discharged from a mental health inpatient facility, residential treatment facility, jail or prison within three (3) month period prior to eligibility determination

ii. For AoD Medically Assisted Treatment, the Provider shall comply with the Ohio Pharmacy Service Center requirements and document the medical necessity for this pharmaceutical intervention.

f. The Provider shall implement procedures to ensure that Central Pharmacy Emergency Prescriptions are utilized as a last resort, arranging for next–day delivery as an alternative.

g. The Provider shall implement procedures to maximize credits for returned unused medications.

h. Central Pharmacy medications shall not be used for resale or redistribution to others.

5.2.4. Pursuant to Article 14 below, the Provider shall not make material changes, as defined in this Contract, in the Quality, Services/Programs Defined in its Agency Services Plan, Funding or Business Structure/Administration unless such changes have been approved in advance in writing by the ADAMH Board. Provider also affirms, understands and agrees that Provider and its subcontractors are under a duty to disclose to the Board any change or shift in location of services performed by Provider or its subcontractors before, during and after execution of this Contract with the Board. Provider agrees it shall so notify the Board immediately of any such change or shift in location of its services.

a. Thirty (30) days prior to planning a significant change, the Provider shall submit a written request for consultation with the ADAMH Board to determine materiality under this Contract.

b. If the ADAMH Board notifies the Provider that the proposed change is material, the Provider shall submit any requests for approval of material changes in its services to the ADAMH Board in writing no less than sixty (60) days prior to the anticipated change, in accordance with ADAMH Board procedures. This includes, but may not be limited to, a revised Agency Services Plan and Budget.

c. Nothing in this section should be interpreted as deterring the provider from developing plans for more efficient strategies in areas of quality, services and programs defined in the provider's ASP, funding, and /or business structure and administration.

5.2.5. The Provider shall present ASP/Budget progress reports in the format established by the ADAMH Board no more than four times during the term of this Contract in accordance with the following:

a. The ADAMH Board shall issue a thirty (30) day notice to the Provider prior to the presentation date.

b. The Provider shall provide data requested by the Board necessary to facilitate the progress report.

c. The Provider shall present its ASP/Budget report to the ADAMH Board, its trustees, its staff and community stakeholders through the "ADAMH Provider–Stat" process.

5.2.6. The Provider shall maintain an Agency Disaster Mitigation and Recovery Plan that addresses Continuity of Operations during an emergency. This plan shall include, at minimum:

a. Plans for staffing the agency if many staff are unable to get to work.

b. Contingency plans for operations if there is substantial physical damage to the agency building(s).

c. Plans for quick data recovery, particularly current consumer contact information and medication information.

d. Plans for fiscal continuity in the event of interrupted business.

e. Contingency plans for care for current consumers.

f. If the agency provides residential services, plans to evacuate and care for consumers separate from emergency community efforts such as police and the Red Cross.

g. *Regulatory Compliance*: The Provider shall comply with all federal and state laws and regulations or funding sources, including the Ohio Department of Mental Health & Addiction Services or the Substance Abuse and Mental Health Services Administration where requirements may be more stringent.

5.2.7. The Provider shall participate in the provision of behavioral health services to the community in the event of a community disaster, and at the request of the ADAMH Board by the Franklin County Emergency Management and Homeland Security Agency.

a. The Provider shall maintain current all–Hazards Coordinator name and contact information with the ADAMH designee.

b. The Provider shall maintain clinicians available for community service that have been trained in disaster counseling techniques, to be deployed at the request of the ADAMH designee.

c. The Provider shall sign a Memorandum of Understanding (refer to Attachment 3 for due date) with the ADAMH Board that describes the details and procedures of provision of behavioral health care services to the community in the event of a disaster.

5.3. Provider Autonomy The Provider is a fully independent and autonomous contractor and retains the ultimate responsibility for the care and treatment of members to whom services are rendered under this Contract. The ADAMH Board recognizes the Provider as an independent contractor in carrying out its duties under this Contract. The ADAMH Board recognizes that the Provider has full and sole authority to determine its governing structure and employees.

5.4. Training, Technical Assistance and Consultation The ADAMH Board shall provide the Provider with training, technical assistance and consultation when such services are reasonably necessary to meet applicable requirements. The ADAMH Board shall, if feasible, give notice of such training at least 30 days prior to the date of such training. The appropriate Provider staff will attend and participate in ongoing core competency learning opportunities offered or sponsored by the ADAMH Board. The ADAMH Board shall take steps reasonably necessary to obtain approval for appropriate continuing education credit if applicable

5.5. Extranet Hotline The ADAMH Board shall offer the 3C Hotline, the secured, web–based request system at https://tracker.phaseware.com/3CHelpdesk/. To increase efficiency and customer service accountability, the Provider shall use the 3C Hotline as the preferred approach for submitting operational questions or concerns to ADAMH for resolution. Operational requests include but are not limited to SHARES, Finance/Fiscal, Evaluation and Accountability, and Network/System Planning.

Article 6. Information and Reports

6.1. General Access by ADAMH Board

6.1.1. The Provider shall provide ADAMH Board with information which is reasonably necessary to permit the ADAMH Board to submit the Community Plan for the Provision of Alcohol, Drug Addiction and Mental Health Services, which is submitted to OhioMHAS in order to fulfill the Plan's intended purposes relating to advocacy and information sharing.

a. Monitor and evaluate the Provider’s compliance with the terms of this Contract, including, ensuring quality, effectiveness and efficiency of services and ensuring the accuracy of claims submitted for reimbursement under this Contract,

b. Verify that costs of services, including all administrative, direct and indirect costs, are being computed in accordance with Article 10,

c. Verify the sources and amount of all income received by the Provider for services provided under this Contract and services similar to those provided under this Contract,

d. Investigate alleged misuse of member funds or funds provided under this Contract, and

e. Perform its duties under applicable requirements.

6.1.2. The Board shall have the right to inspect the Provider's program, personnel, accounting, member residency and financial eligibility documentation and clinical records while complying with HIPAA minimum necessary standards, as required to discharge their legal responsibilities.

6.1.3. The Board and Provider shall maintain the client's right to confidentiality as required by law or as provided by Provider policies to the extent the latter does not conflict with legal responsibilities.

6.1.4. The Provider shall not be required to provide proprietary information unless such information is required to be provided under applicable law or this Contract.

6.1.5. Except under circumstances listed in Section 6.1.6, information shall be provided by the Provider during ordinary business hours and the ADAMH Board shall provide reasonable prior notice of the time and date of the visit.

6.1.6. The ADAMH Board may obtain immediate access to information without prior notice, including access to staff, individual member records and member accounts, under any of the following circumstances:

a. Such information is reasonably related to allegations of abuse or neglect of a member being investigated in accordance with Section 6.7, or

b. To prevent imminent harm to members, or

c. When the ADAMH Board reasonably believes that immediate access is essential to prevent removal or destruction of property or records required to be maintained under this Contract.

d. When the ADAMH Board reasonably believes that there is substantial violation of client rights because of actions by the Provider.

6.2. Basic Documents Upon request of the ADAMH Board, the Provider shall provide the ADAMH Board with the most recent versions of the following documents:

6.2.1. Articles of Incorporation and By–Laws for the Provider.

6.2.2. Evidence of certification as required under applicable requirements.

6.2.3. Risk management procedures.

6.2.4. Current policies and procedures which conform to the ADAMH Board's Member Financial Eligibility, Fee Administration and Public Subsidy Schedule Policies and Procedures as required under Sections11.9 and 11.10.

