MBHP
Massachusetts Behavioral Health Partnership
A Carelon Behavioral Health Company

Organizational Providers Subcontracting Application

All MBHP-contracted facility providers (organizational providers) who seek to use outside subcontractors to provide behavioral health services to MBHP Members must submit this application, along with a detailed description of the proposed subcontracted relationship to MBHP **no later than 60 days prior to entering into an agreement with the vendor, subcontractor, or non-employee**. MBHP reserves the right to approve or deny any and all subcontractor agreements. If approval is granted to the MBHP facility provider, all services rendered by the subcontractor must be billed directly by the MBHP facility provider to MBHP. MBHP shall not be liable to pay any entity or individual except the MBHP facility provider for behavioral health services, regardless of who renders the service. The MBHP facility provider shall indemnify MBHP and its Members and hold them harmless from any and all claims resulting from bills sent to MBHP or its Members by such outside subcontractors for services rendered to MBHP Members on behalf of the MBHP Facility Provider.

A. MBHP Contracted Facility Provider:

Legal business name:____
(*as reported to the Internal Revenue Service*)

Doing business as and/or other names:____

Identify the type of your organizational structure:

Corporation ☐ Limited Liability Corporation ☐ Partnership ☐

Sole Proprietorship ☐ Other☐ (Specify):__________________________________

State where incorporated: _________ Date of incorporation (if applicable):____________________

President/CEO name:____

Medical Director name:____

Primary mailing address:____

City: ___________________________State:____________Zip code:_________-_____

Billing address: ____

City: _________________________________State:______________Zip code: _________-________

Taxpayer Identification number:____

NPI number: ____

Contact name:______________________________Title:__________________________________

Telephone number:___________________Email address:_________________________________

Date of acceptance as a MBHP facility provider:_______________________________

MBHP
Massachusetts Behavioral Health Partnership
A Carelon Behavioral Health Company

B. Subcontractor:

Legal business name: ____
(*As reported to the Internal Revenue Service*)

Doing business as and/or other names:____________________________________

Identify the subcontractor's organizational structure:______________________

Corporation ☐ Limited Liability Corporation ☐ Partnership ☐

Sole Proprietorship ☐ Other ☐ (Specify):______________________________

State where incorporated: _________ Date of incorporation (if applicable):_______________

Date of birth *(if applicable)*:________________________

Social security number *(if applicable)*:___________________________

Licensure level *(if applicable):*______________License number *(if applicable):*________________

Supervisor name and licensure level *(if applicable)*:______________________________________

NPI number: ____

Primary mailing address:____

City: ___________________________State:____________Zip code:_________-______

Site of operations (if different from primary mailing address):________________________________

Taxpayer Identification Number:____

Contact name:______________________________Title:__________________________________

Telephone number:__________________Email address:__________________________________

C. List any and all behavioral health services to be provided by the subcontractor:

____

____

List any and all specialties/clinical expertise of the subcontractor:

____

____

List the reasons why the subcontractor's services are necessary to the MBHP facility provider:

____

Population treated by percentage (must equal 100%):

Children __________% Adolescents __________% Adults __________%

MBHP
Massachusetts Behavioral Health Partnership
A Carelon Behavioral Health Company

Race/Ethnicity - Member Population:

Indicate the percentage distribution of current Member population being treated by you or at your facility/agency, including MassHealth Members.

Race/Ethnic Group	% of Member Population	Race/Ethnic Group	% of Member Population
African-American		Haitian Creole	
Caucasian		Hispanic	
Cambodian		Japanese	
Chinese		Khmer	
Other (specify)		Russian	

D. List the Hours of Operation for the Subcontractor's Site of Operation(s):

Monday:_____________ Tuesday:______________ Wednesday:________________

Thursday:_________________ Friday:________________ Saturday:______________

Sunday:_____________

Is this office handicapped accessible? *(Required)* ☐ Yes ☐ No

Is this office accessible by public transportation? ☐ Yes ☐ No

☐ Bus ☐ Subway

Language fluency in the office:____

Resources for translation:____

E. Subcontractor's Business Classification:

1. Ownership: ☐ Private ☐ Public ☐ Government Program
2. Status: ☐ For-Profit ☐ Not-for-Profit

F. Subcontractor's Licensed Staff:

Does the subcontractor employ individuals who have the following licenses?

