Macomb County Community Mental Health Services
2020 - 2021 Specialty Service Contract
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Contract Index

Incorporated Attachments:

I. PARTIES

This contract (the "Contract") is entered into by and between the Macomb County Community Mental Health Service Board (the "BOARD"), an agency of the County of Macomb, (the "COUNTY"), and _____ (the "AGENCY"), and supersedes all previous contract(s) between these parties. The term "MCCMH" shall mean and refer to Macomb County Community Mental Health.

The AGENCY acknowledges and agrees that the Michigan Department of Health and Human Services (MDHHS) is not a party to this Contract or to any agreement with the BOARD's subcontractors, and that neither the BOARD nor MDHHS are parties to any employer/employee relationship with the AGENCY or its subcontractors.

II. PURPOSE, AUTHORITY AND SCOPE

A. Purpose: The purpose of this contract is to establish the terms and conditions pursuant to which the BOARD will engage AGENCY to provide authorized mental health specialty services, as described in Attachment "B" (the "Contracted Services"), for persons referred to the AGENCY by the BOARD.

B. Authority:

1. This Contract is entered into under the authority granted by Act 258 of the Public Acts of 1974 (the "Mental Health Code"), as amended, and in accordance with the rules and regulations adopted by the Michigan Department of Health and Human Services (MDHHS) under Act 258, and in accordance with the MDHHS/CMHSP Managed Mental Health Supports and Services contract for General Funds (the "CMHSP General Fund Contract") and the MDHHS/PIHP Master Contract for Medicaid Funds (the "PIHP Contract") entered into by MDHHS and MCCMH.

2. Macomb County Community Mental Health Services Board ~ Managed Care Organization policies and policies established in accordance with MCL 330.1204(2) shall govern in any area not specified otherwise in the contract.

C. Scope:

1. The following Attachments are attached hereto and incorporated by reference as material terms of this Contract:

Attachment "A" Provider Profile Application (signatures required);
Attachment "B" Specialty Services Requirements/Documentation Grid;
Attachment "C" Recipient Rights Protection Requirements;
Attachment "D" Reimbursement and Claims Processing;
Attachment "E" Privileging Clinical Staff by License and Payer Coverage;

Attachment "F" Delegated Functions (signatures required);
Attachment "G" Business Associate Agreement (signatures required);
Attachment "H" Qualified Service Organization Agreement; and
Appendix "X" Incorporated BOARD Contracts

2. All of the BOARD's contracts listed on Appendix X to this Contract are incorporated by this reference as material terms of this Contract insofar as they pertain to AGENCY's qualifications, obligations, personnel and reimbursement/payment.

3. Appendix "X" shall be deemed automatically amended whenever BOARD either executes a new contract or amends an existing contract with a governmental or private entity for the provision or management of authorized mental health and substance use disorder specialty services and supports. Promptly upon such execution, Board will cause to be added to the Appendix X posted on the BOARD's or MCCMH's website a copy of the new BOARD contract or excerpts thereof or a summary of the provider requirements under the contract including, but not limited to, all requirements for downstream providers or downstream contracts or contractors, regardless of whether such terms are or are not capitalized in such contracts. Each such summary is referred to as a "Contract Requirements Summary" and collectively, the "Contract Requirements Summaries".

4. Anything in this Contract to the contrary notwithstanding, the terms of the BOARD's CMHSP General Fund Contract shall apply to AGENCY only if AGENCY provides services paid for through general fund allocation.

5. **THIS CONTRACT AND BOARD'S OBLIGATIONS UNDER IT ARE CONDITIONED UPON THE BOARD'S RECEIPT OF FUNDS SUFFICIENT TO DISCHARGE THOSE OBLIGATIONS AND THE ABSENCE OF A MATERIAL CHANGE IN THE BOARD'S FUNDING OR IN THE FUNDING METHODOLOGY FOR ANY CONTRACT OR PROGRAM.**

III. PRINCIPLES OF RECOVERY

A. The BOARD expects all of its providers to follow the principles of Recovery. Staff and providers have the potential to greatly impact how an individual served feels about their own Recovery, their individual ability to recover and the confidence to make it happen; as such, the BOARD supports and encourages the concept of Recovery as a means of enabling the population it serves to reach their full potential.

B. Recovery Defined:

1. Recovery: The BOARD has adopted the following (MDHHS developed) definition of "Recovery": Recovery is "a journey of healing and change allowing a person to live a meaningful life in a community of their choice, while working toward their full potential." Recovery is an individual journey that follows different paths and leads to different locations. Recovery is a process that we enter into and is a lifelong attitude. Recovery is unique to each individual and can truly only be defined by the individual themselves. What might be recovery for one person may be only part of the process for another. Recovery may also be defined as wellness. In recovery there may be relapses. A relapse is not a failure, rather a challenge. If a relapse is prepared for, and the tools and skills that have been learned throughout the recovery journey are used, a person can overcome and come out a stronger individual. It takes time, and that is why Recovery is a process that will lead to a future that holds days of pleasure and the energy to persevere through the trials of life.

2. There is no set time requirement for Recovery, as it is recognized that this is an individualized process whereby each person's journey of Recovery is unique and whereby each person in Recovery chooses supports, ranging from clinical treatment to peer services that facilitate recovery.

3. Through the Recovery Support Strategic Initiative, Substance Abuse and Mental Health Services Administration (SAMHSA) has also delineated four major dimensions that support a life in Recovery:

   i. Health – overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being;
   ii. Home – having a stable and safe place to live;
   iii. Purpose – conducting meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and having the independence, income and resources to participate in society; and
   iv. Community – having relationships and social networks that provide support, friendship, love and hope.

C. Behavioral health supports and services help people with a mental illness/substance use disorder in their Recovery journeys. The person-centered planning process is used to identify the supports needed for individual Recovery.

D. Specialty services provided under this Contract shall encourage individuals served to be (i) empowered to exercise choice, control and self-determination over all aspects of their lives, (ii) involved in meaningful relationships with family and friends, (iii) supported to live with family while children, and independently as adults, (iv) engaged in activities that are meaningful, such as school, work, social recreation and volunteering, fully in community life and activities. Individuals will be offered services, programs, and activities that will be provided in the most integrated setting appropriate to the needs of the individual. They will be offered housing and employment opportunities that meet their needs at any given time in their lives. The concept of Recovery will be utilized and supported for all individuals.