6.3. Essential Periodic Reports

6.3.1. The Provider and the ADAMH Board shall provide the reports listed in Attachment 3 at such times as are specified in said Attachment.

6.3.2. Failure to provide reports in accordance with the requirement of this Contract shall subject the Provider to the sanctions set forth in Section 11.8.8 subject to notice under Sections 11.8.9 and 11.8.11.

6.3.3. Provider shall ensure the accuracy of all reports in Attachment 3, regardless of format.

6.3.4. If the Provider is submitting information in both written and electronic formats, the Provider shall ensure that the information is both consistent and accurate. The ADAMH Board shall not issue reimbursement until paper and electronic data are consistent and accurate.

6.4. Format Any information or report which is required under this Contract shall be submitted in the format prescribed by the ADAMH Board.

6.5. Grants Within thirty (30) days of receipt of new grant funds over the year from any funding source for behavioral healthcare services, which equal or exceed 10% of the total ADAMH Board allocation to the Provider under this Contract, the Provider shall provide the ADAMH Board with written notice of receipt of such grant(s); a copy of the budget approved for the grant(s); and an explanation of how the grant may materially impact its ADAMH Board allocation and services to targeted populations outlined in its ASP/Budget.

6.6. Inventory

6.6.1. *Personal Property Assets (PPA)*

a. The Provider shall prepare a statement defining personal property assets which have been purchased with public block grant funds which define a property interest for the ADAMH Board or State or Federal Government. Upon approval by the ADAMH Board, a copy of said statement shall be attached to this Contract as Attachment 4.

i. The statement shall include a detailed description of such personal property purchased, the purchase date, and funding source in order to facilitate identification of property (i.e.: model number and serial number).

ii. If such personal property is owned in part by the ADAMH Board, State or Federal Government, the parties shall determine which part of the property is owned by the ADAMH Board, State or Federal Government. The Provider shall list the ownership interests in the statement of assets described in Section 6.6.1 and include such list in Attachment 4 and include a label on the equipment to document the ownership of the equipment by the ADAMH Board, State or Federal Government, as the case may be.

b. All future PPA with a cost under $5,000 per each PPA purchased with block grant funds by the Provider shall be the property of the Provider, unless the budget documents specify otherwise.

c. PPA with a cost of $5,000 or greater per each PPA shall be recorded in accordance with applicable requirements, including, but not limited to, audit guidelines adopted by OhioMHAS.

d. Ownership of PPA with a cost of $5,000 or greater per each PPA shall be determined in accordance with applicable requirements, including, but not limited to, audit guidelines adopted by OhioMHAS. For assets purchased with ADAMH Board funds that the Provider received for the purpose of purchasing the specified assets, the ADAMH Board shall retain ownership of all assets with a cost of $5,000 or greater unless the grant award letter or grant contract stipulates that the Provider retains ownership of property purchased through the grant.

e. The ADAMH Board shall retain its designated interest in personal property designated as being owned by the ADAMH Board until such interest is released by the ADAMH Board in writing.

f. The Provider will not take any action to grant a lien on security interests in such property.

6.6.2. *Real Property* Any interest in real property owned by the Provider which is established by the ADAMH Board at the time of the signing of this Contract shall be included in Attachment 4. In order to be an established interest, the interest must be recorded in accordance with applicable law.

6.6.3. *Waiver* It is understood and agreed that the ADAMH Board hereby waives any property interest or right it may have to any property real or personal of the Provider for which the Provider has not received ADAMH Board, State, or Federal funds which have established a property interest and which has not been designated as ADAMH Board property under Section 6.6.1.f after the date of Attachment 4.

6.7. Major Unusual Incidents (MUI—ODADAS) and Incident Notification (IN—ODMH) The Provider and the ADAMH Board shall agree to comply with all applicable requirements in law and in OhioMHAS rules,

guidelines and protocols. In addition, Providers with ODADAS certification shall investigate each allegation of abuse and/or neglect and shall communicate the results to the ADAMH Board.

Article 7. Evaluation and Accountability

7.1. General The Provider shall cooperate with the ADAMH Board in all monitoring activities, including, but not limited to program reviews, audits and other fiscal monitoring. Requests for information shall be made in accordance with the requirements of Section 6.1.

7.1.1. The Provider shall process reversals on ADAMH services claims determined to be ineligible as a result of a review conducted by ADAMH. Reversals must be processed in accordance with ADAMH procedures.

7.1.2. The Provider shall submit encounter data for all non–exempt block grants. ADAMH will determine if the Provider's block grants are exempt from encounter claiming and if claims are to be submitted under individually enrolled client's SHARES ID or under SHARES Group Member.

7.2. Accounting

7.2.1. The Provider shall maintain complete and accurate financial records with respect to all undertakings required by this Contract. The Provider is responsible for ensuring that its financial statements are consistently reported and fairly presented in accordance with generally accepted accounting principles.

7.2.2. All financial reports to the ADAMH Board shall be made on an accrual basis, whether or not the accounts are maintained on a cash basis.

7.3. Audits

7.3.1. The Provider shall submit to an annual financial and compliance audit conducted by a qualified certified public accountant (Audit Contractor) in accordance with generally accepted government auditing standards and the uniform guidance in 2 CFR Chapter II, Part 200 titled *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.*

7.3.2. The Provider shall execute and comply with the Audit Memorandum of Understanding issued by the ADAMH Board to set forth Board audit requirements and standards.

7.3.3. The Provider shall direct the Audit Contractor to submit its report to the ADAMH Board within six (6) months after the end of the Provider's fiscal year being reported.

7.3.4. If the Audit Contractor's report as required herein is not submitted in a timely manner, then the parties shall immediately arrange an audit conference. The ADAMH Board may allow up to 30 additional days for the Provider to submit the Audit Contractor's report. If the report is not submitted within the required time limit, or the time limit as extended, then the ADAMH Board may resort to suspension procedures set forth in Section 11.8.8 or to termination procedures set forth in Article 14 of this Contract. Failure to submit a timely, complete annual financial audit may result in the ADAMH Board assuming responsibility for contracting with an Audit Contractor to ensure a satisfactory completion of the audit. If the Board assumes this responsibility, the costs shall continue to be borne by the Provider.

7.3.5. The Provider shall direct the Audit Contractor to provide four (4) copies of the Audit Contractor's report and one (1) copy of the management letter, if applicable to the ADAMH Board promptly after the audit's completion.

7.3.6. In accordance with the Memorandum of Understanding, the parties shall meet with the Audit Contractor upon receipt of a draft audit.

7.3.7. In the event the audit contains findings in the Schedule of Findings and Questioned Costs, exceptions, or the Provider's records are deemed not auditable, or a qualified opinion is received on the financial statements, then:

a. The parties shall immediately arrange an audit conference.

b. The Provider shall submit a Corrective Action Plan (CAP) within 30 days .

i. Any overpayment resulting from duplicate billings, erroneous billings, deceptive claims, unallowable costs, or any falsification shall be refunded to ADAMH Board in full.

ii. To be deceptive means knowingly to deceive another or cause another to be deceived by a false or misleading representation by withholding of information or by any other act, conduct, or omission which creates, confirms or perpetuates a false impression of another, including a false impression as to law, value, state of mind or other objective or subjective fact.

iii. For any duplicate, erroneous, or deceptive claims which are discovered during the term of this Contract, regardless of the date such claims were initially made, the Provider shall, on a timely basis, submit detailed claim correction reports to the ADAMH Board to allow the ADAMH Board to make manual claims corrections within SHARES, in accordance with applicable requirements.

c. The Provider shall provide the ADAMH Board with quarterly updates of progress made toward implementation of CAP until full implementation is achieved.

