PROVIDER SERVICE AGREEMENT

This Agreement is made by and between **Click or tap here to enter text.** (hereinafter referred to as "CMHSP" and **Click or tap here to enter text.** (hereinafter referred to as "Provider" each may be referred to hereinafter from time-to-time as "Party" or "Parties").

WITNESSETH:

WHEREAS, CMHSP is a Community Mental Health Services Program ("CMHSP") created to operate, pursuant to 1974 PA 258, as amended (the "Mental Health Code");

WHEREAS, under the authority granted by Section 116 (2)(b) and 3(e) and Section 228 of the Mental Health Code, the Michigan Department of Health and Human Services (the "MDHHS") has entered into a Managed Mental Health Supports and Services Contract for General Funds (the "MDHHS/CMHSP Master Contract for General Funds") with CMHSP, to provide or arrange for the provision of mental health supports and services for certain individuals residing in CMHSP's service area;

WHEREAS, Lakeshore Regional Entity ("LRE") was formed as a regional entity under MCL 330.1204b of the Mental Health Code and serves as the prepaid inpatient health plan under 42 CFR Part 438 (the "PIHP") in the MDHHS-designated Region 3, where CMHSP provides services;

WHEREAS, MDHHS has entered into the Medicaid Managed Specialties Supports and Services Concurrent 1115 Demonstration Waiver, 1915(c)(i) Waiver Program(s), the Healthy Michigan Program, the Flint 1115 Demonstration Waiver and Substance Use Disorder Community Grant Programs Agreement with LRE for the provision of Mental Health Services and Supports and substance use disorder ("SUD") services in CMHSP's service area (the "MDHHS/PIHP Master Contract");

WHEREAS, LRE has entered into the Medicaid Managed Specialty Supports and Services Concurrent 1115 Demonstration Waiver, 1915(c)(i) Waiver Program(s), the Healthy Michigan Programs, the Flint 1115 Demonstration Waiver and SUD Community Grant Programs Subcontract with CMHSP, to provide or arrange for the provision of Medicaid Mental health specialty supports/services and SUD services in LRE's service area (the "CMHSP Medicaid Subcontract");

WHEREAS, CMHSP is in need of specific Covered Services for Covered Persons from qualified, licensed and independent contractors;

WHEREAS, Provider provides such Covered Services and has represented to CMHSP that it is duly licensed, qualified, and willing to provide such services as required by CMHSP, and CMHSP desires to obtain such services from Provider pursuant to the terms and conditions set forth herein.

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

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SECTION 1. DEFINITIONS

The following terms, as used throughout the Agreement, its Exhibits, Attachments and Addenda, shall have the meaning set forth below:

1.01 **Abuse.** As defined in 42 CFR 455.2, Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet the professionally recognized standards for healthcare.

1.02 **Agreement.** This Provider Service Agreement is between CMHSP and Provider as indicated on the signature page, and includes all Attachments, Addenda and Exhibits attached hereto.

1.03 **Claim.** Either the uniform bill claim form or electronic claim form in the format prescribed by CMHSP, using correct coding and billing guidelines, which is submitted by Provider to CMHSP for payment for Covered Services rendered to a Covered Person. A Claim means a bill for Covered Services rendered to a Covered Person.

1.04 **Clean Claim.** Unless otherwise defined by any applicable Federal or State law, rule or regulation (which definition then shall be controlling), a Claim submitted by Provider pursuant to this Agreement that can be processed and determined without obtaining additional information from the provider or from a third party and which does not involve coordination of benefits, third party liability or subrogation or any material defect or error that prevents timely adjudication. A Claim from Provider, who is under investigation for fraud or abuse or a Claim under review for medical necessity, is not a Clean Claim or Complete Claim.

1.05 **Community Mental Health Services Program (CMHSP).** A program operated under Chapter 2 of the Michigan Mental Health Code, as defined in MCL 330.1100a(18). CMHSP is a Member of LRE which serves as the PIHP for Allegan, Kent, Lake, Mason, Muskegon, Oceana, and Ottawa, counties (i.e., MDHHS-designated Region 3). LRE/PIHP has five (5) Member CMHSPs: Allegan County Community Mental Health Services, HealthWest (formerly Community Mental Health Services of Muskegon County), Kent County CMH Authority d/b/a Network180, Community Mental Health of Ottawa County, and West Michigan Community Mental Health System, all of which are Community Mental Health Services Programs.

1.06 **Contracting Parties.** This Agreement is solely between and by the Parties named above. Neither MDHHS nor Lakeshore Regional Entity are parties to this Agreement.

1.07 **Covered Person(s).** An individual who resides in CMHSP's service area, receives, or is eligible to receive subsidies from CMHSP, is eligible for Medicaid services under the Behavioral Health and Intellectual and Developmental Disability Supports and Services section of the Michigan Department of Health and Human Service (MDHHS) Medicaid Provider Manual ("MPM"), is enrolled in the MIChild Program or receives, or is eligible to receive, services under the Substance Use Disorder ("SUD") Community Grant Programs, including Covered Persons eligible through (Certified Community Behavioral Health Clinic (CCBHC). SUD Priority Population groups must have access to screening, assessment and treatment service regardless of their residency.

1.08 **Covered Services.** Medically Necessary Health Services that are within the normal scope of service and registration or licensure of Provider and for which a Covered Person is entitled to

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receive coverage under the Behavioral Health and Intellectual and Developmental Disability Supports and Services section of MDHHS' MPM, and/or SUD services covered under the SUD Community Grant Programs.

1.09 **Dispute.** Any dispute or controversy arising under, out of, in connection with or in relation to this Agreement or the breach of this Agreement.

1.10 **Behavioral Health Services.** Those services or supplies that a health care provider is licensed, equipped, and staffed to provide and which such provider customarily provides to or arranges for Covered Person(s).

1.11 **HIPAA.** The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 1996 enacted to improve the Medicare program under Title XVIII of the Social Security Act and the Medicaid program under Title XIX of the Social Security Act.

1.12 **HITECH.** The Health Information Technology for Economic and Clinical Health Act of 2009, Title XIII of the American Recovery and Reinvestment Act of 2009.

1.13 **Laws or Law.** All Applicable Federal, State, and local laws, statutes, regulations, decrees, and ordinances.

1.14 **Limited English Proficiency.** Means being limited in ability or unable to speak, read and/or write English well enough to understand and be understood without the aid of an interpreter.

1.15 **MDHHS/CMHSP Master Contract for General Funds.** The agreement between MDHHS and CMHSP for the provision of mental health supports and services.

1.16 **MDHHS/PIHP Master Contract.** The agreement between MDHHS and Lakeshore Regional Entity for the management of the 1115 Behavioral Health Demonstration Waiver Program, the Healthy Michigan Plan, 1915(c)(i) Waiver Program(s), the Healthy Michigan Program, Flint 1115 Demonstration Waiver, and Substance Use Disorder Community Grant Programs.

1.17 **Medicaid Fraud.** As defined in 42 CFR 455.2,"the intentional deception or misinterpretation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or another person," including any act that constitutes fraud under applicable Federal or State law.

1.18 **Medical Necessity.** Determination by a qualified clinician acting within the scope of licensure that services are reasonable and necessary for the treatment of illness, injury, disease, disability, or developmental condition, including services provided in accordance with generally accepted practices, not primarily for the convenience of the covered individual or another healthcare provider, and not more costly than an alternative treatment at least as likely to produce equivalent therapeutic value. Medical necessity of a service shall be documented in the individual plan of service.

Medical Necessity criteria:

- Necessary for screening and assessing the presence of mental illness, developmental disability or substance use disorder; and/or

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- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his/her goals of community inclusion and participation, independence, recovery, or productivity.

1.19 **Network.** A group of providers that contracts with CMHSP to provide Covered Services to Covered Persons.

1.20 **Network Notifications.** The official means of communication regarding non-material changes related to Claims and/or reimbursement such as new coding edits, documentation requirements, accepted modifiers and other billing issues. Network Notifications are published a minimum of thirty (30) days in advance of the change. For purpose of this definition, "non-material changes" are those changes related to Claims and/or reimbursements that will not decrease Provider's payment or compensation or will not change the administrative procedures in a way that may reasonably be expected to significantly increase Provider's administrative expense.

1.21 **PIHP.** In Michigan and for the purposes of this Agreement, PIHP is defined as an organization that manages Medicaid specialty services under the State's approved Waiver Program(s), on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR Part 438. LRE was created as a Regional Entity under MCL 330.1204b and under the MDHHS/PIHP Master Contract, serves as the PHIP of CMHSP's region. LRE/PIHP also manages PA2 funds.

1.22 **PIHP/CMHSP Subcontract.** An agreement between LRE and CMHSP to provide or arrange for the provision of mental health specialty and supports services and SUD services in CMHSP's service area.

1.23 **Policies and Protocols.** Those policies, programs, protocols, and administrative procedures adopted by CMHSP or LRE to be used by Provider in providing services and doing business with CMHSP under this Agreement, including but not limited to CMHSP's payment policies and CMHSPs/LRE credentialing and re-credentialing processes, Utilization Management, Quality Improvement, peer review, fair hearing, Covered Person grievance process, or concurrent review.

1.24 **Protected Health Information.** For purposes of this Agreement, shall have the meaning as defined in 45 CFR §160.103 and shall also include "Patient Identifying Information" as defined in 42 CFR Part 2, Subpart B, §2.11.

1.25 **Quality Improvement.** The processes established and operated by CMHSP and/or LRE relating to the quality of Covered Services.

1.26 **Sentinel Event**. Any unexpected occurrence involving death or serious physical injury or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome (The Joint Commission, 1998).

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1.27 Utilization Management. The processes to review and determine whether certain health care services provided or to be provided to Covered Persons are in accordance with CMHSP's or LRE's Policies and Procedures.

1.28 Utilization Review. Means monitoring and evaluating Behavioral Health Services and Intellectual and Developmental Disability Services to determine whether such mental health or SUD services are Medically Necessary.

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SECTION 2. GENERAL PROVISIONS

2.01 **Provisions of Health Services.** Provider shall make available to Covered Person those usual and customary services that are offered within the scope of the Provider's licensure and certification under applicable laws and based on the qualifications determined by CMHSP, LRE or MDHHS. Provider shall provide authorized Medically Necessary Covered Services in accordance with provisions contained herein and as required by the Medicaid Provider Manual during the term of this Agreement or as otherwise required by law, whichever is later. LRE acts as fiduciary for Medicaid funding from the State of Michigan.