IV. ETHICS AND EQUAL OPPORTUNITY

A. Ethics. No principal, representative, or agent of the AGENCY is currently an employee of the COUNTY. Nor shall any such person use insider information which secures or gives the appearance of an unfair advantage to the AGENCY in bid processes, contract procurement or related monetary gain. A breach of this condition may be regarded by the BOARD as a material breach of the contract and shall subject this contract to termination. The Macomb County Ethics Ordinance, No. 2011-10, is incorporated by reference into this Contract.

B. Equal Opportunity / Non-Discrimination.

1. The AGENCY shall not discriminate against any employee or applicant for employment with respect to hiring, tenure, terms, conditions, or privileges of employment, or with respect to a matter directly or indirectly related to employment on the basis of race, color, religion, national origin, gender, sex, sexual orientation, height, weight, marital status, physical or mental disability unrelated to the individual's ability to perform the duties of the particular job or position, ancestry, age, political affiliation, known association or relationship with an individual with a disability, or other legally protected status

2. The AGENCY shall not discriminate against the BOARD's recipients or members of the public on the basis of race, color, religion, national origin, age, gender, ancestry, political affiliation, sex, sexual orientation, height, weight, marital status, arrest record, ability to pay, commitment status, disability, or known association or relationship with an individual with a disability, or other legally protected status.

3. Any breach of these Equal Opportunity / Non-Discrimination provisions may be regarded by the BOARD as a material breach of the Contract and shall subject this Contract to termination.

V. FEE FOR SERVICE ARRANGEMENT AND CLAIMS PROCESSING

A. The BOARD agrees, subject to the continued availability and receipt of sufficient federal, State and local government funding, and subject to terms of this Contract, to reimburse the AGENCY according to the Fee for Service Rate(s) listed on Attachment "D".

B. The approved Fee for Service Rate for each service provided by AGENCY under terms of this Contract is listed on the Attachment "D", with the exception of the rates for Fiscal Intermediaries. Fee for Service Rates will be updated as required and at the sole and absolute discretion of the BOARD. To the extent reasonably practicable, the BOARD will provide the AGENCY with thirty (30) days' advance written notice of any such Fee for Service Rate update. In the event that the BOARD fails to provide such thirty (30) days' advanced written notice, however, the Fee for Service Rate change/update will not be ineffective and the AGENCY will not be relieved of its binding effect.

C. Service authorization does NOT guarantee payment. Services must be provided in accordance with primary payer rules and eligibility of the individual served must be maintained for all programs which he/she qualifies in order for the authorized service to be payable (e.g., Medicare, Medicaid, Healthy Michigan Plan, MI Health Link, private third-party coverage, etc.).

D. Claims Processing:

1. The AGENCY will timely submit all claims to the BOARD's Department of Finance & Budget, consistent with BOARD policy (See MCO Policy No. 7-010, "Claims Process"), utilizing the FOCUS system through Direct Data Entry or the equivalent HIPAA compliant electronic format which has been previously approved by the BOARD. Batches must be separated by Fiscal Years.

2. The BOARD will reimburse the AGENCY for each approved clean claim within thirty (30) days of receipt.

E. The AGENCY will assure that all requests for payment of mental health and medical services submitted to the BOARD are submitted as requests for payer of last resort. The BOARD will not supplement the cost of care for individuals who have third-party traditional or commercial HMO coverage. In all cases where the third party coverage had been exhausted, the AGENCY must contact the BOARD's Access Center for prospective service authorization.

F. The AGENCY will be responsible for collecting fees from individuals served that are assessed in accordance with BOARD policy. A current ability to pay must be completed and input into the FOCUS system. The assessed fee will show as a deduction from the amount billed. Any under-recoveries of otherwise available fees resulting from failure to bill or collect for eligible services will be excluded from reimbursable expenditures.

G. The AGENCY agrees to assist in the initiation, submission and follow-up of a Medicaid application for payment assistance for all individuals served pursuant to this Contract who do not have Medicaid coverage. (See Section VI.D.7. of this Contract for additional information). Failure to ensure Medicaid eligibility may result in denial of payment for services rendered. The AGENCY must contact their contract manager in the event that the case management/supports coordination agency is not fulfilling their responsibilities of assisting individuals served with entitlement issues. These denials of payment cannot be appealed.

H. The AGENCY is required to adjudicate all claims and resolve all issues/problems identified through that process prior to submission to the BOARD. The AGENCY has the responsibility of resolving all claims that are problematic by the end of the following month of when the service was provided. The AGENCY should contact the BOARD's claims department for assistance.

I. All claims for the BOARD's Fiscal Year (October 1 through September 30) must be submitted by the 10th business day after the close of the BOARD's Fiscal Year. September denials must be submitted no later than October 31st.

J. The AGENCY shall not incur any indebtedness or make commitments for which repayment with BOARD funds extends beyond the close of the fiscal year without express written permission of the BOARD.

K. The AGENCY may, at any time during the Term of this Contract, submit a written request for the BOARD to adjust any of the Fee for Service Rate(s) on Attachment D. In order to be considered, any such request must include a detailed financial justification in support of the rate adjustment. Within forty-five (45) days after receipt of any such request, the BOARD will review the request and inform the AGENCY whether it has been approved or denied, and the Contract shall be amended, as applicable.

L. The AGENCY must direct all if its questions regarding claims status to the BOARD claims processing department.

M. The AGENCY acting as Fiscal Intermediary under contract with the BOARD shall adhere to the terms and conditions as outlined in the individual budgets for each individual served.

N. Contracted Hospitals:

1. Contracted hospitals will be expected to utilize the FOCUS system to submit their claims. Where the BOARD is the sole responsible payer, the claim must be submitted within 60 days of discharge. For claims which are billable to other third-party payers, claims are to be submitted within 60 calendar days of the final disposition of payment by the third-party(ies) involved, and otherwise consistent with BOARD policy, in order to be considered for payment.

2. In the case of Medicare, the EOB from both the Part A (hospital) and Part B (physician) must be submitted with the batch. The Part B requirement only applies to those agencies that bill Medicare and receive reimbursement for the services provided by their own house physicians or any other appropriately credentialed clinicians who is able to bill according to the Medicare guidelines.