7.3.8. The Provider shall pay for audit costs directly and may include audit costs in costs for services.

7.4. Additional Audits and Reviews

7.4.1. If the Provider is required to submit a CAP as provided in Section 7.3.7.b or a CAP for any other reason, the ADAMH Board may require the Provider to submit to a further examination to determine whether the deficiencies have in fact been corrected.

7.4.2. In the event any Federal or State agency requests an audit in accordance with applicable law, then the Provider shall submit to such an audit.

7.4.3. Costs of additional audits shall be the responsibility of the Provider.

7.4.4. The Provider shall retain financial records, including supporting documentation, for at least six (6) years after records have been audited. Notwithstanding the above, if there is litigation, claims, audits, negotiations or other actions that involve any of the records cited and that have started before the expiration of this time period, such records shall be retained until completion of the actions and resolution of all issues, or the expiration of the six–year period, whichever is the last to occur.

7.4.5. Provider shall direct the Audit Contractor to obtain a review, by an attorney licensed to practice law in the State of Ohio, of all suspected illegal acts and non-compliance findings discovered by the Audit Contractor during the engagement which are incorporated in the Report on Internal Control over Financial Reporting and on Compliance and Other Matters Required by Government Auditing Standards that have a direct and material effect on the determination of financial statement amounts. In this review, the attorney must determine whether there is sufficient evidence to support a written determination the suspected illegal act or non-compliance occurred. Provider shall direct Auditor Contractor to document this legal review in the Audit Contractor's work papers. The legal review may be performed by the Audit Contractor firm's in-house attorney(s) or by subcontract with an attorney not employed by the Audit Contractor.

7.5. Reconciliations

7.5.1. *Cash Payment/Expenditure Reconciliation*—The ADAMH Board will reconcile Provider block grant and claims expenditures to ADAMH Board cash payments and allocations in accordance with ADAMH Board reconciliation procedures as described in Attachment 10 to this Contract.

7.6. Documentation and Records

7.6.1. The Provider shall keep accurate, current and complete clinical records for each member as required by law.

a.

7.6.2. The Provider shall collect and report Youth Mental Health Outcomes, Adult Mental Health Outcomes, Adult Alcohol and Other Drug Outcomes and Consumer Satisfaction–related information to the ADAMH Board in accordance with procedures established by ADAMH.

7.6.3. The ADAMH Board shall monitor the Provider's Outcomes and Consumer Satisfaction-related information reporting and performance in accordance with Attachments 3 of this Contract. The Provider shall be in compliance if it maintains:

a. Compliance with all procedures established by ADAMH and communicated by ADAMH no less than 120-Days before effectiveness, and

b. Compliance with related follow-up inquiries made by ADAMH, including error correction responses and requested corrective action plans resulting from concerns relating to lack of due diligence on Youth Mental Health Outcomes, Adult Mental Health Outcomes, Adult Alcohol and Other Drug Outcomes, or Consumer Satisfaction–related information reporting or performance.

7.6.4. The Provider may avoid payment withholds by submitting and enacting a requested corrective action plans.

7.6.5. Upon ADAMH request, the Provider shall provide rosters with requested information for consumers identifiable by program, treatment modality and/or evidence–based initiatives to collaborate with the ADAMH Board's evaluation, quality improvement and/or other research or monitoring activities.

7.6.6. Providers shall submit clinically accurate primary and secondary diagnosis on all SHARES claims, including:

a. Updating the clinical paper and electronic record/module to reflect the most current diagnoses

b. Updating the billing record/module to reflect the most current diagnoses, in the case where the clinical and billing modules of a provider's MIS are not integrated

c. Ensuring that the software vendor "sets" the provider's billing module to release/include both the primary and secondary diagnosis on the claims.

7.6.7. Reimbursement for services may not be made until documentation necessary to support the billing has been provided in accordance with requirements of this Contract.

7.6.8. The Provider shall adopt a record retention policy in accordance with applicable requirements.

7.7. Prevention Application and Outcome Reporting Procedures

7.7.1. All providers receiving funding to provide alcohol and other drug and/or mental health prevention services to any target population shall provide data and outcomes information for all services funded by the ADAMH Board utilizing SHARES. Applicable state and ADAMH defined prevention strategies include: Prevention & Intervention, Prevention Information Dissemination, Prevention Education, Prevention Community–Based Processes, Prevention Environmental Approaches, Prevention Problem Identification and Referral, and Prevention Alternatives.

7.7.2. The ADAMH Board may provide a specific exemption from Section 7.7.1 in response to the Provider's written request.

7.7.3. All providers receiving funding to provide alcohol and other drug prevention services to any target population shall utilize the OhioMHAS web–based system to submit program and outcome data for all alcohol and other drug prevention services funded by the ADAMH Board.

7.8. Utilization Review, Monitoring, and Levels of Care

7.8.1.

7.8.2. Providers shall cooperate with the ADAMH Board in the development and implementation of utilization review activities and other activities which will assist in improving the quality, efficiency and cost–effectiveness of care under this Contract.

7.8.3. Upon request of the ADAMH Board, Providers shall participate in an annual Provider–Stat session. Provider–Stat is an interdisciplinary performance and quality improvement monitoring process comprised of Financial Performance, System Quality, Access to Services, Customer Satisfaction and Contract Compliance core business areas.

a. Providers will ensure that a consumer or family member associated with the Provider attends the Provider–Stat session.

b. The consumer or family member attending the Provider–Stat session shall be actively involved (Provider Board member or a Consumer & Family Advisory Group) with providing recommendation and advice on the delivery of mental health and alcohol and other drug addiction services per Section 4.1.2.

Article 8. Conflicts of Interest

8.1. Nepotism Policy The Provider shall adopt and implement a policy which prohibits conflicts of interest arising from nepotism which meets applicable requirements.

8.2. Prohibition No member or employee of the ADAMH Board or prohibited family member of a member or employee of the ADAMH Board shall serve on the board of the Provider or as an employee of the Provider. A prohibited family member is a spouse, child, parent, brother, sister, grandchild, stepparent, stepchild, stepbrother, stepsister, father–in–law, mother–in–law, son–in–law, daughter–in–law, brother–in–law, or sister–in–law or a person who stands in the place of such a family member.

8.3. Recruitment of Members No employee of either party shall recruit members receiving services under this Contract into their private practices. Recruitment shall mean referral to the employee or the employee's business in a manner which results in financial gain to the employee when other suitable alternatives for providing services to the member are reasonably available.

Article 9. Transition Procedures

9.1. Applicability This Article 9 shall apply when any service provided under this Contract is terminated for any reason or when this Contract is terminated for any reason including the dissolution or termination of the Provider's business.

9.2. General Requirement The Provider shall work cooperatively with the ADAMH Board to assist in the transition of services and programs as needed to a Provider or Providers designated by the ADAMH Board. Throughout the transition, the parties shall take all steps reasonably necessary for continuity of member care and to protect member interests.

9.3. Member Records To the extent authorized by the member and permitted under applicable law, copies of member records shall be transferred promptly to the designated Provider or Providers. In the event the Provider is ceasing all operations, the Provider shall comply with federal and state record keeping requirements.