Medical Doctor, Board-Certified, Adult Psychiatrist (MD) ☐ Yes ☐ No

Medical Doctor, Board-Certified, Child/Adolescent Psychiatrist (MD) ☐ Yes ☐ No

Doctor of Osteopathy (DO) ☐ Yes ☐ No

Medical Doctor, Board-Certified in Developmental Behavioral Pediatrics (MD-DBP) ☐ Yes ☐ No

Psychiatric Nurse Mental Health Clinical Specialist, Board-Certified, Adult (RNCS) (*Also known as Advanced Practice Registered Nurse-APRN)* ☐ Yes ☐ No

MBHP
Massachusetts Behavioral Health Partnership
A Carelon Behavioral Health Company

	Yes	No
Psychiatric Nurse Mental Health Clinical Specialist, Board-Certified, Child (RNCS) *Also known as Advanced Practice Registered Nurse-APRN*	☐	☐
Registered Nurse (RN)	☐ Yes	☐ No
Licensed Psychologist (PhD, EdD, PsyD)*	☐ Yes	☐ No
Licensed Independent Clinical Social Worker (LICSW)	☐ Yes	☐ No
Licensed Certified Social Worker (LCSW)	☐ Yes	☐ No
Licensed Mental Health Counselor (LMHC)	☐ Yes	☐ No
Licensed Marriage and Family Therapist (LMFT)	☐ Yes	☐ No
Certified Alcohol Counselor (CAC)	☐ Yes	☐ No
Licensed Alcohol and Drug Counselor (LADC)	☐ Yes	☐ No
Certified Alcoholism and Drug Abuse Counselor (CADAC)	☐ Yes	☐ No
Peer Counselor	☐ Yes	☐ No

G. Questions regarding Subcontractor's licensure:

1. Are you or any of your employees and/or owners currently or have you ever been excluded, debarred, suspended, or otherwise ineligible to participate in (a) Federal Health Care Programs as may be identified in the List of Excluded Individuals/Entities maintained by the Office of the Inspector General (OIG), or (b) Federal procurement or non-procurement programs as may be identified in the Excluded Parties List System maintained by the General Services Administration? ☐ Yes ☐ No
2. Have you or any of your employees and/or owners been convicted of a criminal offense subject to the OIG's mandatory exclusion authority for Federal Health Care Programs described in section 1128(a) of the Social Security Act, but have not yet been excluded, debarred, suspended, or otherwise ineligible to participate in state medical assistance programs, including Medicaid, CHIP, or state procurement or non-procurement programs as determined by a state governmental authority? Yes ☐ No ☐
3. Have any disciplinary actions** been threatened, initiated, or are there any pending against you, your employees, and/or owners by any state licensure board? Yes ☐ No ☐
4. Have any of your employees' and/or owners' license to practice in any state ever been denied, limited, suspended or revoked, diminished, not renewed, relinquished (whether voluntarily or involuntarily), or are there any proceedings currently pending which may result in any such action? Yes ☐ No ☐
5. Have any formal or written complaints been filed against you, your employees, and/or owners with any state professional licensing board? Yes ☐ No ☐
6. Do any of your employees/and/or owners hold a narcotic registration for this or any other state? ☐ Yes ☐ No

7. Have any of your employees' and/or owners' privileges to possess, dispense, or prescribe controlled substances ever been suspended, revoked, denied, restricted, not renewed, surrendered (voluntarily or involuntarily), or have any of your employees and/or owners been the subject of a review of potential disciplinary actions regarding their prescribing practices of controlled substances by this state or any jurisdiction or federal agency at any time? ☐ Yes ☐ No
   (a) Is any such action currently pending? ☐ Yes ☐ No

*If a "**Yes**" response was entered on any question in Section G (1-7), provide a full explanation of the details, including the applicable period of time, the state where the incident occurred, and any adverse action(s) taken against your license on a separate sheet.*

H. Questions regarding Subcontractor's legal claims history:

1. Have any owners, officers, or shareholders of the facility/program been convicted of any crime, excluding misdemeanors? ☐ Yes ☐ No
2. Has the program been assessed a penalty, conviction, or suspension, or is the facility/program currently under investigation by the Medicare or Medicaid programs? ☐ Yes ☐ No
3. Have you or any of your employees or owners been named in any medical and/or professional malpractice action? ☐ Yes ☐ No
4. Have you or any of your employees or owners had any malpractice claims in regard to the practice of mental health or substance use disorder treatment where there has been an award or payment of $100,000.00 or more? ☐ Yes ☐ No
5. Has any claim or suit for alleged malpractice been brought against you or any of your employees or owners, or are you aware of any circumstances that might lead to such a claim or suit against you or any of your employees or owners? ☐ Yes ☐ No
6. Have you, your employees, and/or owners ever been a defendant in any lawsuit in regards to the practice of mental health or substance use treatment where there has been an award or payment of $100,000.00 or more? ☐ Yes ☐ No
7. Are there any pending legal actions of any kind against you, your employees, and/or owners? ☐ Yes ☐ No
8. Are you, your employees, and/or owners currently under investigation and/or review by the Medicaid or Medicare programs? ☐ Yes ☐ No