O. Residential Providers:

1. If the BOARD is the lessee for the residential facility, the AGENCY will be responsible for the lease cost, taxes, and insurance, as these are deemed to be routine

room and board costs.

2. The AGENCY understands that the cost of room and board is the responsibility of the individual served, and the AGENCY is responsible for collecting all Supplemental Security Income (SSI) or Social Security (SS) payments directly from the individual served or their representative. The AGENCY is responsible for collecting all Medicaid Spend-Down and Ability to Pay amounts as determined by MDHHS or the BOARD.

VI. AGENCY RESPONSIBILITIES

A. Provider Panel Requirements – General

The AGENCY shall:

1. Accept referrals and provide treatment in accordance with the requirements set forth in Attachment "B".

2. Be responsible for the delivery of the Contracted Services and for the establishment of sufficient administrative capabilities to carry out the requirements and obligations of this Contract. The AGENCY shall report applicable administrative changes (including but not limited to changes in name and address etc.) within five (5) business days to the BOARD. The relocation of panel provider service site requires a 30 day prior notification. However, if there is an emergency situation related to any individual served (including but not limited to relocation of any individual(s) served due to licensing issues, home closure due to fire, etc.), the AGENCY will notify the BOARD within twenty-four (24) hours.

3. Provide the Contracted Services in the most integrated setting appropriate in light of the needs of the individual served, assuring the application of the Person Centered Planning process to treatment and as authorized by the BOARD's Access Center.

4. Employ a sufficient workforce to serve accepted referrals, with such workforce consisting of persons with lived experiences across all levels, and who are paid fair and competitive wages commensurate with their position and with other employees of the same pay grade, and who strive to provide multiple opportunities for full and/or part-time positions and a viable career ladder.

5. Make affirmative efforts to employ individuals with disabilities - recruit, place, with competitive pay scales, fringe benefits, and training included.

6. As applicable based on the contracted service line(s), implement MCCMH medical necessity criteria in determining specific services for individuals served. Medical necessity is commonly defined as a determination that a specific service is medically (clinically) appropriate, necessary to meet the individual's behavioral health needs, consistent with the individual's diagnosis, symptomatology and functional impairments, is the most cost effective option in the least restrictive environment, is

consistent with clinical standards of care, and not primarily for the convenience of the individual served, the individual's family, or AGENCY. In addition, the AGENCY shall also consider social services, community, and natural supports that are crucial for full participation in community life, must apply person-centered planning for individuals with behavioral health, intellectual and developmental disabilities, and substance use disorder needs and must consider physical conditions, environmental factors and other available resources that might address the treatment needs of the individual served. The criteria are intended to ensure appropriate access to care, protect the rights of the individual served and facilitate an appropriate matching of supports and services to individual needs.

7. Support individuals with disabilities to explore opportunities to have person-centered, integrated, and competitive employment opportunities commensurate with their abilities, aptitude, and desires.

8. Protect persons served and, as applicable based on the contracted service line(s), offer opportunities for them to live successfully in the community, work in jobs/ways meaningful to them, and develop and maintain personal, stable, rewarding relationships.

9. As applicable based on the contracted service line(s), and consistent with the Individual Plan of Service, link individuals served to accurate and timely information for continuation of federal/state benefits while preparing for and becoming competitively employed.

10. Where responsible for the development or implementation of the Individual Plan of Service, employ a holistic approach with an aim to address current physical health conditions, health care practitioners available to address physical health conditions, and other assistance needed (referral, coordination, transportation, etc.) to access health practitioners.

11. Provide Contracted Services in a manner which complies with: (i) all policies and procedures determined by the Office of the County Executive; (ii) the BOARD's Managed Care Organization Policies and Procedures Manual (available for review at mcccmh.net); (iii) applicable MCCMH Executive Directives and Compliance Alerts; (iv) the requirements and service descriptions contained in the most current version of the MDHHS Michigan Medicaid Provider Manual; and (v) applicable federal, State and local laws, rules, administrative procedures and regulations that are in effect during the term of this Contract. Federal regulations governing the BOARD with risk-based managed care plans are specified, inter alia, in Section 1903(m) of the Social Security Act, 42 CFR Part 434, and applicable provisions of the Balanced Budget Act of 1997, and will govern the Medicaid portions of this Contract. Subject to the preceding sentence, pertinent state statutes will govern this Contract. The State and BOARD are obligated to require implementation of any changes in federal statutes and regulations and state statutes, rules, and administrative procedures effective during the term of the Contract and applicable to any BOARD contracts.

12. Cooperate with the BOARD and its Behavioral Health - Managed Care Organization responsibilities to include service authorization functions, provider network management functions, financial management functions, utilization management functions, credentialing functions, coordination of care, critical risk auditing, quality improvement process, consumer relations office, corporate compliance plan and discussion of any issues relevant to the provision of services.

13. As applicable based on the contracted services line(s), assure that services to each individual served by the BOARD are coordinated with primary health care providers, including Medicaid Health Plans, and other service agencies in the community that are serving the individual. The AGENCY will implement practices and agreements according to federal and state laws, guidelines and regulations in the implementation of this function.

14. Allow individual(s) served and appropriate stakeholder(s) (e.g., MDHHS, auditors, etc.) access to clinical and financial records that are relevant to the delivery of Contracted Services, to the extent consistent with the Freedom of Information Act, HIPAA, Michigan Mental Health Code, and the BOARD's Managed Care Organization (MCO) policies and procedures.

15. Give the BOARD, as holder of the record (1974 PA 258, Sec. 748(1): OAG 1980, No. 5709), unimpeded access to records of individual(s) served in any form or medium, i.e., paper or electronic, at the discretion of the BOARD.

16. Utilize the Provider Appeals Process, as provided in the BOARD's MCO Policy Manual to resolve disputes related to the service (level of care) determinations. (See, MCO Policy No. 2-006, "Service Provider Appeals").