9.4. Property Transfers Personal property in which the ADAMH Board has any ownership interest either under applicable requirements or in accordance with Section 6.6 shall be made available to the ADAMH Board for transfer. Personal property in which the ADAMH Board is acting as fiduciary on behalf of OhioMHAS or the

Federal Government who has any ownership interest in such property, either under applicable requirements or in accordance with Section 6.6 shall be made available to the ADAMH Board for transfer. The ADAMH Board shall be responsible for the transfer of such property. The ADAMH Board shall have the right of first refusal to buy out any property in which the ADAMH Board has a full or partial interest.

Article 10. Standards for Budgets, Costs, Rates and Fees

10.1. Budget Development and Revision The Provider shall develop and revise budgets in accordance with ADAMH Board budget procedures.

10.1.1. Provider may submit budget revisions at any time during the term of this Contract. Such submissions must comply with Section 5.2 of this Contract.

10.1.2. Budget revisions involving claims reimbursement shall be effective on the date the revisions are entered into SHARES.

10.2. Allowable Costs ADAMH funds allocated in this contract shall not be used for unallowable expenses as defined by the uniform guidance in 2 CFR Chapter II, Part 200 titled *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*.

10.3. :

10.3.1. Compliance Supplements of the applicable Federal financial assistance program(s), or

10.3.2. Award correspondence from OhioMHAS or the ADAMH Board.

10.4. Maximum Reimbursement Rates For ADAMH Services

10.4.1. The ADAMH Board shall not compensate a Provider for any service at an amount which exceeds the budget rate approved by the ADAMH Board or the amount charged by the Provider, whichever is lower.

Article 11. Reimbursement by ADAMH Board

11.1. General The ADAMH Board shall make reimbursement required under this Contract for services rendered under this Contract.

11.1.1. Unless this Contract specifically provides otherwise, all reimbursement shall be made in full for services actually provided and for which there is appropriate documentation as set forth in this Contract.

11.1.2. Reimbursement shall be made within the normal course of ADAMH Board business.

11.1.3. There shall be no alteration in the amount of reimbursement or the allocation of such reimbursement without prior notice as set forth in Article 14, unless the parties have agreed to such changes.

11.2. Block Grant Reimbursement Reimbursement shall be made monthly in accordance with ADAMH Board block grant draw–down procedures and availability of local, state and federal funds as set forth in Attachment 13 to this Contract.

11.2.1. The Provider shall submit its correctly completed Block Grant Funding Request Form by the first business day of the month in order to receive a block grant payment during that month. All other Requests shall be held until the following month for payment.

a. The Provider's Block Grant Funding Request Form, due by the first business day of December, shall include actual expenditure activity through November 30 and projected expenses through December 31.

b. ADAMH shall not process any Block Grant Funding Requests in January for the prior year's expenses.

c. In accordance with 11.2.2, ADAMH shall process final Block Grant payments for the prior year's expenses in February.

11.2.2. To ensure accurate and timely contract payment reconciliation, the Provider shall submit its correctly–completed final Block Grant Funding Request and Block Grant Expense Report(s) for the year no later than contractual claim file submission deadline (January 31, 2018 for Contract Year 2017). ADAMH shall not accept any block grant reports after this deadline. The Provider shall forfeit any funds not drawn down or reported as expenses by this deadline.

11.2.3. The provider shall follow Sections 4.12, 4.13, 7.1 and 7.5.1 for all block grants.

11.2.4. Failure to comply with Section 11.2.1 may result in ADAMH withholding payments per ADAMH's payment withhold policy until corrective action has been taken

11.2.5. Providers submit encounter data representing a minimum of 90% of the value of designated block grant payments received from ADAMH Failure to do so may result in the provider reimbursing ADAMH for unearned/unclaimed payments.

11.3. ADAMH Services Claims Reimbursement

11.3.1. The Provider shall electronically submit all claims for services rendered using an ANSI 837 electronic format or via the SHARES Incedo Provider Connect (IPC) web portal.

11.3.2. The ADAMH Board shall reimburse the Provider at least monthly for all adjudicated claims, unless payment in full is not authorized under applicable requirements.

11.3.3. The ADAMH Board shall publish an annual claims processing and reimbursement schedule. The ADAMH Board shall take all steps reasonably necessary to process and reimburse claims in accordance with such schedule and availability of local, state and federal funds, except that no payment shall be made later than the time set forth in applicable requirements.

a. Subject to allocation limits, otherwise eligible claims for ADAMH services shall be reimbursed or applied toward block grant encounter data if the Provider submits the claims within one hundred (100) days of the date of service.

i. The 100–day period shall be calculated from the date of service the Provider enters on the claim to the SHARES "Received Date".

b. All unreimbursed ADAMH Services claims with a service date prior to January 1, 2018 which are submitted to the ADAMH Board not later than January 31, 2018 shall be processed against the Contract Year 2017 allocations.

11.4. SHARES Service Requests and Wait List Management The ADAMH Board may designate select services that require the Provider to submit a service request prior to claims adjudication. Designated services will be identified in the annual Provider budget. The procedure for service requests is addressed in the Franklin County SHARES Provider Manual. Designated services may also be incorporated into the SHARES Wait List application. The Provider will work cooperatively with ADAMH staff to facilitate the use of this application.

11.5. Advances The ADAMH Board may grant advances in accordance with the ADAMH Board advance procedures, included in this Contract as Attachment 12. The ADAMH Board shall deduct the amount of an advance from any balance remaining of the Provider's ADAMH Services claims allocation.

11.6. Title XX Reimbursement

11.6.1. The Provider shall maintain Title XX records in accordance with applicable requirements and shall include Title XX funds in any audits conducted under this Contract.

11.6.2. The ADAMH Board shall reimburse claims for Title XX services which are submitted in accordance with Article 11 of this Contract and other applicable requirements.

11.7. Other Methods of Reimbursement The ADAMH Board may reimburse the Provider through other mechanisms that are approved by the ADAMH Board in accordance with ADAMH Board procedures, if the Provider has made such a request by invoice and has provided adequate documentation of service.

11.8. Restrictions on Reimbursement

11.8.1. The ADAMH Board shall not make reimbursement to the Provider in excess of the annual amount allocated to the Provider included in Attachment 1 or allocation added subsequently through an Action of the ADAMH Board of Trustees, unless such reimbursement is required under applicable law.

11.8.2. Reimbursement for services is subject to available County Spending Authority as authorized by the Franklin County Board of Commissioners.

11.8.3. Reimbursement for services may be subject to utilization containment limits.

11.8.4. If the ADAMH Board has made a determination, based on substantial evidence, that there has been a violation of Article 10 or this Article 11, then the ADAMH Board shall have the right to set off the amount in dispute from future reimbursement which is due under this Contract, subject to dispute resolution sections.

11.8.5. Except as otherwise provided by law, the ADAMH Board shall be the payor of last resort.

11.8.6. The Provider shall accept any reimbursement from Medicaid and Medicare for services as payment in full and shall not balance bill any unpaid charge to the ADAMH line of business.

11.8.7. No reimbursement shall be made if such reimbursement is not permitted under applicable law. If there is a dispute as to whether a reimbursement is permitted under Federal or State law, the matter shall be submitted to OhioMHAS, whose decision shall be followed pending the exhaustion of the procedures as set forth in Article 13 and Article 14 or until no further administrative or judicial appeals are permitted through waiver or otherwise.

11.8.8. A reimbursement under this Contract may be suspended in accordance with Attachment 8 if the Provider fails to submit or make available for inspection any information or report listed below, or does not allow access in accordance with terms of this Contract, except that reimbursement may only be suspended until such information is furnished or access to information is permitted for the following items:

a. Timely and accurate billing information.

b. Any report listed in attachment 3.

c. Evidence of insurance as required in Article 12.

d. Claims submitted by the Provider fail to conform to the required ANSI 837 electronic format, in accordance with applicable requirements within this Contract and OhioMHAS requirements.

e. Provider fails to allow access as required in Section 6.1.