2.02 **Compliance.** It is expressly understood and agreed by Provider that this Agreement is subject to the terms and conditions of the PIHP/CMHSP Subcontract, which is incorporated herein by reference and made a part hereof, the MDHHS/CMHSP Master Contract for General Funds, and the MDHHS/PIHP Master Contract, together with all Attachments thereto, which are incorporated herein by reference. Copies of these contracts are available by request. Provider shall comply, and shall ensure that its employees and contractors comply, with all applicable provisions and requirements of said contracts, including all Attachments thereto whether or not specifically referenced in this Agreement, as well as applicable provisions of the MPM, CMHSP's Provider Manual, the Inpatient Affiliation Provider Manual, the MDHHS Mental Health & Substance Abuse Administration Family- Driven and Youth-Guided Policy and Guidelines, and the Self-Determination Policy and Practice Guide. The provisions of this Agreement shall take precedence over said contracts unless a conflict exists between this Agreement and any provision of said contract/s. In the event that any provision of this Agreement is in conflict with the terms and conditions of said contract/s, the provisions of said contract/s shall prevail. However, a conflict shall not be deemed to exist where this Agreement:

(a) Contains additional provisions and additional terms and conditions not set forth in said contract(s);

(b) Restates provisions of said contract/s to afford CMHSP or LRE the same or substantially the same rights and privileges as the MDHHS; or

(c) Requires Provider to perform duties and services in less time than required of CMHSP or LRE in said contract/s with the PIHP or the MDHHS, respectively.

2.03 **Contract Authority.** This Agreement is entered into for Mental Health Services under the authority granted Section 116(2)(b) and (3)(e) and Section 228 of 1974 PA 258, as amended; and/or, for substance use disorder services under the authority granted by 2012 PA 500, as amended. Applicable provisions of those Acts, all rules promulgated and adopted under those Acts and applicable State and Federal laws and regulations and Administrative Rules, shall govern the expenditure of funds and provision of services. This Agreement is entered into for services under the authority granted by the MDHHS/PIHP Master Contract and the MDHHS/CMHSP Contract for General Funds.

2.04 **Mental Health and SUD Services.** When providing services pursuant to this Agreement, Provider shall abide by the applicable provisions and requirements of services as set forth in the Mental Health Code and the Behavioral Health and Intellectual and Developmental Disability Supports and Services section of the MPM (as revised), 2012 PA 500, and LRE's Annual Plan for Substance Use Disorder services.

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2.05 **Payment.** CMHSP agrees to provide payment to Provider for the purchase of authorized mental health and/or SUD services that are considered Medically Necessary as guided by the Medical Necessity Criteria found in the MPM. Conditions for payment are described in the **Attachment A:** Service Description(s) which are considered to be part of this Agreement. CMHSP's payment of funds for purposes of this Agreement is subject to and conditioned upon the receipt of funds for such purposes, those being Federal, State and/or local funds.

CMHSP has the right to withhold payment of any disputed amounts until the Parties agree as to the validity of the disputed amount.

Funds paid to Provider for the purchase of authorized mental health and/or SUD services come from a variety of sources including Medicaid and other Federal, State and local sources, and as such, are subject to the rules, regulations, and laws of Medicaid and other Federal, State and local funding sources.

2.06 **Policies and Procedures.** Provider shall comply with all LRE/CMHSP Policies and Procedures and LRE/CMHSP Compliance Plan.

2.07 **Term of Agreement.**

(a) This Agreement shall be effective on **Click or tap here to enter text.** ("Effective Date") and continue in full force through **Click or tap here to enter text.**, unless amended or terminated as set forth herein.

(b) CMHSP shall have the option to renew this Agreement, upon completion of the term, for an additional term of one (1) year, commencing on the day of expiration of the initial term. Said option shall be exercised by CMHSP providing written notice of its intent at least thirty (30) days prior to the termination of the initial term of this Agreement.

(c) Provider shall have the opportunity to review the initial agreed upon rate with CMHSP on an annual basis. Such requests shall be provided to CMHSP, in writing, by July 15th of each year. Provider agrees that if any change to the rate is not agreed to and fully executed by September 15th of each year, the rate currently in effect shall remain unchanged.

2.08 **Statement of Work.** Provider agrees to undertake, perform and complete the services described in **Attachment A: Service Description** and CMHSP's Provider Manual or the Inpatient Affiliation Provider Manual as the case may be and/or applicable Policies that are hereby made a part of this Agreement through reference.

2.09 **Method of Payments and Financial Reports.** The payment procedures and reporting shall be followed as described in the CMHSP's Provider Manual or the Inpatient Affiliation Provider Manual as the case may be and/or applicable Policies.

2.10 **Medical Records of Covered Persons.**

(a) Provider shall prepare and maintain complete and accurate medical records, in either paper or electronic form, for all Covered Persons receiving services. For purposes herein, references to any Covered Person's medical, clinical and/or program records shall mean such records in either paper or electronic form. The medical records shall contain such

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information as may be required by CMHSP, LRE, MDHHS and any other State or Federal agency with jurisdiction over the delivery of services contemplated under this Agreement. The CMHSP shall supply Provider with copies of its clinical protocols and Provider must use the protocols in planning and providing treatment to Covered Persons. Provider shall retain all Covered Person medical records according to the retention schedules in place by the Department of Technology, Management, and Budget #20 (which can be located at: DTMB - General Schedules for Local Government (michigan.gov)), regardless of any change in ownership or termination of service for any reason. The provisions of this section shall survive the expiration or termination of this Agreement, regardless of cause.

(b) Provider shall make medical records available to CMHSP or to LRE for the purpose of assessing quality of care, coordination of care, meeting CMHSP's contractual obligations, conducting medical care evaluations and audits, determining the medical necessity and appropriateness of services provided to a Covered Person, and investigating grievances or complaints made by a Covered Persons or Covered Person's legal representative as permitted by law. Provider shall also make Covered Person's medical records available to LRE, MDHHS, and other State and Federal regulatory bodies having jurisdiction over the delivery of services provided to a Covered Person under this Agreement for purposes of assessing the quality of care or investigating individual grievances or complaints, as permitted by law. The right to under this section exists for ten (10) years from the final date of this agreement period or from the date of completion of any audit, whichever is later. If any financial errors are revealed, the amount in error must be reflected as a credit or debit on subsequent invoices until the amount is paid or refunded. Any remaining balance at the end of the Agreement must be paid or refunded within forty-five (45) calendar days.

(c) Provider shall retain all medical records in accordance with the retention schedules in place by the Department of Technology, Management and Budget's (DTMB) General Schedule #20 at http://Michigan.gov/dmb/0,4568,7-150-9141_21738_31548-56101--,00.html and MCL 333.16213, unless these records are transferred to a successor organization or the LRE is directed otherwise in writing by MDHHS. Medical records of a Covered Person with SUD may not be disclosed to CMHSP on behalf of LRE without the Covered Person's or Legal Representative's consent, except as may be allowed by State and Federal law, including the Mental Health Code and 42 CFR Part 2. The provisions of this section shall survive the expiration or termination of this Agreement regardless of cause, including non-payment by CMHSP, insolvency or breach of this Agreement by either Party.

(d) Upon receipt of written request from CMHSP, Provider shall transfer to the requesting CMHSP Provider's copies of all Covered Person's medical records, and other data in the possession or control of Provider pertaining to the named Covered Person within ten (10) business days of such notice. In the event of an agency or program closure, Provider shall transfer to CMHSP copies of all Covered Person's medical records, and other data in the possession or control of Provider pertaining to the named Covered Person within ten (10) business days of such notice.

(e) SUD records – Said clinical records shall be maintained by Provider consistent with Michigan and Federal law, including 1974 PA 258, 1978 PA 368, 42 CFR Part 2, and 42 USC 290dd-2. Provider will permit access to records by authorized representatives of CMHSP, LRE, MDHHS, the Federal Grantor Agency, Comptroller General of the United

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States, or any of their duly authorized representatives as allowed by State and Federal law, including 42 CFR Part 2.

2.11 Protected Health Information.

(a) To the extent that CMHSP and Provider are HIPAA Covered Entities and/or Programs under 42 CFR Part 2, each agrees that it will comply with HIPAA's Privacy Rule, Security Rule, Transaction and Code Set Rule and Breach Notification Rule and 42 CFR Part 2 (as now existing and as may be later amended) with respect to all Protected Health Information and substance use disorder information that it generates, receives, maintains, uses, discloses or transmits in the performance of its functions pursuant to the Agreement. To the extent that Provider determines that it is a HIPAA Business Associate of CMHSP, then the CMHSP and Provider shall enter into a HIPAA Business Associate Agreement that complies with applicable laws and is in a form acceptable to both the CMHSP and Provider. CMHSP and Provider shall maintain the confidentiality, security and integrity of Covered Person information that is used in connection with the performance of this Agreement to the extent and under the conditions specified in HIPAA, the Michigan Mental Health Code**,** the Michigan Public Health Code (PA 368 of 1978 as amended), and 42 CFR Part 2.

(b) The Parties hereby agree to appropriately use and safeguard a Covered Person's health information provided or disclosed to each other and to keep such information in strictest confidence in order to protect the privacy of all Covered Persons, including but not limited to, providing Covered Persons with a Notice of Privacy Practices. In addition, the business affairs and information of the Parties, including, and without limitation to, information shared pursuant to this Agreement, are confidential and neither Party will discuss such matters with or disclose the contents of this Agreement to anyone who is not a trustee, officer, agent, or a fiduciary of either Party having a need to know such information in performance of his/her duties, all of whom shall be subject to this provision concerning confidentiality, except as otherwise permitted by law. The obligations set forth in this Section are intended to carry on beyond the term of this Agreement, irrespective of whether this Agreement is terminated as provided herein or expires by its own terms.

2.12 Transmittance of Information. Provider will provide and facilitate ready access of a Covered Person's records for referral of Covered Persons and for transmittal of information as required between Provider and other appropriate services to ensure continuity of services to the Covered Person. Such transmittal of information for Covered Persons with mental health diagnoses and for Covered Persons with substance use disorders shall be consistent with the Mental Health Code and with Federal laws and regulations that regulate the release of such information. Electronic Data Interchange ("EDI") will comply with HIPAA. To comply with the Administrative Simplification mandate of HIPAA, all persons and organizations who meet the definition of health care provider described in 45 CFR 160.103, and/or as defined by MDHHS as a required provider type, will obtain a National Provider Identifier ("NPI") to be reported in all standard transactions. For covered health care providers, the NPI must be submitted to CMHSP as it is a required field for billing.