17. Indemnify, defend and hold harmless the BOARD and Macomb County, and their respective elected and appointed officials, successors, assigns, agents, representatives, directors, officers, employees, attorneys and affiliated, entities, and all persons acting by, through, under, or in concert with any of them (collectively "BOARD Indemnified Parties" or "BOARD Indemnified Party" individually) from and against any and all demands, claims, actions, causes of action, assessments, losses, diminution in value, damages (including but not limited to special, punitive, consequential, and/or exemplary damages), liabilities, statutory or other penalties, costs and expenses, actual costs and expenses incurred in the defense of any litigation, including but not limited to actual attorneys' fees and any liability (collectively, "Losses"), suffered or incurred by any BOARD Indemnified Party by reason of, or arising out of, any of the following by way of illustration and not limitation: (a) AGENCY's provision of or failure to provide Contracted Services; (b) AGENCY's breach of any term of this Contract; (b) AGENCY's breach of any representation or warranty to the BOARD Indemnified Parties; (c) AGENCY's fraud, negligence, gross negligence or intentional wrongdoing; and/or (d) AGENCY's violation of any federal statue or regulation or any state statue, rule, or administrative procedure effective during the term of this Contract and applicable to the Board's subcontracts.

18. Pro-actively seek to identify and encourage the participation of minority-owned, women-owned, and handicapper-owned businesses in contract solicitations. AGENCY is prohibited from discriminating against minority-owned, women-owned, and handicapper-owned businesses. Discrimination by AGENCY is a material breach of this contract.

19. Return to the BOARD three (3) executed signature pages, after the AGENCY reviews the materials on the Provider Portal within 60 days of issuance. The AGENCY shall upload required information to the Provider Portal at the time of execution and re-contracting. Such information shall include by way of illustration and not limitation:

    i. Complete and updated Provider Profile Application (Attachment "A");
    ii. Supporting documentation to Attachment "A" (copies of accreditation/reports, licensures, certifications, professional/corporate liability insurance, Credential Verification Form, Quality Improvement Plan, Staff Training, Criminal Background Checks, Staff NPI numbers, Corporate Compliance Plan, W-9 Form, Provider Disclosure Information Request) for both the AGENCY and any subcontractors;
    iii. Direct and subcontracted workforce training and FTE information spreadsheet in the prescribed format;
    iv. Direct and subcontracted workforce cost information; and
    v. Copies of each subcontract and/or delegation agreement for any subcontracted or delegated services.

    AGENCY shall be required to submit an updated Provider Profile Application annually, and any other updated or additional information as requested by the BOARD.

20. Maintain quarterly business contact with the BOARD's assigned contract manager, which shall require, minimally, attendance at the Quarterly Provider Meetings coordinated by the BOARD's Network Operations Division.

21. Retain full responsibility for ensuring that direct and subcontracted workforce meet the training standards required by the contracts specified on Appendix X, as amended from time to time, the BOARD's MCO Policy Manual (see MCCMH MCO Policy No. 3-015, "Contract Network Provider Mandatory Training and Network Development"), relevant accrediting bodies, and all federal, state, and local laws, guidelines, rules, and regulations, and provide the BOARD with documentation demonstrating that such training requirements have been satisfied. The cost of training shall not be directly billed to the BOARD.

22. For BOARD-contracted provision of services to children and adolescents, comply with all provisions of Administrative Rules 330, Subpart 6, "Children's Diagnostic and Treatment Services," including the mandatory twenty-four (24) hours of training specific to the treatment and diagnosis of children/adolescents and comply with

application of CAFAS for minors 7 to 17 years of age. The cost of related training shall not be billed to the BOARD, nor shall it be paid by the BOARD.

23. Be financially solvent prior to commencing performance of the Contracted Services, and give the BOARD immediate written notice of any change, at any time during the term of this Contract, in AGENCY's financial position material to such solvency and to continuing in operation as a going concern.

24. Give the BOARD immediate written notice, to the attention of AGENCY's contract manager at BOARD, of any changes in third party payers that AGENCY is able to bill.

25. Participate in all contracts specified on Appendix X to this Contract, as amended by BOARD from time to time, and comply with all provider and subcontractor requirements under those contracts including, but not limited to, all requirements for downstream providers or downstream contracts or contractors, regardless of whether such terms are or are not capitalized in such contracts, and the requirements specified in the contracts and the Contract Requirements Summaries incorporated into Appendix X to this Contract. AGENCY's participation in each such contract is expressly conditioned upon AGENCY's satisfaction of all criteria for participating provider status under that contract and satisfactory performance of all of its obligations thereunder.

    In the event and to the extent of any conflict between the terms of this Contract regarding AGENCY's requirements or obligations and the terms of any BOARD contract included on Appendix X, the terms of the BOARD contract included on Appendix X shall supersede and govern. A conflict between this Contract and the Appendix X contract(s), however, shall not be deemed to exist where this Contract: (1) contains additional non-conflicting provisions not set forth in the Appendix X contract(s); (2) restates provisions of the Appendix X contract(s) to afford the BOARD the same or substantially the same rights and privileges as the Appendix X contract(s); (3) requires the AGENCY to perform duties and/or services in less time than that afforded the BOARD in the Appendix X contract(s).

26. Provide all BOARD mandated reports within the timeframes and in the manner specified by the BOARD.

27. Maintain positive working relationships with other contracting providers within the BOARD's provider network in order to best meet the needs of the individuals served by the BOARD.

B. **Provider Panel Requirements - Access to Care**

The AGENCY shall:

1. Ensure that access to care and service delivery is timely, as defined by applicable law

and as required by this contract, including but not limited to the standards delineated in Section VI.F and/or the various Attachments and Appendix X contracts.

2. Assist the BOARD in the data collection and completion of Board and state-required data, outcome, and performance indicator measures at the specified points in time. At its sole cost and expense, the AGENCY shall collect and report, in the format specified by the BOARD, performance and outcome measures as required by the BOARD.

3. Assure equal access for people with diverse cultural backgrounds and/or limited English proficiency, as outlined by the Office of Civil Rights Policy Guidance on Title VI "Language Assistance to Persons with Limited English Proficiency" and the Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency, and in compliance with applicable state and federal laws, rules and regulations, including but not limited to Title VI of the Civil Rights Act, the Americans with Disabilities Act, Section 1557 of the Patient Protection and Affordable Care Act, Executive Order 13166 (August 11, 2000), applicable Medicaid regulations (42 CFR 438.10; 438.206(c)(2)), and the BOARD's MCO Policy Manual.

4. For the supports and services provided by the AGENCY, demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all individuals served by the BOARD. Such commitment includes acceptance and respect for the cultural and religious values, beliefs and practices of the community, as well as the ability to apply an understanding of each individual and the relationships of language and culture to the delivery of supports and services.