11.8.9. No reimbursement shall be withheld unless the ADAMH Board has given the Provider notice of the ADAMH Board's intent to withhold reimbursement and a statement of the reasons for the proposed action. Notice shall be in writing and received by the Provider not less than ten working days prior to the withholding of reimbursement. Reimbursement shall only be suspended until such information is furnished or access to information is permitted.

11.8.10. A reimbursement under this Contract may be forfeited in accordance with Attachment 8 if the Provider fails to submit or make available for inspection any information or report listed in 11.8.8 or does not allow access in accordance with terms of this Contract within sixty (60) days of the required deadline.

11.8.11. No reimbursement shall be forfeited unless the ADAMH Board has given the Provider notice of the ADAMH Board's intent to deny reimbursement and a statement of the reasons for the proposed action. Notice shall be in writing and received by the Provider not less than ten (10) working days prior to the denying of reimbursement.

11.9. Fees and Duty to Bill

11.9.1. The Provider shall implement the policies and procedures for Member Financial Eligibility, Fee Administration, and Public Subsidy Schedule specified in Attachment 14 to this Contract.

11.9.2. The Provider shall, to the extent reasonably possible, establish and implement procedures to recover payment from Medicaid, Medicare or private insurance and other third party payors. ADAMH Board reimbursement will not be requested until third party payors verify non–coverage or 60 days after billing of the third party payors, whichever occurs first. In the event (partial) reimbursement is received from third party payors subsequent to submission to the ADAMH Board, the Provider shall submit a claim correction in accordance to SHARES guidelines.

11.9.3. Per Sections 11.8.5 and 11.9, the provider will use the Coordination of Benefit (COB) indicator in SHARES to appropriately account for other party payments and patient responsibility.

11.9.4. The Provider shall facilitate Spend–down clients' access to Medicaid eligibility:

a. The full cost of service must be charged to all members for all services received.

b. The full cost of service may be billed directly to third party payors, including Medicaid, for those members who have coverage.

c. The ADAMH Board is responsible for preparing the "ODMH BHO Statements of Account" for clients who have incurred charges at the Regional Psychiatric Hospitals which are posted in the ODMH Patient Care System (PCS), and transmitting these Statements to the client's SMD Lead Agencies to help meet spend–down amounts.

d. For members eligible for Medicaid spend–downs, the Provider is responsible for preparing statements of incurred charges, as soon as sufficient Medicaid billable costs have been accumulated to meet the spend–down amounts.

e. The statements are to be submitted to the Franklin County Department of Job and Family Services as soon as possible, to allow Medicaid cards to be released to members.

f. No less frequently than monthly, the Provider must credit payments from the ADAMH Board to members' accounts according to the *Schedule of Public Subsidies*.

11.10. Duty to Appeal In the event that payment by a third–party payor, including, but not limited to, Medicaid, Medicare or private insurance has been denied and there is a reasonable basis for appeal, the Provider shall either:

11.10.1. Take steps reasonably necessary to perfect and pursue appeals of denial of payment by third party payors, or

11.10.2. Provide to the member or entity filing the appeal, information reasonably necessary to pursue the appeal, to the extent that such information may be released in accordance with applicable requirements.

11.11. Loss of Funds

11.11.1. The ADAMH Board is not required to make reimbursement in full or in part if funds to the ADAMH Board have been reduced or eliminated.

11.11.2. In the event ADAMH Board receives notice from a funding source that funding from that source shall be reduced or eliminated, the ADAMH Board shall give the Provider prompt notice of the proposed reduction or elimination.

11.11.3. In the event that funds for one or more services or programs are eliminated by the ADAMH Board or by a funder whose funds are used as match for ADAMH–funded services, the Provider shall provide the ADAMH Board with a transition plan with such information as is reasonably necessary to carry out the transition, including, but not limited to the members being served and the services and programs required to be provided to such members. The Provider shall continue to provide services and programs required by the members until the Provider has arranged for alternative services or for a period of 30 days after receipt of the notice required under Section 11.11.2, whichever period is shorter. The ADAMH Board shall assist in locating appropriate services for the members being served by the Provider and shall pay for services actually provided by the Provider during such period.

11.11.4. In the event that ADAMH receives notice from a funding source that funding from that source shall be reduced or eliminated occurs after said funds have been claimed or drawn down by the provider and paid by ADAMH, any necessary reduction to the provider's allocation will occur in the next allocation period.

Article 12. Insurance

12.1. Responsibility for Claims and Liability To the extent permitted by Law, the Provider shall hold and save the Board harmless for all claims and liabilities due to the Provider's negligent acts or due to the negligent acts of the Provider's sub–contractors, agents or employees responsible for executing the work encompassed in this Contract.

12.2. General Liability The Provider shall carry comprehensive general liability insurance in no less than the amounts set forth in Attachment 9.

12.3. Automobile The Provider shall insure that there is automobile liability insurance for passenger vehicles for all such vehicles used to transport members, whether such vehicles are owned by the Provider or its agents or employees in no less than the amount set forth in Attachment 9. The Provider shall also conduct appropriate due diligence on the individual's driving record.

12.4. Employee Dishonesty It is recommended that the Provider provide coverage against employee dishonesty. The ADAMH Board shall not make any payments to cover losses incurred as a result of employee dishonesty and the ADAMH Board reserves the right to recover amounts due to the ADAMH Board as a result of employee dishonesty.

12.5. Employers' Liability To the extent permitted by Law, the Provider shall carry employers' liability insurance in no less than the amount set forth in Attachment 9.

12.6. Professional Liability The Provider shall carry professional liability insurance providing single limit coverage in no less than the amount set forth in Attachment 9.

12.7. Additional Insured To the extent permitted by Law, the ADAMH Board shall be named as an additional insured and "Certificate Holder" in its liability insurance policies referred to in Article 12 of this Contract. Providers must name the ADAMH Board by an Endorsement to the agency's insurance policies and require its insurance company to provide notification to the ADAMH Board on a standard "Certificate of Liability" form, which summarizes insurance coverage and/or changes reflected in the insurance policies.

12.8. Workers' Compensation The Provider shall provide evidence of proper worker's compensation coverage.

12.9. Claims–made Policies To the extent permitted by Law, in the event that the Provider meets any of its obligations under this Article 12 by obtaining a "claims–made" policy, to the extent permitted by law, the Provider shall provide evidence of either of the following for each type of insurance which is provided on a claims–made basis.

12.9.1. Unlimited extended reporting period coverage which allows for an unlimited period of time to report claims from incidents that occurred after the policy retroactive date and before the end of the policy period (tail coverage), or

12.9.2. Continuous coverage from the original retroactive date of coverage. The original retroactive date of coverage means original effective date of the first claims–made policy issued for similar coverage while the provider was under contract with the ADAMH Board.

12.10. Evidence of Coverage The Provider shall provide the ADAMH Board with a certificate of insurance evidencing each type of coverage required or provided under this Article 12 at the time of renewal, and shall provide the ADAMH Board notice of cancellation or non–renewal of any such coverage within thirty (30) days of the time the Provider receives such notice.

Article 13. Dispute Resolution

13.1. General Procedures

13.1.1. Dispute resolution procedures under this Article 13 shall apply to disputes arising out of the termination, renewal or non–renewal of this Contract, disputes arising out of services or programs covered by this Contract or disputes arising out of clinical issues which involve member care. All other disputes shall not be subject to any requirement for dispute resolution under this Contract and may be pursued by the parties under applicable law.