2.13 Independent Contractor. Provider shall perform the services under this Agreement as an independent contractor and not as an employee, agent, partner or any other relationship with CMHSP or LRE. Provider further understands and acknowledges that it shall not be entitled to any of the benefits of a CMHSP or LRE employee including, but not limited to vacation, sick

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leave, administrative leave, health insurance, disability insurance, retirement, unemployment insurance, workers' compensation and protection of tenure. The officers, employees, servants, and agents of Provider shall in no way be deemed to be and shall not hold themselves out as officers, employees, servants or agents of CMHSP and/or LRE.

2.14 **Taxes.** Provider shall be responsible for paying any taxes required by any State, Federal or local taxing jurisdiction. Provider agrees that CMHSP is not responsible for any of its tax obligations and further agrees that should CMHSP be compelled to pay any of its tax obligations, it shall promptly reimburse CMHSP for the full value of such paid tax obligation plus any applicable interest and penalty.

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SECTION 3. PROVIDER RESPONSIBILITIES

3.01 **Electronic Data Interchange ("EDI") and Information Systems ("IS")**.

Provider shall:

(a) Ensure that EDI, data handling, Network configuration, systems security and data storage will be conducted in a manner that is in compliance with the security, privacy and administrative simplification mandates required by HIPAA and HITECH.

(b) Maintain an IS system sufficient to support, at a minimum, the following requirements: history of encounter experiences for all Individuals in service; Quality Improvement; reporting of encounter data, including but not limited to BHTEDS, financial data, demographic information, and service use and performance indicators; coordination of care; and evaluation of services and programs.

(c) Maintain policy and procedures to ensure compliance with Federal, State and CMHSP stipulations regarding the integrity and security of IS, including the following: deterrence of sabotage; fraud and criminal mischief; facilitation of continued operation of the system in the event of an emergency; and protection of confidentiality of client level information.

3.02 **Data Management.**

(a) CMHSP is the owner of all data related to Covered Persons pursuant to this Agreement including all data entered into Provider's management information system(s), such as all eligibility and demographic data, utilization data, claims data; any other service; administrative or financial information that has passed through CMHSP or Provider's operation and resides with Provider. Notwithstanding the foregoing, Provider is not precluded from maintaining and utilizing the data identified in this section in support of the services provided to a Covered Person and internal Provider operations.

(b) Provider agrees to provide information to CMHSP related to encounters, services, and administrative costs as required by MDHHS, as described in **Attachment B: Compensation Schedule.**

(c) Provider shall implement tools to prevent unauthorized access and virus protection to its internal transaction and office system using planning, management, and system monitoring techniques. To ensure adequate system security, CMHSP reserves the right to require a review of Provider IS systems by a Third Party.

3.03 **Timely Filing of Claims.**

(a) Provider shall submit Clean Claims to CMHSP within sixty **(60)** days of the date Covered Services were rendered, and for series billing, within sixty **(60)** days from the end date of service. If CMHSP is not the primary payor, and Provider is pursuing payment from the primary payor, Provider shall submit claims within ninety **(90)** days from the date of the remittance advice. In no event, regardless of the cause or circumstance, shall Covered Person be responsible or liable for any Claim submitted by Provider to CMHSP after the expiration of the filing deadlines set forth in this Section.

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(b) **Denied or Corrected Claims**. Any claims to be resubmitted must be resubmitted within sixty **(60)** days of the date of the Denied Claims Report for CMHSP process. If a Provider error was made in billing, the Provider will make the necessary correction(s) and resubmit the claim. If after checking for errors the Provider believes that the claim was rejected due to an error in the CMHSP claims processing system, the Provider will submit the reason for the appeal in writing to CMHSP, along with any copies of backup evidence.

3.04 Reimbursement/Claims/Rates.

(a) CMHSP shall reimburse Provider at the rates identified in **Attachment B: Compensation Schedule** for services rendered by Provider that have been authorized by CMHSP as the case may be. Actual payments are subject to Ability to Pay in accordance with Chapter 8 of the Mental Health Code and Chapter 8 of the Michigan Administrative Rules when applicable.

(b) For claims payment, CMHSP shall adjudicate or arrange for adjudication and where appropriate make payment for Clean Claims for Covered Services submitted by Provider as follows:

(1) 90% or higher for all Clean Claims from network subcontractors within thirty **(30)** business days of receipt, and

(2) At least 99% of all Clean Claims within ninety **(90)** business days of receipt, except services rendered under a subcontract in which other timeliness standards have been specified and agreed upon by both parties.

(c) CMHSP and Provider shall be responsible for the coordination of public and private benefits for each Covered Person under this Agreement. Provider acknowledges that CMHSP is the payer of last resort. Provider shall be required to identify and seek recovery from all liable first and third parties, except where Provider is furnishing Certified Community Behavioral Health Clinic (CCBHC) services as a Designated Collaborating Organization under the requirements of a CCBHC. Third Party Liability refers to any health insurance or carrier, (e.g., individual, group, employer-related, self-insured, or self-funded plan or commercial carrier, automobile insurance and worker's compensation) or program (e.g., Medicare) that has liability for all or part of a Covered Person's covered benefit.

(d) In cases where Medicaid funds are used, Provider may not bill Covered Person for the difference between Provider's charges and CMHSP's or LRE's rate for Services nor seek nor accept additional supplemental payment from the Covered Person, his/her family, or representative in addition to the amount paid by CMHSP.

(e) In cases where non-Medicaid funds are used exclusively, Provider may not bill Covered Person for the difference between Provider's charges and CMHSP's or LRE's rate for Services nor seek nor accept additional supplemental payment from the Covered Person, his/her family, or representative in addition to the amount paid by CMHSP, without prior written authorization from CMHSP.

(f) Provider agrees not to maintain any action against a Covered Person to collect sums that are owed to Provider under the terms of this Agreement, even in the event CMHSP fails

to pay, becomes insolvent, or otherwise breaches the terms and conditions of this Agreement. This section will survive the termination of this Agreement, regardless of the cause of termination and will be construed to be for the benefit of the Covered Person.

(g) For services provided to all Medicaid/SUD Community Grant/PA2/General Fund beneficiaries, Provider's maximum reimbursement (the sum of first Party, third Party, and CMHSP payments) shall not exceed the lesser of the third-Party payer's maximum allowed amount, CMHSP's or LRE's contracted rate, or Provider's reasonable and customary charge.

3.05 **<u>Provider Eligibility Requirements</u>.** Exclusion of Certain Persons and Entities from Participation in Medicare and State Health Care Programs. To ensure compliance with the Social Security Act Sections 1128, 1128A, 1156, 42 CFR 438.214, 455.10 and 45 CFR Part 76, Provider must ensure the following:

(a) Provider and its subcontractors, Board members, and employees are not debarred, suspended, proposed for debarment, declared ineligible, or excluded from a Federal or State health care program.

(b) Provider and its subcontractors, Board members, and employees have not been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract; violation of Federal/State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property.

(c) Provider and its subcontractors, Board members, and employees are not indicted or otherwise criminally or civilly charged by a government entity (Federal, State or local).

(d) Provider and its subcontractors, Board members, and employees have not within a three (3) year period preceding this Agreement had one or more public transactions (Federal, State or local) terminated for cause or default.

(e) Provider shall ensure an initial examination of Federal and State databases of excluded parties and litigation checks are conducted on Provider's employees and Board members. Such examination must take place at the time of hire, and monthly thereafter, for all Provider employees and members of Provider's Board.

(f) Provider will notify CMHSP/LRE immediately when there is litigation initiated against Provider.

(g) Provider shall immediately disclose to CMHSP any information regarding the ownership or control by a person convicted of a criminal offense described under Sections 1128(a)(b) and 1128(b)(1), (2), or (3) of the Social Security Act and if any staff member, member of the Board of Directors, manager, or person with an employment, consulting or other arrangement with Provider has been convicted of a criminal offense described under Section 1128A of the Social Security Act.

(h) Provider agrees to immediately notify CMHSP of any threatened, proposed, or actual exclusions of Provider or its staff from any Federally-funded health care program.

(i) Provider shall furnish CMHSP with notice of proof of Provider's authority to conduct business in the State of Michigan and in what business capacity (Corporation, etc.), prior to commencing the provision of Supports/Services under this Agreement, and with notice of any related organization of Provider per alliance, affiliation, joint venture, parent/subsidiary or other business relationship that Provider is a party to during the term hereunder.

3.06 Accreditation.

(a) To maintain certification from a national accrediting organization recognized by MDHHS and CMHSP. Accreditation may be issued by the following accrediting organizations:

(1) The Joint Commission (TJC)
(2) CARF International
(3) Council on Accreditation for Families and Children (COA)
(4) The American Osteopathic Association (AOA)
(5) National Committee on Quality Assurance (NCQA)
(6) Accreditation Association for Ambulatory Health Care (AAAHC) may be chosen as the organization's accrediting organization for Substance Use Disorder Providers only.
(7) Utilization Review Accreditation Commission (URAC) (not applicable to SUD)
(8) Other accrediting organizations/certifications may be considered, but must be approved by CMHSP

(b) To provide CMHSP with a copy of the accreditation notification letter or certificate. The survey report must be available to CMHSP upon request.

(c) To notify CMHSP of any change or cancellation in accreditation status.

3.07 Financial Requirements.

(a) To use the accrual method of accounting.

(b) To annually obtain a financial audit when total fiscal year revenue from all sources for Provider is $750,000.00 or more. The American Institute of Certified Public Accountants Audit and Accounting Guides shall be used as applicable. The following items are specific requirements:

(1) The audit will cover Provider's fiscal year.

(2) Audit must be performed by a Certified Public Accountant to ensure the financial statements are presented in conformance with accounting principles generally accepted in the United States of America.

(3) The audit must include the required internal control and compliance reports when Government Auditing Standards (Yellow Book) or Single Audit requirements apply.

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(4) The audit must comply with regulations set forth in the Single Audit Act, OMB Circular A-87, and Circular A-122 when applicable. New grants after 12/26/2014 will follow the OMB Guidance 2 CFR 200.

(5) Management letter issued as a result of the audit by the certified public accountant must be submitted to CMHSP.

(6) To submit a separate schedule of revenue and expense by CMHSP program in accordance with CMHSP contract policy when Provider's fiscal year revenue from CMHSP is five million dollars ($5,000,000.00) or more.

(c) To annually obtain a financial review when total fiscal year revenue for Provider is between $250,000.00 and $750,000.00, unless Provider is required to obtain an audit for some other reason. In cases where Provider's total fiscal year revenue is less than $250,000.00, CMHSP may request a financial review. The American Institute of Certified Public Accountants Statements on Standards for Accounting and Review Services shall be used. The following items are specific requirements:

(1) The review will cover Provider's fiscal year.

(2) The review must be performed by a Certified Public Accountant to provide limited assurance that there are not material modifications that should be made to the financial statements in order for them to be in conformance with accounting principles generally accepted in the United States of America.