5. As applicable based on the contracted service line(s), be capable of providing the Early Periodic Screening, Diagnostic and Treatment (EPSDT) corrective or ameliorative services that are required by the MDHHS/PIHP specialty services and supports contract, and assist the BOARD in helping those identified individuals in obtaining necessary transportation to EPSDT services through either the Michigan Department of Health and Human Services or the individual's Medicaid Health Plan.

6. Follow, abide by and comply with the BOARD's MCO Policy Manual, Michigan Medicaid Provider Manual, Level of Care Criteria guidelines, and applicable Local and National Coverage Determinations, as well as all applicable federal, state and local statutes, regulations, and guidelines in the request for authorization of services on behalf of the individuals served by the BOARD. Failure by the AGENCY to request PRIOR authorization of services may result in denial of payment.

C. **Provider Panel Requirements - Documentation Standards**

The AGENCY shall:

1. Maintain clinical documentation that demonstrates that billed Contracted Services

were, in fact, delivered by the AGENCY and were provided in accordance with each individual's person-centered plan as authorized by the BOARD. The AGENCY is required to provide timely encounter data to the BOARD on all services provided by the AGENCY at intervals required by the BOARD.

2. Utilize FOCUS as AGENCY's Electronic Medical Records (EMR) Package, subject only to any variation approved in writing by the BOARD (Outpatient, Case Management, and Supports Coordination AGENCIES).

3. Where granted approval by the BOARD to use an EMR other than FOCUS:

   i. Remain solely responsible for all costs incurred by BOARD as a result of AGENCY's failure to use FOCUS including, but not limited to, all costs of accessing, obtaining, converting and translating AGENCY's data and reports to permit their use with FOCUS. BOARD may offset such costs against any sum otherwise payable to AGENCY under this Contract; and

   ii. Comply with all BOARD directives requiring the AGENCY to enter data or upload information directly into FOCUS;

4. Document appropriately when an individual is discharged from all services or is deceased. In all cases, this will require manual entry in FOCUS in order to, among other things, close the administrative layer and complete all discharge documentation.

5. Maintain and timely update documentation of insurance or payer information for all types of coverage. In all cases, this will require manual entry in the FOCUS Insurance Policies section.

D. **Provider Panel Requirements- Financial**

The AGENCY shall:

1. Submit timely Clean Claims to the BOARD for only those services authorized by the BOARD and described in Attachment "D" of this contract. A Clean Claim is one completed in the correct format as specified by the BOARD and that can be processed without obtaining additional information from the provider of service or a third party. For example, Minimum Data Set Requirements must be completed before submission of a claim in order for it to be deemed a Clean Claim.

2. Comply with BOARD policy regarding fee determinations as specified in the BOARD's MCO Policy Manual. The AGENCY shall collect fees that are assessed, in accordance with BOARD policy, from the individual served. The AGENCY shall not require any co-payments, additional payments from the individual served or other cost sharing arrangements for services authorized by the BOARD unless specifically authorized by state or federal regulations and consistent with BOARD policy. The AGENCY shall not bill the individual served for the difference between

the AGENCY's charge and the BOARD's payment for covered services. The AGENCY shall not seek nor accept additional supplemental payment from the individual served, his/her family, or representative, in addition to the amount paid by the BOARD for services authorized by the BOARD, even when the recipient has signed an agreement to do so.

3. The AGENCY shall not seek nor accept any additional payment for Medicaid covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the individual served would owe if the BOARD provided the services directly.

4. The AGENCY shall not seek payment from a Medicaid enrollee individual served or otherwise hold the Medicaid enrollee individual served liable under any of the following circumstances:

   i. For the BOARD's debts, in the event of the BOARD's insolvency;
   ii. For covered services provided to the Medicaid enrollee for which the State does not pay the BOARD; or
   iii. For covered services provided to the Medicaid enrollee for which the BOARD does not pay the AGENCY.

5. Ensure that the BOARD is the payer of last resort. The AGENCY shall be required to: (i) ensure that all individuals served apply for all entitlements (i.e. Medicaid, Medicare, Social Security, Unemployment) for which they may be eligible and complete the Ability To Pay documenting entitlements received or reasons for denial in the notes section of the Self-Pay Insurance Policy layer in Focus; and (ii) identify and seek recovery from all other liable third parties. Third Party Liability (TPL) refers to any other health insurance plan or carrier, (e.g., individual group, employer-related, self-insured, or self-funded plan or commercial carrier, automobile insurance and worker's compensation or other) or program (e.g., Medicare) that has liability for all or part of covered benefit for an individual served. The AGENCY shall provide services in compliance with the individual's third party-payer and collect all payments available from other health insurers including Medicare and private health insurance for services provided to the BOARD's recipients of services in accordance with Section 1902(a) (25) of the Social Security Act and 42 CFR 433 Subpart D, the Michigan Mental Health Code, and the Michigan Public Health Code as applicable. The AGENCY shall be responsible for identifying and collecting third-party liability information. The AGENCY is responsible to report third-party collections as required by the BOARD. The AGENCY may retain third-party collections, as provided for in Section 226a of the Michigan Mental Health Code as part of its payment in full. The AGENCY shall bill the Board only for the net cost of services after payment from all other sources not to exceed the lesser of the third party's reasonable/allowable/customary charge or the AGENCY's contract rate with the BOARD.

6. Assure that services for which reimbursement is sought from the BOARD are provided by appropriately credentialed and enrolled workforce as required by the BOARD or the individual's third-party carrier, whichever is more stringent.

7. As applicable based on the contracted service line(s), assist in initiation and submission of, and follow-up on on-line Medicaid applications for all individuals served pursuant to this Contract. The AGENCY shall maintain documentation of application by scanning the confirmation page from MI Bridges showing the tracking number of the application into the MDHHS/SSA Documents section of FOCUS. If a paper application is necessary, AGENCY will contact the MCCMH MDHHS liaison. AGENCY agrees to monitor on-going Medicaid eligibility and assist in the submission and follow-up of the MDHHS Re-Determination (MDHHS Form 1010) online. AGENCY will assist in the preparation and submission of the Medicaid Deductible Report Form, with information reflecting the actual cost of services provided, for all Medicaid Deductible (Spend-down) individuals. The AGENCY will report third-party collections as required by the BOARD and in accordance with applicable MCO policy. When a Medicaid beneficiary is also enrolled with a liable third party (Medicare, etc.), the liable third party will be the primary payer ahead of any BOARD payment.