13.1.2. The procedures for dispute resolution under this Article 13 shall be completed within 60 days after service of the 120–day notice unless the parties otherwise agree.

13.1.3. Parties shall meet at least once to resolve the issues prior to the expiration of 60 days.

13.1.4. The parties shall engage in good faith efforts to resolve disputes informally.

13.1.5. Either party may require the other party to convene a meeting of the board of the other party to review the dispute.

13.1.6. If the parties cannot agree informally to a resolution of the dispute, the matter shall be submitted to OhioMHAS for further proceedings.

a. Any decision by OhioMHAS shall be non–binding.

b. The decision by OhioMHAS shall be presented to the ADAMH Board and the Provider and shall be made a part of the record of any further proceedings, regardless of forum.

c. In the event that either party rejects the decision of OhioMHAS, then it shall provide written reasons which shall also be a part of the record of any further proceedings, regardless of forum.

13.1.7. At the conclusion of the review by OhioMHAS, the ADAMH Board shall make a final decision which is subject to review under O.R.C. Chapter 2506.

a. Proceedings shall meet due process requirements under Chapter 2506 and the ADAMH Board shall make a record.

b. Hearing and decision shall be complete not later than 60 days from date of decision by OhioMHAS.

c. Nothing in this Section 13.1.7 shall be construed as limiting the rights of the parties to any other available legal remedies.

13.1.8. Except as otherwise noted provided herein Sections 11.2, 11.8, and 16.1, status quo shall be maintained during review by OhioMHAS through final decision by the ADAMH Board.

13.1.9. The Provider reserves all rights to legal representation and/or court proceedings and does not waive any rights or protections afforded by law or by operation of this contract.

13.2. Clinical Disputes Any dispute regarding clinical issues involving member care shall be initially resolved by the Agency Chief Clinical Officer (ACCO) or an individual with equivalent clinical authority. If a dispute arises concerning clinical issues involving appropriate member care under standards agreed to by the parties, then the System Chief Clinical Office (SCCO) for the ADAMH Board and the ACCO shall meet to attempt to resolve the matter. In the event the ACCO and SCCO cannot resolve the matter, then the matter shall be referred to a neutral third party selected by agreement of the parties whose decision shall be final and binding. In the event that the parties cannot agree on a neutral third party, the parties shall request that the Medical Director of OhioMHAS appoint such neutral third party.

Article 14. Modification, Renewal and Termination

14.1. Modifications This Contract, including, without limitation, the term, may be modified by the mutual consent of the parties in writing.

14.2. Content of 120–day Notice

14.2.1. In the event that either party is required to provide a 120–day notice under applicable Ohio law, ADAMH Board policies or this Contract, the notice shall include all of the following:

a. A summary of the rationale for the proposed Contract change, non–renewal, or termination and

b. A summary of the following:

i. A summary of the nature and approximate scope of the projected change, and

ii. The approximate timing of the projected change and,

iii. If relevant, a reasonably approximate estimate of the financial impact of the projected change.

14.2.2. The content of the notice required under Section 14.2.1 shall be based on information which is reasonably available at the time of the issuance of the notice and may be supplemented by information after the date of the notice.

14.3. Coordination of Notice Requirements

14.3.1. A 120–day notice of termination or non–renewal which is served by the ADAMH Board in accordance with the requirements of this Contract shall satisfy the notice requirements in contracts between OhioMHAS and the ADAMH Board to the extent notices are required in such contracts.

14.3.2. A copy of any notice provided under this Section 14.3 shall be served on the OhioMHAS Office of Fiscal Administration.

14.4. Dispute Resolution Any dispute arising under this Section 14.3 shall be subject to the dispute resolution procedure as set forth in Article 13.

14.5. Non–Renewal In the event either party proposes not to renew this Contract, notice of non–renewal shall be given to the other party at least 120 days prior to the expiration of this Contract.

14.6. Renewal With Contract Changes

14.6.1. If either party proposes to make changes in the terms of this Contract, the party desiring to make such changes shall give the other party notice of the proposed changes at least 120 days before the expiration of this Contract. The notice of proposed changes shall conform to the requirements of Section 14.2.

14.6.2. The parties shall engage in good faith efforts to negotiate a new contract.

14.6.3. In the event the parties are unable to negotiate a new contract, then either party may give the other notice of non–renewal in accordance with Section 14.5, which notice shall be given as soon as practicable.

14.6.4. In the event a notice of non–renewal is served under these circumstances, then the Contract shall be extended as necessary to provide the other party with 120 days' notice of termination.

14.7. Termination

14.7.1. This Contract may be terminated by the ADAMH Board without the requirement for a 120–day notice under the following circumstances:

a. In the event of any Provider loss of certification status, the ADAMH Board may terminate sections of the contract consistent with, but not in excess of, the specific certification loss with OhioMHAS;

b. Serious and imminent risk to the health or safety of members;

c. Bankruptcy, dissolution, receivership or other court order which effectively removes the Provider from control of services;

d. Any audit disclosures of uncertainties about a Provider's ability to continue as a going concern;

e. Material, uncured breaches of this Contract.

14.7.2. This Contract may be terminated by the Provider without the requirement for a 120–day notice if the ADAMH Board fails to make reimbursements as required in this Contract.

14.7.3. Procedure

a. If either party believes that the conditions listed in Sections 14.7.1 or 14.7.2 exist, the party shall notify the other party of the fact in writing.

b. Immediately upon notification, the parties shall arrange a meeting with OhioMHAS to review whether conditions warranting termination exist.

c. In the event OhioMHAS agree the conditions warranting termination exist, the parties shall cooperate in an immediate transfer of programs and services to an alternative provider, if applicable. If OhioMHAS do not agree that conditions warranting expedited termination exist, then the matter will be resolved in accordance with Article 13 for as long as services under this Contract continue to be delivered by the Provider, the Provider will be reimbursed for its services.

14.8. Transition Requirements Continue In the event that services are terminated under Section 14.7 the requirements of Article 9 shall remain in full force and effect until the completion of the transition.

Article 15. Duties of Designated Agencies Under O.R.C. Chapter 5122

15.1. General Requirements

15.1.1. The Provider shall provide such services as the SCCO shall designate in writing in accordance with the requirements of O.R.C. Chapter 5122 and this Article 15.

15.1.2. Services designated by the SCCO to be provided by the Provider under this Section 15.1 shall be provided to all eligible members.

15.1.3. Services shall include only those which have been designated by the SCCO to be the responsibility of the Provider. Designated services may include the following:

a. Evaluation and approval of all voluntary admissions to public hospitals as required by O.R.C. §5122.02(B).

b. Evaluation of all emergency admissions to any hospital as required by O.R.C. §5122.05(A).

c. Upon request by the ADAMH Board, evaluation of all affidavits referred by probate court as required by O.R.C. §5122.13.

d. Treatment of all members committed to the Provider pursuant to O.R.C. §5122.15 or committed to the ADAMH Board pursuant to O.R.C. §5122.15 and referred to the Provider by the ADAMH Board.

15.2. Acceptance of Court Commitments. In the event that the Provider has been designated by the SCCO to receive commitments from the Probate Court, or if the commitment has been made to the ADAMH Board and the SCCO has designated the Provider to provide treatment, the ACCO shall ensure that the requirements of this Section 15.2 are met.