(2) Management letter issued as a result of the review by the Certified Public Accountant must be submitted to CMHSP.

(d) To submit the items above to CMHSP Financial Compliance Auditor within one hundred and fifty (150) days following Provider's fiscal year end. Any deviation from this requirement must be requested in writing and in advance and must be approved by CMHSP

(e) To submit a copy of Provider's Federal Form 990 – Return of Organization Exempt from Income Tax to CMHSP Financial Compliance Auditor within thirty (30) days of submission to the Internal Revenue Service (IRS), if Provider is required to file Form 990 under IRS regulations.

(f) Provider shall maintain all pertinent financial and accounting records and evidence pertaining to this Agreement based on financial and statistical records that can be verified by CMHSP/LRE and/or its auditors in accordance with CMHSP/LRE Retention Policy for financial and accounting records. Financial reporting shall be in accordance with Generally Accepted Accounting Principles (GAAP) applicable to State and local governments as promulgated by the Governmental Accounting Standards Board (GASB).

(g) CMHSP, LRE, the Federal government, the State of Michigan, or their designated representatives shall be allowed to inspect, review, copy, and/or audit all financial records pertaining to this Agreement.

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(h) Pursuant to 42 CFR 455.104-106, Provider shall furnish CMHSP with notice of proof of financial solvency, prior to commencing supports/services, and with immediate notice of any change in financial position material to Provider's solvency and to its continuing operation as an on-going concern, at any time during the term of this Agreement.

(i) Service Provider Loans, Fund Transfers, Liens, and Encumbrances Prohibited. Provider shall not lend, transfer, create or permit to be created, a lien or encumbrance, or grant a security interest in, or with respect to any funds provided in whole or in part by CMHSP, to any third party for any purpose without prior written approval from PIHP.

3.08 Insurance Requirements.

(a) Provider shall maintain liability insurance during the life of this Agreement. The liability insurance policy shall provide limits which are consistent with industry standards based upon the services provided by Provider under this Agreement if applicable to services hereunder. (See **Attachment C: Insurance Requirements**).

(b) CMHSP shall be identified as an additional insured on the liability insurance policy required above to the extent that the additional insured is held responsible for the acts, omissions, or negligence of Provider pertaining to Provider's work under this Agreement. The insurance company providing liability insurance to Provider shall be an authorized or eligible unauthorized State of Michigan insurer. Provider shall provide to CMHSP evidence of the liability insurance maintained by Provider. (See **Attachment C: Insurance Requirements**)

(c) Provider shall give CMHSP written notice of any changes in or cancellation of the insurance policies required to be maintained by Provider at least fifteen (15) days before the effective date of such changes or cancellations. If Provider's insurance coverage is at any time reduced or terminated during the duration of this Agreement, CMHSP may terminate this Agreement effective immediately upon delivery of notice of termination to Provider.

3.09 Notifications. Provider will notify CMHSP in writing when there is a change of status resulting in any of the following;

(a) Loss of insurance.

(b) Qualified opinion on financial audit or financial review.

(c) Pending or successful litigation claim against Provider.

(d) Loss of SUD treatment, prevention, or DEA license or MDHHS certification.

(e) Any change in state licensure or certification, including but not limited to termination, revocation, suspension or investigation.

(f) Loss of accreditation (if applicable).

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3.10 Provider, if delegated by CMHSP, shall annually provide all Covered Persons with information on recipient rights and protections as required by the Mental Health Code. Documentation of providing this information must be recorded within the Covered Person's case file.

3.11 Provider, if delegated by CMHSP, shall ensure that Covered Persons are informed of their right to be free from any forms of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. Documentation of providing this information must be recorded within the Covered Person's case file.

3.12 **Contract Monitoring/Performance Evaluation/Plan of Correction.**

(a) Provider agrees that all records, books, documents, accounting procedures, practices or any other items relevant to this Agreement shall be made available for examination or audit by personnel authorized by CMHSP or law including State and Federal auditors. As applicable to Inpatient Facilities, Provider agrees to demonstrate continuous improvement in meeting standards as indicated in MPM and the Inpatient Affiliation Provider Manual *(SECTION VI: QUALITY INDICATORS)*.

(b) As applicable to Inpatient Facilities, CMHSP and LRE may utilize a variety of remedies ranging from requiring a corrective plan of action to withholding payment or contract termination to assure compliance with this Agreement and incorporated covenants, laws, rules, policies, and procedures as indicated in the MPM or LRE's Inpatient Affiliation Provider Manual.

(c) All work performed under this Agreement will be performed and reviewed according to timetables set by CMHSP. CMHSP has identified timetables, formats, and content areas for reporting as referenced in this Agreement and its Attachments. If Provider is out of compliance, Provider will have thirty (30) days after written notice of noncompliance to present a plan of correction acceptable to CMHSP notwithstanding any other provisions of this Agreement. Issues related to patient health and safety will require corrective action immediately, and written correction will occur within three (3) business days.

(d) CMHSP and/or LRE will assign staff to engage in regular monitoring of and reporting on Provider's performance, including taking action to ensure performance improvement, such as implementing plans of correction. LRE will follow the monitoring and reporting procedures in MPM and/or CMHSP Policies in order to ensure high quality services and compliance with Agreement requirements (See **Attachment D: Contract Monitoring/Provider Quality Review).**

(e) Provider agrees to cooperate with CMHSP and/or LRE in carrying out compliance auditing and monitoring responsibilities, including producing the documents needed to assist with these functions.

3.13 **Licensure and Certification.** Provider agrees to maintain in full force and effect any licensing required as a condition of performing services and to ensure services will be provided by staff who are licensed or certified under applicable State statutes and regulations. Failure to maintain such by Provider may result in immediate termination of this Agreement.

(a) Provider will maintain policies and procedures to ensure that contracted physicians and other health care professionals (e.g., social workers, OT, etc.) are licensed by the State of

Michigan and are qualified to perform their services. Provider must immediately notify CMHSP if any license is lapsed, terminated, revoked or suspended during the term of this Agreement.

(b) Provider will maintain policies and procedures to ensure that licenses and certifications are current and valid.

(c) Provider will maintain policies and procedures to ensure that support care staff who are not required to be licensed are qualified to perform their jobs, including, but not limited to, any requirements in the MPM, any MDHHS certifications, and as required in the MDHHS provider qualifications chart.

(d) Provider agrees to immediately notify CMHSP of any State licensure or certification investigation.

(e) For SUD Providers: Organizations/programs must be licensed for SUD service provision.

3.14 Credentialing.

(a) Provider will maintain policies and procedures consistent with CMHSP's or LRE's policies, on personnel selection, credentialing, re-credentialing, and privileging, including job descriptions or similar documents that describe specific credentialing, privileging and other requirements for all staff that deliver services to Covered Persons and including mechanisms to ensure requirements are met by all staff consistent with MDHHS/PIHP Credentialing and Re-Credentialing Processes. Prior to provision of services by Provider staff, Provider will submit to CMHSP and/or verification of staff credentials, as requested.

(b) Provider will ensure that staff credentials are consistent with Medicaid and Medicare regulations, and other applicable laws, regulations and rules.

(c) Provider will comply with the Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services and HCPCS/CPT Codes requirements (as updated).

(d) Provider will require criminal background checks at a minimum of every two years for all persons (staff, management and non-management) providing services to or interacting with Covered Persons served by CMHSP or persons who have the authority to access or create CMHSP information. Criminal background checks must be completed through the State of Michigan Licensing and Regulatory Affairs ("LARA") Workforce Background Check system; Internet Criminal History Access Tool ("ICHAT"); or other service as approved by the LRE prior to starting work with Covered Persons. Provider shall inform CMHSP if any Board member has been convicted of a felony or misdemeanor related to patient abuse, health care, or any type of fraud, a controlled substance, or any obstruction of any investigation.

3.15 Quality Improvement.

(a) Provider will maintain a systemic Quality Improvement process to measure, evaluate and improve performance.

(b) At the discretion of the CMHSP, Provider's Quality Improvement Process must be clearly described in a Quality Improvement Policy/Plan which may include the following:

credentialing and re-credentialing processes; a plan for assessing customer satisfaction; evidence of active participation of Covered Persons served; utilization of standardized performance measures; a process for gathering and utilizing performance data; a process for reporting and reviewing adverse events; and procedures for adequate documentation of complaints, actions taken, and utilization of information obtained to develop Quality Improvement plans.

(c) Provider will establish and monitor performance indicators for the purposes of identifying process improvement projects that achieve a beneficial effect on health outcomes and Covered Person satisfaction.

3.16 **Cultural Competence.**

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

(b) To effectively demonstrate such commitment, it is expected that Provider has five (5) components in place: (1) a method for assessing the cultural needs of Covered Person(s) being served; (2) sufficient policy and procedure to reflect Provider's value and practice expectations; (3) a method of service assessment and monitoring; (4) ongoing training to ensure that staff are aware of, and able to effectively implement policy; and (5) the provision of supports and services within the cultural context of the Covered Person.

(c) Provider shall participate in CMHSP's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with Limited English Proficiency and diverse cultural and ethnic backgrounds.

3.17 Provider or any health care professional employed or contracted by Provider may not be restricted, when acting within the lawful scope of practice and with consent of Covered Person or their legal representative, from advising or advocating on behalf of a Covered Person for the following:

(a) Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

(b) Any information the Covered Person needs to decide among relevant treatment options.

(c) The risks, benefits, and consequences of treatment or non-treatment.

(d) The Covered Person's right to participate decisions regarding his or her health care, including the right to refuse treatment and the right to express preferences about future treatment decisions.

3.18 If the health and safety of the Covered Person is in jeopardy, it is the duty of both Parties to cooperate in the immediate resolution of the situation.

3.19 **Selected Specific Block Grant requirements applicable to Providers:**

(a) Shall not be used to pay for inpatient hospital services except under conditions specified in Federal law.

(b) Shall not be used to make cash payments to intended recipients of services.

(c) Shall not be used to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or any other facility or purchase major medical equipment.

(d) Shall not be used to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funding.

(e) Shall not be used to provide Covered Persons with hypodermic needles or syringes so that such Covered Persons may use illegal drugs.

(f) Shall not be used to enforce State laws regarding the sale of tobacco products to individuals under the age of eighteen (18).

(g) Shall not be used to pay the salary of an individual at a rate in excess of Level I of the Federal Executive Schedule, or approximately $199,700.00.

The PIHP shall assure that, for any subcontracted treatment or prevention service, each subcontractor maintains service availability throughout the fiscal year for persons who do not have the ability to pay.