8. Maintain all pertinent financial and accounting records and evidence pertaining to this Contract based on financial and statistical records that can be verified by the BOARD and/or its auditors. Financial reporting shall be in accordance with Generally Accepted Accounting Principles (GAAP) and as otherwise required by the BOARD.

9. Agree that the BOARD may recover payments as permitted or required by law, and as described in Section VII.A.12 of this Contract.

10. As applicable based on the contracted service line(s), at the AGENCY's sole cost and expense, collect and report, in the format specified by the BOARD, performance and outcome measures as required by the BOARD and as described in the Quality Improvement section of this Contract (Section VI.F.).

11. Maintain satisfactory and timely resolution of financial restitution as required resulting from AGENCY audits and corporate compliance investigations conducted by the BOARD.

12. With respect to provider-preventable conditions: (i) acknowledge and agree that no payment will be made for provider-preventable conditions, as identified by the State plan or applicable federal or State law, as any may be amended; and (ii) agree to comply with the reporting requirements of 42 C.F.R. § 447.26 (d), which requires providers to identify provider-preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available, as a condition of payment.

E. **Provider Panel Requirements - Audits**

1. The AGENCY and the BOARD will agree to an appropriate time frame for auditing, monitoring, and evaluating the AGENCY'S performance under this Contract; provided, however, that in the event of failure to reach agreement, the BOARD's decision shall govern. The AGENCY further agrees to be solely liable for increased audit costs attributable to any rescheduling of audit field work requested by the AGENCY and/or due to the delay in providing required documentation. The AGENCY is required to have an annual financial audit completed by an independent external auditor.

2. The AGENCY shall provide the BOARD with a copy of all audit engagement letters or agreements immediately following execution of such letters or agreements if such letter or agreement is related to financial statement audits of services funded in whole or in part pursuant to this Contract. The AGENCY shall also provide the BOARD with a copy of all audit reports issued during the term of this Contract immediately upon receipt of such reports.

3. The AGENCY agrees to permit authorized representatives and designees of the BOARD to review all activities and records of the AGENCY as BOARD deems necessary to satisfy financial audit, claims audit, program audit and program evaluation requirements and purposes of or pertaining to this Contract. The AGENCY shall submit a Plan of Correction within the time established in the BOARD'S notification of audit results to correct any deficiencies noted as a result of site review/audit findings.

4. The BOARD, CMS, the DHHS Inspector General, the Comptroller General or any of their designees, or any other applicable funding source (including, but not limited to MDHHS), may audit, evaluate or inspect the premises, physical facilities, equipment, books, records, contracts, computers or other electronic systems, and operations of the AGENCY, its subcontractors, and any other third party, related to it/s their Medicaid enrollees and/or its/their provision of the Contract Services. The AGENCY agrees to and shall require its subcontractors and any third party to cooperate with any such audit, evaluation or inspection, which shall include the making available of any relevant premises, physical facilities, equipment, books, records, contracts, computers or other electronic systems, and electronically stored information and other information. The AGENCY shall ensure that all files are available for review during onsite visits and that all personnel responsible for this Contract meet with the BOARD's or other investigators' representatives to respond to questions or concerns. Failure to be prepared for said visits, having inadequate or incorrect paperwork, or other issues of compliance, will result in a more thorough investigation into the AGENCY's financial reporting and business activity. Consistent failure to meet these requirements will lead to sanctions against the AGENCY as provided in this Contract and/or BOARD policy.

5. The AGENCY agrees that the right to audit by MDHHS, CMS, the DHHS Inspector General, the Comptroller General, or any of their designees, will exist through ten

(10) years from the final date of the contract period or from the completion of any audit that occurs during such ten year period, whichever is later. The AGENCY further agrees that if MDHHS, CMS, or the DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, then MDHH, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the AGENCY or any of its subcontractors at any time.

6. The state Medicaid agency and/or Health and Human Services may evaluate, through inspection or other means, the performance, appropriateness, and timelines of any services provided under this Contract and funded with Medicaid funds.

7. The Secretary, the Department of Health and Human Services (DHHS) and the state (or any person or organization designated by either) have the right to audit and inspect any books or records of the AGENCY pertaining to (i) the ability of the BOARD to bear the risk of financial losses; or (ii) services performed or payable under this Contract.

8. Annual Independent Financial Audit ("Annual Financial Audit"):

   i. Completion & Submission: Unless an "Financial Audit Waiver" is granted by the BOARD, the AGENCY shall obtain, and submit to the BOARD, through the MCCMH Chief Financial Officer, within ninety (90) days of the close of its fiscal year, an Annual Financial Audit consistent with the following principles: (i) completed according to GAAP; (ii) includes a balance sheet and income statement that demonstrates the AGENCY's fiscal solvency; (iii) demonstrates adherence to the terms of this Contract and applicable law. The Annual Financial Audit must include a list of revenues and expenses by funder. Failure to timely submit the Annual Financial Audit according to the guidelines described herein may result in the imposition of a financial penalty.

   ii. Corrective Action: Any audit finding shall be addressed in a corrective action plan, which shall be submitted by the AGENCY to the BOARD, through the MCCMH Chief Financial Officer, within thirty (30) days of the issuance of the Annual Financial Audit. The Agency shall submit status reports and/or finished products as required under the corrective action plan. Corrective action shall be completed no later than six (6) months after the date of the Annual Financial Audit.

   iii. Financial Audit Waiver: The AGENCY may request a Financial Audit Waiver if one or more of the following conditions are met: (i) AGENCY provides services to six (6) or less MCCMH individuals served, annually; (ii) AGENCY receives thirty thousand dollars ($30,000.00) or less annually from

the entire MCCMH to provide services; or (iii) AGENCY employs ten (10) or less employees or full-time equivalents (FTEs). If the AGENCY meets any of these criteria and desires a Financial Audit Waiver, it must submit a written request detailing its justification to the MCCMH Chief Financial Officer at least ninety (90) days prior to the due date of the Annual Financial Audit. Meeting these criteria does not guarantee a waiver; Financial Audit Waivers will be granted at the sole and absolute discretion of the BOARD.