9. Have you, your employees, and/or owners ever been the subject of a compliance and/or corporate integrity agreement implemented by a federal or state agency? ☐ Yes ☐ No

*If a "**Yes**" response was entered on any question in Section H (1-9), provide a full explanation of the details, including date, the state where the conviction, malpractice judgment, or investigation occurred, and the applicable case number(s) on a separate sheet.*

I. Miscellaneous (Applicable to Subcontractor):

1. Have any memberships in professional organizations been revoked, reduced, denied, or suspended by others or voluntarily given up by you, your employees, and/or owners, or are any actions now under way, which may lead to such sanctions? ☐ Yes ☐ No
2. Have you, your employees, and/or owners ever withdrawn an application to any governmental authority, healthcare facility, group practice, employer or professional association, or commercial health plan? ☐ Yes ☐ No
3. Has any license or certification been revoked, denied, or suspended by others, or voluntarily given up by the facility/program, or are any actions now under way which may lead to such sanctions? ☐ Yes ☐ No
4. Has the facility/program or any individual provider employed by the facility/program ever been sanctioned, had an arrangement suspended, been placed on probation, been excluded from participation, had disciplinary charges initiated, or have proceedings toward these ends been instituted or recommended by a committee or governing body of any healthcare insurer, managed care organization, healthcare entity, or healthcare organization? ☐ Yes ☐ No

*If a "**Yes**" response was entered on any question in Section I (1-4), please provide details on a separate sheet.*

J. Questions regarding Subcontractor's liability insurance coverage and claims:

1. Have you, your employees, and/or owners had professional liability insurance refused, revoked, declined, or accepted on special terms? ☐ Yes ☐ No

2. Number of claims (check one): ☐ 0 ☐ 1 ☐ 2 ☐ More

*If a "**Yes**" response was entered on any question in Section J (1-2), please provide details on a separate sheet.*

K. Please include the following documentation with this application:

☐ Copies of all subcontractor's applicable state licenses (i.e., DMH/DPH, Massachusetts Board of Medicine, Division of Professional Licensure)

☐ Certificate of Prescriptive Authority *(if applicable)* (i.e., DEA, CSR)

- ☐ Subcontractor certification(s) (i.e., Medicaid, Medicare, other state licensure reports - Department of Human Services, Department of Mental Health, Department of Developmental Disabilities)
- ☐ Copy of current medical malpractice, comprehensive professional, general, and/or umbrella liability insurance certificates that identify the limits of liability of $1 million/$3 million and the policy period (insurance documents must show “Professional Liability”)
- ☐ Copy of subcontractor’s National Accreditation certificate (JCAHO, COA, CARF, etc.)
- ☐ Restraint and Seclusion - Please submit a copy of your facility’s policy regarding restraint and seclusion *(if applicable).*

L. MBHP Facility Provider’s Oversight of the Subcontractor:

Please document the MBHP facility provider’s plan for oversight of the subcontractor, which should include, but not be limited to, the following:

- Monitoring billing practices
- Clinical supervision of staff
- Credentialing procedures
- Productivity report requirements
- Managing utilization management, denials, appeals
- Monitoring complaints and grievances
- Notifying MBHP of any contract violations
- Developing corrective action plans as needed
- Monitoring quality of care including conducting record audits

Unanswered or missing information will delay processing of this application and/or may result in the application being returned as incomplete.

Please return all materials within 60 days of receipt of this application by emailing to

MBHP_PR@carelon.com.

Please make a copy of the completed application for your files. Photocopying/reproducing this application for any purpose other than to seek MBHP’s authorization to contract with a subcontractor is strictly prohibited.

MBHP
Massachusetts Behavioral Health Partnership
A Carelon Behavioral Health Company

The subcontractor certifies that the responses in this MBHP subcontractor application are accurate, complete, and current as of this date.

Signed:_______________________________
Name: ______________________________
Title: _________________________________
Date: _________________________________

Read and acknowledged by MBHP facility provider:
Signed:
____
Name: ___________________________
Title:____________________________
Date:____________________________