3.20 Recipient Rights.

For Mental Health Service Providers:
Providers shall ensure that all persons employed receive MDHHS approved Recipient Rights training within thirty (30) days of being employed. The rights of recipients, as described by the Mental Health Code and the Michigan Administrative Rules, will be protected. Provider will be in compliance with the Recipient Rights requirements as described in **Attachment E-1: Recipient Rights for Mental Health Services.**

(a) Provider shall ensure that Covered Persons served are allowed to choose their health care professional(s) to the extent possible in accordance with 42 CFR 438.3(1).

(b) Provider will comply with CMHSP mechanisms required by the PIHP/MDHHS Master Contract for Recipients/applicants to pursue resolution of appeals regarding services and supports managed and/or delivered by CMHSP.

(c) Provider will not prohibit, or otherwise restrict, a health care professional acting within his/her lawful scope of practice, from advising or advocating on behalf of a Covered Person regarding health status, medical care, treatment options, risks, benefits and consequences of treatment, or non-treatment, and Covered Person's rights to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

(d) Provider will allow persons who properly identify themselves as representatives of Disability Rights Michigan ("DRM") access to the premises, the Covered Person, and records pertaining to those Covered Persons, in compliance with the Mental Health Code and applicable Federal law. If DRM receives a complaint or has probable cause to suspect

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abuse or neglect, the following conditions must be met before DRM may have access to records of a Covered Person, according to 45 CFR 164.512 (c), (e), and (f):

(1) DRM must demonstrate that it has the authority to access a Covered Person's record under the Mental Health Code and applicable Federal law.

(2) DRM must request the Covered Persons' records in writing.

(3) Provider may question DRM's authority if it is unclear.

(4) Provider must limit the disclosure to the relevant information expressly authorized by statute or regulations.

(5) Provider must maintain documentation of all disclosures.

<u>For Substance Use Disorder Service Providers</u>:
Providers shall ensure that all persons employed receive SUD Recipient Rights training within thirty (30) days of being employed. Providers will protect the rights of Covered Persons through comprehensive compliance with applicable State and Federal recipient rights requirements, including:

(1) Federal Confidentiality Law and Regulations (codified as 42 USC § 290dd2 and 42 CFR Part 2.

(2) MDHHS Recipient Rights (R325.14302 to R325.14306).

(3) Provider will be in compliance with the SUD Recipient Rights requirements as described in **Attachment E-2: Recipient Rights Substance Use Disorders.**

3.21 **<u>Circumstances that Interfere with Performance</u>.** In the event that circumstances occur which substantially reduce or otherwise interfere with either Party's ability to perform their respective obligations under this Agreement, immediate notification to the other Party is required. A meeting shall be convened as soon as possible in order to determine the immediate course of action and possible resolution of the situation.

3.22 **<u>Conflict of Interest</u>.** Provider affirms that no principal, representative, agent, or employee of Provider or anyone acting on behalf of or legally capable of acting on behalf of Provider shall engage in activities which are incompatible or in conflict with the discharge of their duties and responsibilities under this Agreement. Provider represents that no employee, officer, or agent of Provider has participated in the selection, award, or administration of this Agreement, which involved a conflict of financial or other interest that is either real or apparent. Provider agrees that no principal, representative, agent, employee, or anyone acting on behalf of or legally capable of acting on behalf of Provider is currently an employee of CMHSP nor is any person using or privy to insider information which would give the appearance of providing an unfair advantage to said Provider. Provider agrees to immediately complete **Attachment G: Disclosure of Ownership & Controlling Interest Statement** and **Attachment J: Conflict of Interest Compliance Certificate** and return both to CMHSP with this executed Agreement.

3.23 **<u>Utilization Management</u>.** Provider agrees to participate in the implementation of CMHSP and/or LRE Utilization Management program, including clinical protocols.

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3.24 Provider Manual/Policies/Best Practice Guidelines/Attachments. Provider is responsible for the knowledge of, and to implement as practice, minimally:

(a) CMHSP's or LRE's SUD and/or MDHHS - Mental Health Provider Manual

(b) the Inpatient Affiliation Provider Manual

(c) Policies/Best Practice Guidelines/Attachments.

CMHSP, LRE and/or MDHHS may amend these items from time to time. All such documents shall constitute a part of this Agreement and shall be deemed to be incorporated herein.

3.25 Corporate Compliance.

(a) Provider shall participate in the implementation of CMHSP's Corporate Compliance Office compliance audits, reviews, investigations, and remediation. Provider will promulgate policy that specifies procedures and standards of conduct that articulate Provider's commitment to comply with all applicable Federal and State standards.

(b) CMHSP has responsibility and authority to make fraud and/or abuse referrals to the Office of the Michigan Attorney General, Health Care Fraud Division, the Office of Inspector General ("OIG"), and MDHHS.

(c) If Provider has any suspicion or knowledge of fraud and/or abuse with any provision of service under the Terms of this Agreement, Provider must report directly to CMHSP Corporate Compliance Officer, or designee. Provider shall not attempt to investigate, beyond initial inquiry of basic information, or resolve the suspected, known, or reported alleged fraud and/or abuse without first reporting the suspected, known, or reported to the CMHSP Corporate Compliance Officer, or designee.

(d) Any unreasonable delay in reporting known or suspected fraud and/or abuse shall be considered a material breach of this Agreement, which may result in sanctions up to and including termination of this Agreement, at CMHSP's sole discretion.

(1) Provider shall ensure that staff, Board, and any or all agents acting on behalf of Provider reasonably cooperate and assist any ongoing investigation, whether conducted by CMHSP, PIHP, any State or Federal authority charged with identifying, investigating, sanctioning, or prosecuting suspected fraud and/or abuse.

3.26 Compliance In General.

(a) Provider agrees to ensure that all Federal, State and local laws and regulations are followed. Compliance includes a commitment to uphold a high standard of ethical and legal business practices and to prevent misconduct.

(1) MDHHS administration of this Agreement is subject to the State of Michigan State Ethics Act. Act 196 of 1973, "Standards of Conduct for Public Officers and

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Employees. Act 196 of 1973 prescribes standards of conduct for public officers and employees."

(2) MDHHS administration of this Agreement is subject to the State of Michigan Governor's Executive Order No: 2003-01, "Procurement of Goods and Services from Vendors."

(b) Any Provider articles or publications that result from information gathered through use of State or Federal funds, must acknowledge receipt of that support from the MDHHS, LRE, CMHSP and/or the appropriate Federal or State agencies.

(1) **<u>Applicable to Substance Use Disorder Providers only</u>:** The Federal awarding agency, Substance Use Disorder and Mental Health Services Administration/Department of Health and Human Services ("SAMHSA/DHHS"), reserves a royalty-free, nonexclusive and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, for Federal Government purposes: (a) The copyright in any work developed under a grant, sub-grant, or contract under a grant or sub-grant; and (b) any rights of copyright to which a grantee, sub-grantee or a contactor purchases ownership with grant support.

(c) This Agreement shall be construed according to the laws of the State of Michigan as to the interpretation, construction and performance.

(d) CMHSP and Provider agree that the venue for the bringing of any legal or equitable action under this Agreement shall be established in accordance to the statutes of the State of Michigan and/or Michigan Court Rules. In the event that any legal action is brought under this Agreement in Federal Court, the venue for such legal action shall be the Federal Judicial District of Michigan, Western District, Southern Division.

(e) When providing Supports/Services under this Agreement, Provider, its officers, employees, servants, and agents shall abide by all applicable provisions and requirements for Supports/Services as set forth in the Mental Health Code, the MDHHS Rules, Medicaid and Medicare Regulations, the MDHHS/CMHSP Master Contract for General Funds, the MDHHS/PIHP Master Contract, the PIHP/CMHSP Subcontract and in Policies, Procedures, standards, and guidelines established by CMHSP and LRE.

(f) Provider, its principals, officers, employees, contracted and subcontracted providers, servants and agents are subject to and shall comply with all the applicable requirements of CMHSP's Compliance Program Plan, as annually approved by CMHSP's Board. Failure to do so will result in remediation action and/or termination of this Agreement for material breach of this Agreement.

(g) Provider shall comply under this Agreement with the applicable requirements of the Balanced Budget Act of 1997 (BBA), as amended, and the regulations promulgated thereunder, Federal regulations, and standards of the Concurrent 1115 Demonstration Waiver, 1915(c)/(i) Waiver Program(s), the Healthy Michigan Program, Flint 1115 Demonstration Waiver, and Substance Use Disorder Community Grant Programs.

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(h) Provider shall abide by and post a copy of the Whistleblower's Protection Act (Act 469 of the Public Acts of 1980) in a conspicuous place at its service location(s) and its headquarters.

(i) Provider shall comply with the Anti-Lobbying Act, 31 USC 1352 as revised by the Lobbying Disclosure Act of 1995, 2 USC 1601 et seq., and Section 503 of the Departments of Labor, Health and Human Services and Education, and Related Agencies Appropriations Act (Public Law 104-208). Further, Provider shall require that the language of this assurance be included in the award documents of all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

(j) Provider shall comply with all applicable standards, orders, or regulations issued pursuant to the Clean Air Act (42 USC 7401 et seq.) and the Federal Water Pollution Control Act, as amended (33 USC 1251 et seq.).

(k) If any laws or administrative rules or regulations that become effective after the date of the execution of this Agreement substantially change the nature and conditions of this Agreement, they shall be binding to the Parties, but the Parties retain the right to exercise any remedies available to them by law or by any other provisions of this Agreement.

(l) Provider shall comply with the Hatch Political Activity Act, 5 USC 1501-1508, and Intergovernmental Personnel Act of 1970, as amended by Title VI of the Civil Service Reform Act, P. L. 95-454, 42 USC 4728. Federal funds cannot be used for partisan political purposes of any kind by any person or organization involved in the administration of federally assisted programs.

(m) Assurance is hereby given to CMHSP that Provider will comply with Public Law 103-227, also known as the Pro-Children Act of 1994, 20 USC 6081 et seq., which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of eighteen (18), if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan or loan guarantee. The Law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The Law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where Women, Infants, and Children (WIC) coupons are redeemed. Failure to comply with the provisions of the Law may result in the imposition of a civil monetary penalty of up to $1,000.00 for each violation and/or the imposition of an administrative compliance order on the responsible entity. Provider also ensures that this language will be included in any sub-awards that contain provisions for children's services. Provider also ensures, in addition to compliance with Public Law 103-227, any service or activity funded in whole or in part through this Agreement will be delivered in a smoke-free facility or environment. Smoking shall not be permitted anywhere in the facility, or those parts of the facility under the control of Provider. If activities or services are delivered in residential facilities or in facilities or areas that are not under the control of Provider (e.g., a mall, residential facilities or private residence, restaurant or private work site), the activities or services shall be smoke free.