9. Annual Program Audit: The AGENCY may be required to provide an Annual Program Audit relating to contracted services, which shall be consistent with the following principles: (i) completed according to GAAP; (ii) demonstrates adherence to the terms of this Contract, including accurate reporting of expenses and revenue; and (iii) demonstrates compliance with applicable federal, state, and local laws, local ordinances, codes, rules and regulations. If the BOARD requires an Annual Program Audit, it must be submitted to the BOARD, through the MCCMH Chief Financial Officer, within ninety (90) days of the close of the AGENCY's fiscal year or the termination of this Contract, or upon the BOARD's request. Failure to provide an Annual Program Audit according to the guidelines described herein may result in the imposition of a financial penalty.

10. Financial Compilation: The AGENCY will be required to provide an Annual Financial Compilation prepared by an external auditory or firm in lieu of an Annual Financial Audit or Annual Program Audit if a Financial Audit Waiver has been approved. The BOARD also reserves the right to request copies of the AGENCY's 990's or comparable tax return documentation. When the Annual Financial Compilation is required, it must be submitted to the BOARD, through the MCCMH Chief Financial Officer, within ninety (90) days of the close of the AGENCY's fiscal year or the termination of this Contract, whichever occurs first. Failure to provide the Annual Financial Compilation according to the guidelines described herein may result in the imposition of a financial penalty.

11. Right to Audit at Termination: The AGENCY acknowledges that the BOARD reserves the right to conduct a financial audit of the AGENCY, or to request an AUDIT to be conducted (at the expense of the AGENCY), if this Contract is early terminated by either party for any reason.

12. Single Audit Requirement: If AGENCY expends more than seven hundred fifty thousand dollars ($750,000.00) (according to Section 200.501 of OMB Super Circular) during the fiscal year, it must obtain a single audit (or program specific audit when administering only one federal program) in accordance with CFR 4, Part

96.31; the Single Audit Act Amendments of 1996 (31 USC 7501-7507); and updated OMB Super Circular. The audit must be performed by an independent auditor, in accordance with Generally Accepted Government Auditing Standards (GAGAS). The applicable reporting package described below must be submitted to the BOARD, through the MCCMH Chief Financial Officer, ninety (90) days after the close of the AGENCY's fiscal year.

i. If the AGENCY is subject to the Single Audit requirement (even if federal funding received from, or indirectly from MCCMH is less than $750,000.00), the reporting package that must be submitted to the BOARD must include the following:

    a. The single audit reporting package describe in the Single Audit Act Amendment of 1996 (31 USC 7501-7507), including the Corrective Action Plan;
    b. Supplemental Audit Schedules A and B; and
    c. Management letter, if one is issued, and management's response.

ii. If the AGENCY is exempt from the Single Audit requirement, but spends $750,000.00 or more in total funding from, or indirectly from, the BOARD in state and federal grant funding, the reporting package includes:

    a. The financial statement audit prepared in accordance with GAGAS;
    b. Supplemental Audit Schedules A and B; and
    c. Management letter, if one is issued, and management's response.

iii. If AGENCY is exempt from the Single Audit requirement, and spends less than $750,000.00 in total funding from the BOARD in state and federal grant funding, but a financial statement audit includes disclosures that may negatively impact BOARD-funded programs, including but not limited to, fraud, ongoing concern uncertainties, and financial statement misstatements, the reporting package includes:

    a. The financial statement audit prepared in accordance with GAGAS; and
    b. Management letter, if one is issued and management's response.

iv. If the AGENCY is exempt from the Single Audit and spends less than $750,000.00 in total funding from the BOARD in state and federal grant funding, and the financial statement audit does not include any disclosures

that may negatively impact MDHHS-funded programs, the reporting package includes:

a. An Audit Status Notification Letter certifying the exemptions.

v. None of the Single Audit requirements described herein relieve the AGENCY of their obligation to obtain an Annual Financial Audit in accordance with Subsection 8, above.

F. **Provider Panel Requirements: Quality Improvement.**

The AGENCY shall:

1. Demonstrate participation in the BOARD's Quality Assessment and Performance Improvement Program (QAPIP) and comply with the standards that the QAPIP measures, including, among other things, the performance metrics established by the BOARD in the areas of timely access to services, program effectiveness, efficiency, performance outcomes, direct and subcontracted workforce credentialing, privileging, and performance monitoring, including but not limited to those described below (as applicable, based on the contracted service line(s)):

i. Access Domain Indicators: "Access" is defined as the ease with which care can be initiated and maintained

a. All emergency mental health screenings will be completed, with disposition established (i.e., approval by the BOARD's Access Center of the need for hospitalization, diversion, denial or other action), within three hours of the initial request for service, once the patient has been medically cleared for psychiatric consultation. The AGENCY will record the time the original request is made for an inpatient screening, or the time the patient has been medically cleared and the psychiatric consultation has been requested, and provide that information to the BOARD through the certificate of need process.
Standard: 95% in three hours

b. The percentage of new persons receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service (MI adults, MI children, DD adults, DD children, and Medicaid SA).
Standard: 95% in 14 days

c. The percentage of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional (MI adults, MI children, DD adult, DD children, and Medicaid SA).
Standard: 95% within 14 days

d. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days (MI adults, MI children, DD adult, DD children, and Medicaid SA who are discharged from sub-acute detox).
Standard: 95% within 7 days

ii. Outcomes Domain Indicators: "Outcomes" are defined as changes in an individual's current or future health status, level of functioning, quality of life or satisfaction, that can be attributed to the care provided.

a. The percent of adults with mental illness and the percent of adults with developmental disabilities who are in competitive employment, as documented in the FOCUS record.

b. The percent of adults with mental illness and the percent of adults with developmental disabilities who earn minimum wage or more from employment activities (competitive, supported or self-employment, or sheltered workshop) as documented in the FOCUS record.

c. The percent of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.
Standard: 15% or less within 30 days

d. The annual number of substantiated recipient rights complaints per thousand persons served, in the categories of Abuse I and II, and Neglect I and II (MI and DD only).

e. The number of sentinel events per thousand Medicaid beneficiaries served (MI adults, MI children, persons with DD, HSW enrollees, Children's Waiver enrollees, and SA). Sentinel events require review and action, including the completion of a Root Cause Analysis in accordance with Board policy.

f. The number of suicides per thousand persons served (MI, DD).

g. The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s) as documented in the FOCUS record.

h. The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s) as documented in the FOCUS record.

i. Percentage of children with developmental disabilities (not including children in the Children's Waiver Program) in the quarter who receive at least one service each month other than case management and

Respite.