15.2.1. *General Requirement* The Provider shall provide or arrange for all available treatment, facilities and services required by members who have been either:

a. Committed to the Provider under O.R.C. §5122.15(C), or

b. Committed to the ADAMH Board and placed by the SCCO at the Provider for treatment.

15.2.2. Outpatient Commitment Response Timeframe: The Provider shall provide an outpatient service in the community within seven (7) days of notification that a member has been committed to the Provider of committed to the ADAMH Board and placed by the SCCO at the Provider for treatment and an appointment with the Provider psychiatrist within fourteen (14) days notification that a member has been committed to the Provider of committed to the ADAMH Board and placed by the SCCO at the Provider for treatment.

15.2.3. *Notice of Final Disposition* The ACCO shall notify the SCCO, counsel for the member, and the court of the final placement within three (3) working days after the placement is made.

15.3. Applications for Continued Commitment

15.3.1. The ACCO shall notify the SCCO of the necessity for further commitment pursuant to court order not less than twenty days prior to the expiration of time limits set forth in O.R.C. §5122.15(H).

15.3.2. The ACCO shall prepare all applications for continued commitment required under O.R.C. §5122.15(H) within the time limits set forth in the statute. A copy of such application shall be provided to counsel for the member and counsel for the ADAMH Board.

15.4. Availability of Records The ACCO shall ensure that all records required to provide treatment or services to the member are transferred in a timely manner.

15.5. Change of Status The ACCO may accept an application for voluntary treatment from any member committed by the court to the ADAMH Board. Upon acceptance of such application, the ACCO shall provide notice of such acceptance as required by O.R.C. §5122.15(G)(1).

15.5.1. If at any time after the first ninety-day period the ACCO determines that the member has demonstrated voluntary consent for treatment, the ACCO provide notice as required by O.R.C. §5122.15(H).

15.6. Evaluation and Approval of Voluntary Admissions

15.6.1. In the event that the Provider has been designated by the SCCO to evaluate and approve voluntary admissions to public hospitals, the ACCO shall ensure that the requirements of this Section 15.6 are met.

15.6.2. The ACCO shall review all applications for voluntary admission to State hospitals and approve such admissions as the ACCO deems appropriate using standard industry practices.

15.6.3. Evaluations shall be completed within four hours after application.

15.6.4. The ACCO shall submit monthly reports to the SCCO of the ADAMH Board on evaluations and approvals of admissions under this Section 15.6.

15.7. Evaluation of Affidavits Referred by Probate Court In the event that the Provider has been designated by the SCCO to evaluate and approve affidavits referred by the Probate Court, the ACCO shall ensure that the requirements of this Section 15.7 are met.

15.7.1. The ACCO shall review all affidavits referred by the Probate Court for involuntary commitment.

15.7.2. Evaluations shall be completed no later than three (3) days after referral or at such other time as is specified by the Probate Court.

15.7.3. The ACCO shall report the results of evaluations of affidavits to the Probate Court and to the SCCO.

15.8. Evaluation of Emergency Admissions

15.8.1. In the event that the Provider has been designated by the SCCO to evaluate and approve emergency admissions, the ACCO shall ensure that the requirements of this Section 15.8 are met.

15.8.2. The ACCO shall review all applications for emergency admission to all hospitals and approve them as the ACCO deems appropriate using standard industry practices.

15.8.3. Evaluations to determine whether emergency admissions are in compliance with criteria under Ohio Revised Code Chapter 5122 shall be completed in advance of admissions where possible, but in no case longer than 72 hours after admission.

15.8.4. The ACCO shall ensure that prompt reports are made orally, by fax transmittal or in writing to the CCO of the facility receiving the emergency admission immediately upon completion of the evaluation. The report shall include the following information:

a. Name of the member,

b. Date of admission,

c. Place of admission,

d. Conclusion on whether the member is mentally ill, subject to hospitalization by court order, with specific facts to support the conclusion,

e. Recommendation for the least restrictive alternative, with specific facts to support the recommendation. Oral reports shall be confirmed in writing within 24 hours of the oral report.

15.8.5. The ACCO shall submit a written summary report of evaluations of emergency admissions to the SCCO of the ADAMH Board or its designee each month. Such summary reports to the ADAMH Board shall include the name of the member, the date of admission, the place of admission, the results of the evaluation, the expected discharge date and the name of the assigned community support worker.

15.9. Evaluation of Appropriateness for Outpatient Commitment

15.9.1. In the event that the Provider has been designated by the SCCO to evaluate members for outpatient commitment, the ACCO shall ensure that the requirements of this Section 15.9 are met.

15.9.2. The ACCO shall review all requests for outpatient commitment referred by the Probate Court for consideration of appropriateness for outpatient commitment using standard industry practices (ORC 5122.01).

15.9.3. An evaluation to determine whether the member meets criteria for outpatient commitment as defined in Ohio Revised Code Chapter 5122 shall be completed no later than three (3) days after referral or at such other time as is specified by the Probate Court.

15.9.4. The ACCO shall report the results of evaluations to the Probate Court and the SCCO in the form of a written report, in open court or in chambers, or as directed by the Probate Court. This report shall contain the following information (O.R.C. 5122.13):

a. If the member is a mentally-ill individual subject to court-ordered treatment.

b. What is the least restrictive environment that is appropriate for treatment.

c. The availability of appropriate treatment alternatives.

d. Additional information as directed by the Probate court.

15.10. Hearings before Probate Court In the event that the Provider has been designated by the SCCO to accept commitments from the Probate Court, or if the SCCO has determined that the Provider has information which is necessary to present a case before the Probate Court, the ACCO shall ensure that the requirements of this Section 15.10 are met.

15.10.1. The Provider shall cooperate with the attorney for the ADAMH Board in the preparation and presentation of the case.

15.10.2. The Provider shall make necessary documents and personnel available to the attorney, subject to all requirements of privilege and/or confidentiality that apply under Federal law, State law, or ADAMH Board policies.

15.11. Notices The ACCO shall be responsible for providing all notices required under this Contract and Chapter 5122 for members committed by court order. Notices shall conform to the requirements of the court, Chapter 5122 and other applicable law. Unless this Contract or applicable law requires otherwise, notices to the ADAMH Board shall be addressed to the SCCO in writing and shall be made within ten days of the event required to be reported.

15.12. Periodic Evaluations The ACCO shall evaluate all members committed by the court to the ADAMH Board. Such evaluations shall be conducted in accordance with the requirements of Chapter 5122 and ADAMH Board policies. The ACCO shall discharge all members found not to be mentally ill members subject to court order as defined by O.R.C. §5122.01(A) and (B).

15.13. Transfers

15.13.1. All transfers to a less restrictive setting shall be at the discretion of the ACCO.

15.13.2. The ACCO shall ensure that any transfer to a more restrictive setting is carried out in accordance with procedures required under Chapter 5122 and shall transport or arrange for the transport of members.

15.14. Lead Agency Involvement In situations where the ACCO involved in the processes described herein is not the lead agency ACCO for the member, the lead agency ACCO will receive all pertinent information and be involved in these processes as possible and appropriate.