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(n) Provider agrees to comply with all applicable Federal and State laws including, but not limited to the following:

(1) Davis-Bacon Act (40 USC 276a to a-7).
(2) Contract Work Hours and Safety Standards (40 USC 327-333).
(3) Rights to Inventions Made Under a Contract or Agreement. Contracts or agreements for the performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and the recipient in any resulting invention in accordance with 37 CFR Part 401.
(4) Contracts of Public Servants with Public Entities, 1973 PA 317, as amended; and Standards of Conduct for Public Officers and Employees, 1973 PA 196, as amended.
(5) The Drug Free Workplace Act of 1988, 34 CFR Part 85, Subpart F.
(6) Deficit Reduction Act (DRA) of 2005, PL 109-17, section 6032 codified at Section 1902(a)(68) of Title XIX (Social Security Act) requires Employee Education about False Claims Recovery.
(7) Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1973, and the Americans with Disabilities Act, PL 101-336 (42 USC 12101 et seq.)
(8) The Elliot Larsen Civil Rights Act, 1976 PA 453, as amended; the Persons with Disabilities Civil Rights Act, 1976 PA 220, as amended; and, Section 504 of the Federal Rehabilitation Act. Any breach of these Acts may be considered a material breach of this Agreement.
(9) HIPAA/HITECH Omnibus Rule, 42 USC 1320a-7b(b), prohibiting knowing and willful solicitation, receipt, offer, or payment of remuneration in return for referring a customer or services under a Federal Health program; and 42 USC 1395nn, as implemented by 42 CFR 411 and 424, relating to self-referrals by physicians. **Federal False Claims Act, 31 USC §§ 3729 – 3733.**
(10) Michigan Medicaid False Claim Act, MCL 400.601 et. seq.
(11) Michigan Social Welfare Act, MCL 400.111d.
(12) Charitable Choice Regulations. To ensure compliance with Federal Regulation 45 CFR Parts 54 and 96, regarding Charitable Choice regulations in the use of Substance Abuse Prevention and Treatment (SAPT) block grant funds with application to both substance use disorder prevention and Substance Use Disorder Treatment Providers/Programs. Accordingly, if Provider identifies itself to CMHSP as a faith-based provider, it agrees:

(i) To be identified by CMHSP as a religious or faith-based organization.

(ii) To ensure that a Covered Person who objects to the religious character of Provider's program(s) has a right to notice, referral, and alternative services which meet standards of timeliness, capacity, accessibility, and equivalency.

(iii) To abide by all other requirements of the Federal regulations, including an exclusion of the use of Federal funds for inherently religious activities and a prohibition against discriminating against a program participant on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice.

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(iv) To notify CMHSP, on an annual basis, regarding the number of Covered Persons who choose to be referred to an alternative service because they object to the religious character of Provider's program.

(o) Provider will comply with Protection of Human Subjects Act, 45 CFR, Part 46, subpart A, sections 46.101-124 and HIPAA.

(p) In addition, the PIHP's Substance Use Disorder service delivery system shall comply with:

(1) The Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse;

(2) The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616) as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism;

(3) §§523 and 527 of the Public Health Service Act of 1912 (42 USC §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records;

(4) Any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and,

(5) The requirements of any other nondiscrimination statute(s) which may apply to the application.

(q) In performing its duties and responsibilities under this Agreement, Provider shall comply with all applicable Federal and State laws, rules and regulations prohibiting discrimination.

(r) Provider shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, gender identity, or national origin. The Contractor will take affirmative action to ensure that applicants are employed, and that employees are treated during employment without regard to their race, color, religion, sex, sexual orientation, gender identity, or national origin. Such action shall include, but not be limited to the following: Employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided setting forth the provisions of this nondiscrimination clause, as required pursuant to: the Elliott Larsen Civil Rights Act of 1976 PA 453, as amended; the Persons with Disabilities Civil Rights Act, 1976 PA 220, as amended; and Section 504 of the Federal Rehabilitation Act 1973, P.L. 93-112. Provider will, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, or national origin.

(s) Provider shall comply with the provisions of the Michigan Persons with Disabilities Civil Rights Act of 1976 PA 220, as amended, and Section 504 of the Federal Rehabilitation Act of 1973 P.L. 93-112, 87 Stat 394, as amended.

(t) Provider shall comply with MCL 15.342 Public Officer or Employee prohibited conduct, the Americans with Disabilities Act of 1990 (ADA), P.L. 101-336, 104 Stat 328 (42 USCA S 12101 et. seq.), as amended; the Age Discrimination Act of 1973; the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964; and Title IX of the Education Amendments of 1972.

(u) Provider shall not refuse to treat, nor will it discriminate in the treatment or referral of, any Covered Person under this Agreement based on the Covered Person's source of payment, including reimbursement rates for services, or on the basis of age, sex, height, weight, marital status, arrest record, race, creed, handicap, color, national origin or ancestry, religion, political affiliation or beliefs, or involuntary patient status.

(v) Provider shall comply with the: Title VI of the Civil Rights Act of 1964 (42 USC 2000 D et seq.) and Office of Civil Rights Policy Guidance on the Title IV Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency; Title IX of the Education Amendment of 1972, as amended (20 USC 1681-1683; and 1685-1686) and the regulations of the U. S. Department of Health and Human Services issued thereunder (45 CFR, Part 80, 84, 86 and 91).

(w) Any breach of this section shall be regarded as a material breach of this Agreement and may be a cause for termination thereof by CMHSP or LRE.

(x) Where applicable, Provider will work with CMHSP and PIHP to assure full compliance with the MDHHS Master Contract related to Home and Community Based Setting requirements for CMS approved Medicaid Authorities and the State's approved transition no later than the final date set forth by MDHHS. Activities to include but not limited to, complete survey process, review data collected from survey, notify providers of corrective action, collect corrective action, approve corrective action and resurvey to assure both initial and ongoing compliance.

3.27 **Coordinating with Health Care Providers.** Provider must ensure that mental health and substance use disorder treatment services are coordinated with primary health care. Treatment case files must include, at minimum, the Primary Care Physician's name and address, a signed waiver release of information for purposes of coordination, a statement that the Covered Person has refused to sign this waiver, or a statement that the Covered Person does not have a Primary Healthcare Provider. Coordination of care is also recommended with any other health care providers, agencies, natural or community support as specified in the Covered Person's Treatment Plan/Individual Plan of Service.

3.28 **Service to Covered Persons Out of County.** When Provider assumes responsibility for serving a Covered Person from any CMHSP (County of Financial Responsibility "COFR") other than CMHSP named in this Agreement, Provider retains responsibility for meeting the service needs of that Covered Person until (1) the responsibility is expressly and knowingly assumed by CMHSP, or (2) the Covered Person served relocates to another state or service area by choice.

3.29 **Collaboration and Joint Planning.** Provider agrees:

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(a) To assist the CMHSP with the planning and management of the system of care. The goal of this partnership is to ensure quality services to Covered Persons, ensure timely and proactive decision making, and to enhance community involvement in the system of care.

(b) To assist in the design and implementation of a services system that is responsive to Covered Person's needs.

(c) To engage with CMHSP and LRE in ongoing Quality Improvement ("QI") processes by being an active participant in systemic QI projects for clinical and cultural process improvements, engaging in training opportunities to develop clinical and cultural competencies, and to support efforts to move CMHSP system forward in providing culturally competent, evidence-based, effective services to all Covered Persons.

3.30 **Event Notifications.** In addition to other reporting requirements outlined in this Agreement, Provider shall immediately notify CMHSP of the following events:

(a) Any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a Recipient Rights, licensing or police investigation. This report shall be submitted electronically to CMHSP within twenty-four (24) hours of either the death, Provider's receipt of notification of the death, or Provider's receipt of notification that a Recipient Rights, licensing, and/or police investigation has commenced. CMHSP shall notify the LRE consistent with its contract requirements. Provider shall report the following information to the CMHSP:

(1) Name of Medicaid beneficiary (Covered Person).
(2) Covered Person's ID number (Medicaid, MIChild).
(3) Customer ID ("CONID") if there is no beneficiary ID number.
(4) Date, time and place of death (if a licensed foster care facility, include the license number).
(5) Preliminary cause of death.
(6) Contact person's name and e-mail address.

(b) Relocation of a Covered Person's placement due to licensing issues.

(c) An occurrence that requires the relocation of Provider or Provider service site, governance, or administrative operation for more than twenty-four (24) hours.

(d) The conviction of Provider or a Provider staff member for any offense related to the performance of their job duties or responsibilities.

(e) With the exception of deaths, notification of these events shall be made telephonically or through other forms of communication within two (2) business days to CMHSP who shall then immediately provide notice to LRE.

3.31 **Critical Incidents**. Provider shall cooperate with CMHSP's preparation and filing reports of critical incidents, as defined in the MDHHS/PIHP Master Contract. Provider shall comply with the reporting requirements and guidelines identified in the Critical Incident Reporting and Event Notification Requirements which can be found on the MDHHS website: MDHHS - Policies & Practice Guidelines (michigan.gov).

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(a) Provider will fully cooperate with Sentinel Event determinations, root cause analysis investigations, and implementation of corrective action plans to prevent further Sentinel Events.

(b) Provider shall report any incidents and Sentinel Events (as defined herein and by the CMHSP's Recipient Rights/Confidentiality Procedures, as incorporated herein by reference) involving the Covered Person(s) immediately upon receipt to CMHSP's CEO or the CEO's designated representative and as appropriate to the applicable licensing MDHHS or agency of the State of Michigan (Adult and Children Protective Services Divisions), law enforcement, and other public agencies, as required by law. Provider agrees to allow persons who properly identify themselves as representatives of DRM access during reasonable hours to applicable premises, the Covered Person receiving Supports/Services, and service records in compliance with Section 748(7) and Section 931 of the Mental Health Code. Provider shall provide CMHSP's Recipient Rights Officer with copies of all investigative reports and summary reports involving the Covered Persons.

(c) For purposes of the MDHHS/PIHP Master Contract and the MDHHS/CMHSP Master Contract for General Funds, CMHSP, the Federal government, the State of Michigan, or designated representatives, shall be allowed to inspect, review, copy, and/or audit all financial records and license, accreditation, certification, and program reports of Provider and to review all clinical records of Provider pertaining to performance of this Agreement, to the full extent permitted by applicable Federal and State law. All financial, administrative, and clinical records pertaining to this Agreement must be retained according to the retention schedules in place by DTMB's General Schedule #20 at: http://michigan.gov/dmb/0,4568,7-150-9141_21738_31548-56101--,00.html unless these records are transferred to a successor organization or as otherwise directed in writing by MDHHS.

(d) Any breach of this section shall be regarded as a material breach of this Agreement and may be a cause for termination thereof by CMHSP.

3.32 **Covered Person Plans of Service (IPOS)/Treatment Plan ("TP").** Provider, pursuant to this Agreement, shall establish and maintain a comprehensive individual service record system consistent with the provisions of the MDHHS Medical Services Administration (MSA) Policy Bulletins and appropriate State and Federal statutes, which includes a copy of the current Treatment Plans/Individual Plans of Service ("IPOS"), IPOS Amendments, and case files, on site or immediately accessible either through a physical record or electronically. Provider shall maintain on file during the term of this Agreement a current copy of the IPOS/TP of each Covered Person placed with Provider to receive services hereunder that specifies amount (number of units), scope (who, how where), and duration (how long) of each service as those terms are defined in the MPM, as well as the cost of each service.

3.33 **Standard Consent Form**. For all electronic and non-electronic Health Information Exchange environments, Provider will follow PIHP's and CMHSP's policies requiring the Parties to use and accept the standard release form MDHHS-5515 created under Public Act 129 of 2014.

3.34 **Transporting Covered Person(s).** Provider shall permit only responsible staff with an appropriate valid driver's license, as required by State law, to operate motor vehicles while transporting

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Covered Person(s) hereunder. Provider shall have policies and procedures in place to ensure safe transportation of Covered Person(s) served. Provider will ensure that vehicles are maintained in safe working order.

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SECTION 4. STANDARD CONTRACT PROVISIONS

4.01 **Non-Exclusivity.** This Agreement is not exclusive, and nothing contained within shall be construed to restrict the right of either Party to enter into other similar contracts.

4.02 **Amendment.**

(a) This Agreement and its referenced Attachments are intended by the Parties to constitute the entire and integrated understanding between them and supersedes all previous agreements related to the subject matter, such previous agreements being void and having no force and effect.

(b) Amendments to this Agreement must be in writing and signed by the Parties. However, CMHSP may amend this Agreement or Attachments immediately if such amendment is necessary to comply with Federal or State statutes or regulations, or as otherwise required by CMHSP's funders, with prompt written notice of such amendment to Provider.

4.03 **Delegation.** The provisions of the Balanced Budget Act (hereinafter "BBA") of 1997, allow states to establish Medicaid beneficiary protections in areas such as quality assurance, grievance rights, and customer service.

(a) CMHSP is required by contract to oversee and be accountable for any administrative function or responsibility that it delegates to any subcontractor. 42 CFR 438.230 (b)(2).

(b) CMHSP is required to provide for the revoking of delegation or the imposition of other sanctions if its subcontractor's performance is inadequate.42 CFR 438.230(c)(iii).

(c) CMHSP may conduct periodic formal scheduled reviews of Provider's activities.

(d) LRE, or designee, will conduct annual performance review of the Provider's activities. The quality audit will include monitoring of administrative functions delegated to Provider as described in **Attachment D: Contract Monitoring**, if applicable.

(e) Unsatisfactory performance, lack of response, failure to submit a plan of correction within required timeframes, and/or discovery of significant risks may result in CMHSP application of a sanction or termination of this Agreement.

4.04 **Attachments.** Attachments to this Agreement are referenced below and are incorporated into this Agreement. With the exception of **Attachment G: Disclosure of Ownership and Controlling Interest Form**, Attachments do not require individual signatures.

(a) Attachment A: Service Descriptions
(b) Attachment B: Compensation Schedule
(c) Attachment C: Insurance Requirements
(d) Attachment D: Contract Monitoring
(e) Attachment E-1: Recipient Rights for Mental Health Services
(f) Attachment E-2: Recipient Rights for Substance Use Disorders
(g) Attachment F: Performance Indicators

(h) Attachment G: Disclosure of Ownership & Controlling Interest Statement (to be immediately completed by Provider and returned to LRE or CMHSP) as requested.
(i) Attachment H: Delegated Functions
(j) Attachment I: Training Requirements
(k) Attachment J: Conflict of Interest
(l) Attachment K: CCBHC
(n) SUD/Mental Health Provider Manual/Policies/Best Practice Guidelines
Allegan: **http://www.accmhs.org/SitePages/Providers.aspx**
HealthWest: **https://healthwest.net/for-providers/provider-network-contracts/**
Network180: **https://extranet.network180.org/SitePages/Home.aspx**
CMH of Ottawa County: **http://www.miottawa.org/Health/CMH/**
West Michigan CMH Provider Manual: **www.wmcmhs.org**
(o) Inpatient Affiliation Provider Manual: **http://www.lsre.org/provider-network**

4.05 Notice Provision.

(a) It is agreed that written communication and/or notification pursuant to this Agreement shall be deemed to have been duly given if delivered or mailed, postage prepaid, to the respective Party as follows:

Person/Title:	Click or tap here to enter text.	Person/Title:	Click or tap here to enter text.
CMHSP	Click or tap here to enter text.	Contractor:	Click or tap here to enter text.
Address:	Click or tap here to enter text.	Address:	Click or tap here to enter text.
City/State/Zip:	Click or tap here to enter text.	City/State/Zip:	Click or tap here to enter text.
Fax #:	Click or tap here to enter text.	Fax #:	Click or tap here to enter text.
E-mail:	Click or tap here to enter text.	E-mail:	Click or tap here to enter text.
CC:	Click or tap here to enter text.	CC:	Click or tap here to enter text.

(b) These are the contact people who will be notified of termination, breach, or any other significant issues. If one of these contact people changes, that Party must inform the other.

(c) Written communication is required for notice of termination, breach and/or other significant issues (e.g., investigations by Federal or State authorities, Michigan Protection and Advocacy Services, Inc., etc.).

4.06 Assignment. This Agreement shall be binding upon and inure to the benefit of the respective legal successors and assignees of the Parties. However, neither this Agreement, nor any rights or obligations hereunder may be assigned by operation of law or otherwise, delegated, transferred in whole or part, without the prior written consent of the other Party. The term "assign" shall include any assignment to any successor in interest from a merger, acquisition, reorganization, or sale of all or substantially all of a Party's assets. Any attempted assignment in violation of this paragraph shall be void.

4.07 Indemnification.

(a) All liability, loss or damage as a result of claims, demands, costs or judgment arising out of activities to be carried out pursuant to the obligations of Provider under this Agreement shall be the responsibility of Provider, and not the responsibility of CMHSP or LRE if the

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liability, loss or damages caused by, or arises out of, the actions or failure to act on the part of any Provider, its employee or agent, provided that nothing herein shall be construed as a waiver of any governmental immunity Provider or its employees have as provided by statute or modified by court decisions. Provider agrees to hold harmless and indemnify CMHSP and/or LRE as the case may be from and against all loss, liability, or expense that may be incurred including reasonable attorney fees and costs by reason of any claim arising out of or in connection with Provider's work.

(b) All liability, loss, or damage as a result of claims, demands, costs, or judgment arising out of activities to be carried out pursuant to the obligations of CMHSP or LRE as the case may be under this Agreement shall be the responsibility of CMHSP or LRE and not the responsibility of Provider, if the liability, loss or damages caused by, or arises out of, the actions or failure to act on the part of any CMHSP, LRE or its employee or agent, provided that nothing herein shall be construed as a waiver of any governmental immunity CMHSP, LRE or employees have as provided by statute or modified by Court decisions.

4.08 **Governing Law.** This Agreement shall be governed by and enforced in accordance with the laws of the State of Michigan. If any action is filed, it shall be in the Court for the county of the primary administrative location of CMHSP or if in Federal Court, it shall be in the Southern Division of the Western District.

4.09 **Dispute Resolution.** Issues between Provider and CMHSP involving contractual terms will be addressed by their respective designated representatives utilizing CMHSP dispute resolution process. All decisions to authorize, continue, or discontinue CMHSP payments for services to Covered Persons will be those of CMHSP's Executive Director or designee. If disputes as to essential terms of this Agreement are not resolved by the Executive Director or designee for CMHSP, these issues will be referred for dispute resolution to the Governing Board of CMHSP and Provider's Governing Body per CMHSP Dispute Resolution Policy(ies).

(a) Disputes that cannot be resolved between CMHSP and Provider shall be reviewed by LRE consistent with LRE Policy 4.7 Provider Grievance and Appeals.

(b) If the disputes cannot be resolved through the LRE Provider Grievance and Appeal Policy process, either Party may seek any available legal and/or exhaustion of remedies**.**

4.10 **Severability.** If any provision of this Agreement is deemed to be invalid or unenforceable by a Court, this Agreement shall be considered severable as to such provision and such provisions shall be inoperative. The remaining provisions of this Agreement, however, shall be valid and binding.

4.11 **Termination of Agreement, Service(s), or Program(s).**

(a) Provider acknowledges that CMHSP may terminate this Agreement immediately if the Office of Inspector General determines the Provider is an "excluded provider" from any Federally-funded or State health care program. Federal regulations and State law preclude reimbursement for any services ordered, prescribed, or rendered by a Provider who is currently suspended or terminated from direct or indirect participation in the Michigan Medicaid program or Federal Medicare program. Provider is also prohibited from having an employment, consulting, or any other agreement with a debarred or suspended person for the provision of items or services that are significant and material to Provider contractual obligation with CMHSP.

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(b) This Agreement is contingent upon the availability of sufficient funding. In the event circumstances occur which are not reasonably foreseeable, or are beyond the control of the Parties, reduces or otherwise interferes with the ability of CMHSP to provide or maintain services or operational procedures for its service area, CMHSP shall give immediate notice to Provider if it would result in any reduction of funding upon which this Agreement is contingent. In such an event, either Party may terminate this Agreement, service(s), or program(s) as provided in this section or as otherwise mutually agreed to by the Parties.

(c) This Agreement, service(s), or program(s) may be terminated or not renewed by either Party without cause and without remedy within sixty (60) calendar days written notification to the other Party unless another date is mutually agreed to, in writing, by both Parties.

(d) This Agreement shall terminate effective immediately upon the revocation, restriction, suspension, discontinuation or loss of any certification, accreditation, authorization, or license required by Federal, State and local laws, ordinances, rules and regulations for Provider to provide Covered Services within the State of Michigan with said termination to be effective as of the date of delivery of written notice to Provider.