Article 16. Lead Providers Serving Adults with Serious Persistent Mental Illness

16.1. Assignment, Acceptance and Transfer of Members with SPMI For those Providers who have entered into a Continuity of Care Agreement with ADAMH and Twin Valley, the following shall apply:

16.1.1. *Lead Provider Assigned* Twin Valley Behavioral Healthcare, all other OhioMHAS Regional Psychiatric Hospitals, The Ohio State University, Mount Carmel Hospital, Riverside Methodist Hospital, and the Netcare Crisis Stabilization Unit (CSU) shall assign/link all new members to a Lead Provider for all clinically appropriate community services, and/or care coordination including state hospitalizations.

a. The hospitals/CSU shall work with the member to make an assignment that considers member choice and needs, and that considers provider location, services and service capacity.

b. The Lead Provider shall be subject to the requirements of this 15.14 only during the period when the member's SHARES eligibility record reflects assignment of the member to the Lead Provider.

c. The effective date of Lead Provider assignment shall be the later date of either:

i. member hospitalization, or

ii. Provider notification of the assignment from TVBH;

iii. Member's Consent for Treatment, documented on the TVBH Supplied Consent Form.

16.1.2. *Acceptance of Members* The Lead Provider shall accept all members with SPMI assigned by the participating hospital/CSU and shall provide services to such members under this Contract. Services will be rendered as outlined in the Providers' Agency Services Plan (ASP) and the Continuity of Care Agreement. Services shall be provided to all members until the member is transferred or terminated in accordance with Section 4.9.

a. The Provider agrees to:

i. Accept all referrals from participating hospitals and the CSU consistent with Section 4.8 of this Contract and commensurate with proportion of allocation for this service, including referrals of consumers with no payor source.

ii. Keep participating hospitals and crisis stabilization units informed of names and contact information for hospital linkage clinicians, clinical supervisors and others performing work under this agreement.

iii. Submit quarterly activity reports to the ADAMH Board of all hospital admissions that require assessment to link or appointment to do so post discharge, with other identifying information as requested.

b. If the Provider violates this Section 16.1 and refuses referrals the ADAMH Board shall document such violations. The ADAMH Board may review the pattern of referrals and may take appropriate action, including, but not limited to suspending future referrals and withholding ADAMH–service payments.

c. If there are disputes, regarding Section 16.1, the Provider shall provide services to the member until the dispute is resolved. Reimbursement for services under dispute shall be made in accordance with applicable requirements.

16.1.3. *Member Request for Another Lead Provider* In the event that the member requests a transfer to another Lead Provider, the Lead Provider shall encourage the member to address any concerns with the member's current Lead Provider. The current Lead Provider shall cooperate fully in the transfer to the new Lead Provider, including, but not limited to the transfer of records and other information to ensure continuity of care, subject to the requirements of applicable law.

16.2. State Hospital Bed Day Utilization This Section 16.2 applies to all members assigned to the Lead Provider in accordance with Section 16.1.1.

16.2.1. The following procedures outline the utilization monitoring of hospital bed day use:

a. The Lead Provider shall have a Strategic Action Plan for Crisis and Hospitalization Management, updated annually and submitted as a component of the Agency Services Plan that is focused on risk reduction, programmatic efficiency, fiscal management, and achieving clinically sound and satisfying results for consumers and families. The plan shall offer well–defined strategies for the crisis prevention, crisis intervention & resolution, and crisis post–intervention phases and shall identify the specific clinical, utilization management, technological and fiscal action steps, timelines and lead persons responsible for plan implementation. The Board and Provider shall routinely monitor the effectiveness of the plan against applicable System Quality Indictor results, continuity of care performance indicators and Regional Psychiatric Hospital utilization rates.

b. The Lead Providers shall conduct utilization reviews on all hospitalized individuals assigned to them while they are actively receiving care from TVBH to determine readiness for discharge.

c. The ADAMH Board reserves the right to conduct utilization reviews on hospitalized individuals and will work with the hospital staff and the Lead Provider staff when it is determined that further action is warranted. The results of the ADAMH Board's utilization review will be forwarded to the lead provider within three (3) business days of the review.

d. The Provider, the hospital and the ADAMH Board will work together to coordinate utilization review.

16.2.2. If the Lead Provider disagrees with any decision made by the staff at TVBH which affects the Lead Provider under this Contract, the Clinical and Discharge Dispute Process in the Continuity of Care Agreement shall be used to seek resolution to this disagreement.

16.3. Residential Care Facilities and Service Enriched Housing Providers shall ensure continuity of care for all clients residing in ADAMH–funded Residential Care Facilities and Permanent Supportive Housing units by abiding by the requirements set forth in Attachment 16.

Article 17. Miscellaneous

17.1. Attachment Incorporation The attachments are hereby incorporated as a part of this Contract. In the event that any section of any attachment is inconsistent with any requirement of this Contract, the terms of this Contract shall be binding on the parties unless otherwise legally required.

17.2. Debarment and Suspension The Provider certifies that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from entering into this agreement by any federal department or agency.

17.3. Entire Agreement It is acknowledged by the parties hereto that this Contract supersedes any and all previous written or oral agreements between the parties concerning the subject matter of this Contract.

17.4. Severability Should any portion of this Contract be deemed unenforceable by any administrative or judicial officer or tribunal of competent jurisdiction, the balance of this Contract shall remain in full force and effect unless revised or terminated pursuant to Article 14 of this Contract.

17.5. Notices All notices, requests and approvals shall be made in writing and shall be deemed to have been properly given if and when personally delivered or sent, postage prepaid, by certified mail:

TO: ADAMH BOARD OF FRANKLIN CO
447 E BROAD ST
COLUMBUS OH 43215-3822

TO: «COMPANY»
«ADDRESS1»
«ADDRESS2»

17.6. Governing Law This Contract shall be governed by and interpreted in accordance with the laws of the State of Ohio.

17.7. Captions The paragraph captions and headings in this Contract are inserted solely for the convenience of the parties and shall not affect the interpretation or construction of this Contract or any of the terms of this Contract

17.8. Waiver The waiver of breach of any term of this Contract shall not be interpreted as waiver of any other term of this Contract.

17.9. Unresolved Findings of Recovery Ohio Revised Code (O.R.C.) §9.24 prohibits the ADAMH Board from awarding a contract to any party against whom the Auditor of the State has issued a finding for recovery if the finding for recovery is "unresolved" at the time of the award. By signing this Agreement, Provider warrants that it is not now, and will not become subject to an "unresolved" finding for recovery under O.R.C. §9.24.

17.10. Anti–Discrimination Provisions Per Ohio Revised Code (O.R.C.) §125.11, Provider warrants and agrees to the following:

17.10.1. That in the hiring of employees for the performance of work under the contract or any subcontract, Provider shall not, by reason of race, color, religion, sex, sexual orientation, Vietnam–era veteran status, age, handicap, national origin, or ancestry, discriminate against any citizen of this state in the employment of a person qualified to perform the work in which the contract relates; and

17.10.2. That neither Provider nor any of its subcontractors or any person acting on behalf of Provider shall in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance of work under the contract on account of race, color, religion, sex, sexual orientation, Vietnam–era veteran status, age, handicap, national origin, or ancestry.

17.10.3. Provider warrants that it has a written affirmative action program for the employment and effective utilization of economically disadvantaged persons, as defined in section 122.71 of the Ohio Revised Code. Annually, Provider shall file a description of the affirmative action program and a progress report on its implementation with the Ohio civil rights commission and the minority business development office established under section 122.92 of the Ohio Revised Code.

IN WITNESS WHEREOF, the parties hereto have caused this Contract to be executed by their duly authorized officers as of the day and year first above written.
THE ALCOHOL, DRUG AND MENTAL HEALTH BOARD OF FRANKLIN COUNTY

David A. Royer,
Chief Executive Officer_____ Witness_____

«COMPANY»

Board Chair_____ Witness_____

_____Witness_____
«FirstMiddle» «Lastname», «Suffix», «Job_Title»

NPI NUMBER (NPID):_____