(e) This Agreement shall terminate effective immediately upon receipt of notice and/or discovery by CMHSP that Provider is: 1) listed by a Federal agency or the State of Michigan as being suspended from participation in the Medicare or the Michigan Medicaid Programs (including but not listed to the Michigan Sanctioned Provider List, the OIG Exclusion Databases (LEIE and GSA), and the System for Award Management (SAM)); and/or 2) listed by a MDHHS or agency of the State of Michigan in its registry for Unfair Labor Practices pursuant to 1980 P.A. 2789, as amended, MCL 423.321 et. Seq.; and/or 3) Provider is listed by the U.S. Office of Inspector General in its "Excluded Provider List" as to payment made by any Federal health care program.

(f) This Agreement may be terminated effective immediately upon receipt or notice to and/or discovery by CMHSP of any failure of the Provider to meet the requirements hereunder of solvency and of continuing as a going business concern or if the Provider generally fails to pay its debts as they become due.

(g) Any material breach of this Agreement which has not been cured within fifteen (15) days of receipt of notice of the breach, may result in the non-breaching party's immediate termination of this Agreement, with said termination effective as of the date of delivery of written notification from the non-breaching party to the breaching party. Material breach is defined as the substantial failure of a party to fulfill its obligations under this Agreement, including without limitation, the Provider's failure to comply with the CMHSP's Compliance Plan. The termination of this Agreement shall not be deemed to be a waiver by the non-breaching party of any other remedies it may have in law or in equity.

(h) This Agreement, service(s), or program(s) may be terminated at the sole discretion of CMHSP with written notification to Provider for any of the following reasons:

(1) Reduction in funding.

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(2) The CMHSP determines or has reason to believe that the health, safety, or welfare of a Covered Person is jeopardized by continuation of this Agreement. (The Covered Person will be immediately transferred to a new provider by CMHSP.)

(3) Commits any fraud or misrepresentation relating to the services performed under this Agreement.

(i) Should this entire Agreement, service(s), or a program(s) covered by it, be terminated or not renewed by either Party, CMHSP and Provider agree to participate in the development of a written transition plan within ten (10) days of notice of termination or non-renewal of Agreement.

(1) The transition plan shall specify all financial obligations known to both Parties at the time of termination.

(2) The transition plan shall specify each Party's responsibilities with dates of completion. In the event a date of completion cannot be met by either Party, notification shall be provided in writing to the designee identified in the plan prior to the identified due date.

(3) The transition plan shall specify responsibility and dates of completion to transfer possession of relevant clinical documents, billing information for each Covered Person and all medications, personal funds, and personal property of the Covered Person.

(4) Provider shall provide written termination notice within fifteen (15) business days of terminating to each Covered Person who is an open case receiving service from Provider.

(5) Provider shall discuss with the Covered Person and provide written notice of transfer of services to another provider if it is determined the Covered Person has not met all the goals for discharge and still medically needs continued treatment.

(6) Provider shall ensure written notice of termination is documented in the case record.

(7) Provider shall provide proof of the written notices given to Covered Persons as a result of Agreement termination to the CMHSP contract manager.

(j) During the transition period, Provider shall not be released from any obligation to continue to provide Medically Necessary Covered Services to a Covered Person until the responsibility for the Covered Person's services can be transferred to another Provider. CMHSP shall make payments to Provider for such covered services in accordance with the terms of the Agreement. Provider's responsibility shall continue for a period of up to sixty (60) days or a date agreed upon in writing by the Parties. In emergent situations potentially impacting placement, Provider shall notify and coordinate care with the CMHSP.

(k) Any termination of this Agreement, service(s), or program(s) shall not relieve either Party of the obligations incurred prior to the effective date of such termination.

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4.12 Waivers.

(a) No failure or delay on the part of either of the Parties to this Agreement in exercising any right, power or privilege hereunder shall operate as a waiver, thereof, nor shall a single or partial exercise of any right, power or privilege preclude any other further exercise of any other right, power or privilege.

(b) In no event shall the making by CMHSP of any payment to Provider constitute or be construed as a waiver by CMHSP of any breach of this Agreement, or any default which may then exist, on the part of Provider, and the making of any such payment by CMHSP while any such breach or default shall exist, shall in no way impair or prejudice any right or remedy available to CMHSP in respect to such breach or default.

4.13 Binding Effect. This Agreement shall be binding upon CMHSP and Provider and their respective successors and permitted assigns.

4.14 Provider Subcontracts.

(a) If Provider, with CMHSP's prior written consent, subcontracts any supports/services required of Provider under this Agreement, any such subcontract shall:

(1) Be in writing and include a full specification of the subcontracted supports/services;

(2) Contain a provision stating that this Agreement is incorporated by reference into the subcontract and made a part thereof; and

(3) Contain a provision stating that the subcontract is subject to the terms and conditions of this Agreement. Any such subcontract shall not terminate the legal responsibility of Provider to ensure that supports/services required of Provider hereunder are fulfilled.

(b) Prior to the execution of any such subcontract, Provider shall use commercially reasonable efforts to furnish CMHSP with notice verifying that:

(1) The subcontractor and its professional staff, if any, maintain all approvals, licenses, certifications, registrations, accreditations, and authorizations required by Federal, State and local laws, ordinances, rules and regulations to perform the subcontracted supports/services for Covered Persons.

(2) The subcontractor is not listed by a MDHHS or agency of the Federal government or the State of Michigan as being suspended from participation in Medicaid or Medicare Programs;

(3) The subcontractor is not listed by a MDHHS or agency of the State of Michigan in its registry for unfair labor practices;

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(4) The subcontractor is not listed by the U.S. General Services Administration in its "Excluded Parties List" as to Federal funding;

(5) The subcontractor maintains workers' compensation and unemployment insurance coverage for its employees; and

(6) The subcontractor maintains liability insurance coverages required by CMHSP and/or LRE for all contracted services. Provider shall immediately notify CMHSP in writing if, subsequent to execution of any such subcontract, Provider discovers that any of the above cited verifications are no longer true.

(c) Any subcontractor shall ensure, as applicable, that its professional staff, if any, meet CMHSP's and/or LRE's as the case may be, credentialing and privileging requirements, including privileging and competency standards and/or that its nonprofessional staff meets the CMHSP's or LRE's, as the case may be, requirements for qualifications and competency standards, necessary to perform the subcontracted Supports/Services.

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

4.16 **Completeness of the Agreement.** This Agreement, Attachments, and additional and supplementary documents incorporated herein by specific reference contain all terms and conditions agreed upon by CMHSP and Provider and no other agreements, oral or written, regarding the subject matter of this Agreement or any part thereof shall have any validity to bind either CMHSP or Provider unless this Agreement is amended as referenced in Section 4.02.

4.17 **Certification of Authority to Sign the Agreement.** The persons signing this Agreement on behalf of the Parties hereto certify by said signatures that they are duly authorized to sign this Agreement on behalf of said Parties and that this Agreement has been authorized by said Parties. This Agreement shall be deemed executed, valid, enforceable and binding upon the Parties once signed in handwriting or by any electronic means and may be delivered by facsimile or electronic transmission.

*********SIGNATURE PAGE FOLLOWS**********

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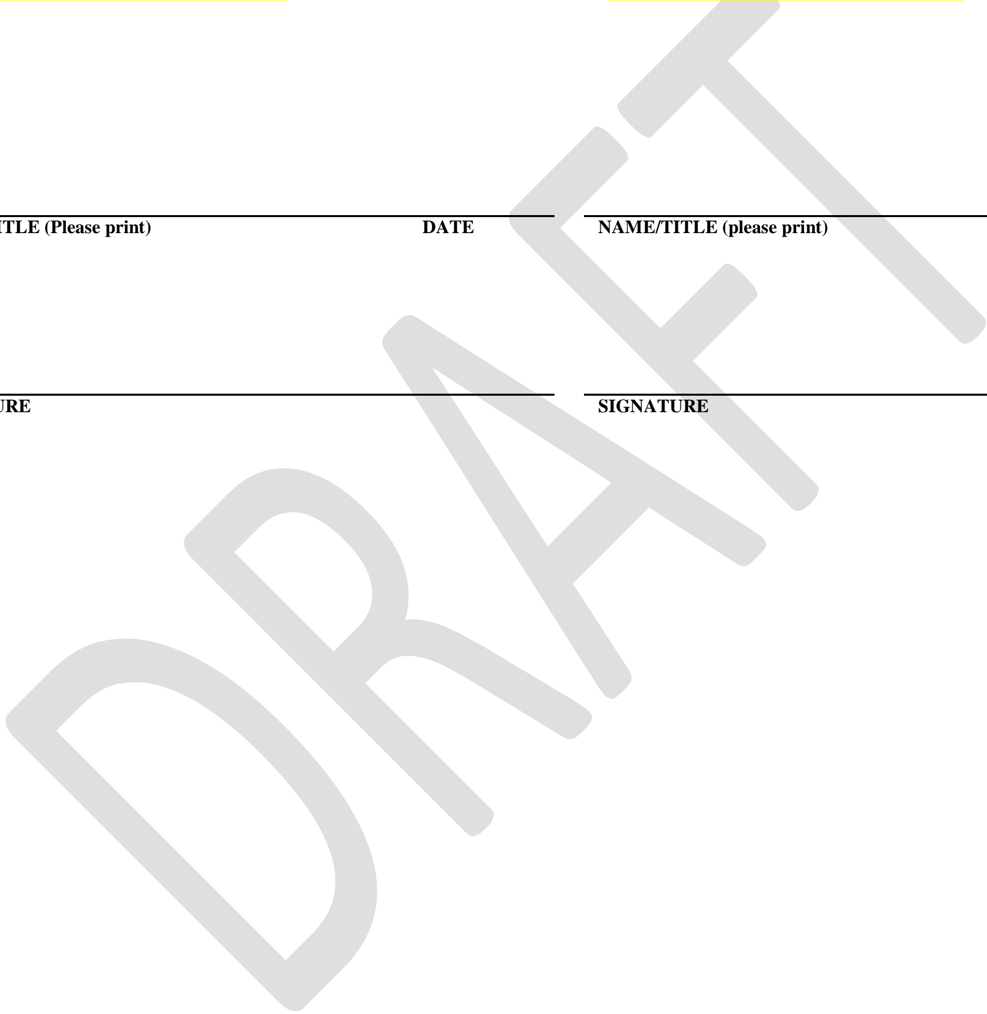
IN WITNESS WHEREOF, the authorized representatives of the Parties hereto have fully executed this Agreement on the day and the year written in Section 2.07.



FOR THE PROVIDER:	**FOR THE CMHSP:**
[Provider Name]	[CMHSP Name]
[Provider Address]	[CMHSP Address]
[Provider City, State, Zip Code]	[CMHSP City, State, Zip Code]
NAME/TITLE (Please print) **DATE**	**NAME/TITLE (please print)** **DATE**
SIGNATURE	**SIGNATURE**