NOTE: Demographic data are to be submitted to the Board upon initial contact (intake) and updated at least annually thereafter.

j. Any additional outcome measures described on Attachment "B".

2. Maintain an internal Continuous Quality Improvement (CQI) program in conformance with national standards for Quality Improvement Programs, including those standards in 42 CFR, Part 438, Managed Care. The AGENCY's CQI program shall include ongoing measurement of key performance indicators which, through ongoing measurement and intervention, can be expected to lead to demonstrable and sustained improvement in significant aspects of clinical and non-clinical services affecting health outcomes and satisfaction of individuals served. The AGENCY will maintain a current copy of the AGENCY CQI plan, and annual evaluation for Quality Improvement/Outcomes (as appropriate to the AGENCY accrediting body findings) on file with the BOARD.

3. Demonstrate an ability to provide timely, valid, and reliable data to the BOARD, including but not limited to: (i) data supporting the Michigan Department of Health and Human Services – Key Performance Indicators (KPI's) reporting requirements for the then-current Contract period; (ii) reports and information related to mortality review, sentinel event review, performance indicators, and satisfaction assessments of individuals served; (iii) BH-TEDS, (iv) updated diagnosis information, and any other data requested or required by the BOARD.

4. Demonstrate compliance with standards for those Managed Care functions delegated by the BOARD to the AGENCY, including remedial action taken as a result of BOARD initiated corrective action plans.

5. Maintain a process for the root cause analysis (RCA) of sentinel events involving individuals served, including deaths, and shall report results of its analysis, including recommendations, to the BOARD promptly upon their completion.

6. Maintain satisfactory compliance with standards for clinical service record documentation as required by federal and state regulations and by the BOARD in the MCCMH MCO Policy Manual. If the AGENCY, with BOARD's prior written consent, utilizes an Electronic Medical Record (EMR) other than the BOARD's EMR, FOCUS, AGENCY shall, as directed by the BOARD: (i) provide access to all data specified by BOARD to all individuals specified by BOARD, at AGENCY's sole cost and expense; and (ii) upload or enter any required data elements into FOCUS. The AGENCY will include periodic systematic review of clinical record quality as part of its Continuous Quality Improvement program.

7. Conduct satisfaction surveys of persons receiving treatment and provide outcome results to the BOARD no less than annually.

G. **Provider Panel Requirements - Corporate Compliance**

1. The AGENCY shall maintain and operate a program integrity corporate compliance program designed to detect and guard against fraud, waste, and abuse with respect to the provision of Contracted Services that meets the requirements of the Medicare Managed Care Compliance Program Guidelines and all other applicable federal and Michigan standards and guidelines. The AGENCY shall furnish the BOARD with an updated and current copy of the AGENCY's corporate compliance plan prior to the full execution of this Contract. The AGENCY will:

   i. Designate, and make known to the BOARD, a Corporate Compliance Officer, Privacy Officer, and Security Officer to provide functions as described in the AGENCY's corporate compliance plan and HIPAA Privacy and Security policies;

   ii. Submit to the BOARD, in the format designated by the BOARD, quarterly reports detailing program integrity activities, including but not limited to documentation to support that the program integrity activities described in this Section VI.G.1. of the Contract were performed;

   iii. Conduct routine internal monitoring to detect and guard against fraud, waste and abuse;

   iv. Promptly respond to potential program integrity / corporate compliance program violations and implement corrective action plans;

   v. Report all suspected fraud, waste or abuse to the BOARD (suspected fraud must be reported within 24-hours; suspected waste and/or abuse must be reported within thirty (30) days), in the form required by the MCCMH Corporate Compliance Officer;

   vi. Implement training procedures regarding fraud, waste and abuse for the AGENCY's workforce, at all levels.

   vii. After identifying any overpayments received (i) report them to the MCCMH Chief Privacy and Compliance Officer within ten (10) calendar days, and (ii) return them to the BOARD within sixty (60) calendar days. All returned overpayments must be accompanied by a written explanation describing why/how the overpayment occurred.

   viii. Report all fraud, waste, abuse, and program integrity initiatives on a quarterly basis in the format specified by the MCCMH Corporate Compliance Officer.

2. In the event MDHHS-OIG sanctions AGENCY, the BOARD will, at minimum, apply the same sanction, and may pursue additional measures/remedies independent of the State.

3. The AGENCY shall cooperate with the BOARD's corporate compliance program,

including but not limited to, providing requested information for completion of compliance audits, reviews, compliance investigations and remediation. The AGENCY will require all direct and subcontracted workforce to attend specialty training as required by the BOARD and shall participate in all mandatory training, as further described in Section VI.A.21 specified in the Appendix X contracts, the BOARD's MCO Policy Manual (see MCCMH MCO Policy No. 3-015, "Contract Network Provider Mandatory Training and Network Development"), relevant accrediting bodies, and all federal, state, and local laws, guidelines, rules, and regulations, all as amended from time-to-time. The AGENCY shall provide to its direct and subcontracted workforce corporate compliance training at the time of hire/contract, on an annual basis thereafter, and as necessary.

4. Pursuant to Section 1932 (d)(1) of the Social Security Act, the AGENCY shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than five (5) percent of the entity's equity who is currently disbarred, sanctioned, or suspended by any state or federal agency. The AGENCY is also prohibited from having an employment, consulting, or other agreement with a currently disbarred, sanctioned, or suspended person for the provision of items or services that are significant and material to the contractual obligations with the Board / State of Michigan. By executing this Contract, AGENCY represents and warrants to the BOARD that the AGENCY is in full compliance with this subsection VI.G.4.

5. AGENCY shall immediately notify the BOARD through its Network Operations Division Contract Manager of any direct or contracted workforce member, director, officer, or manager; individual with a beneficial ownership of five (5) percent or more, a subcontractor, or an individual with an employment, consulting, or other arrangement with AGENCY has been convicted of a criminal offense described under Sections 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act or who has had civil money penalties or assessments imposed under Section 1128A of the Act or who has been excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act.

6. The AGENCY, in its hiring practices, shall ensure that its professional staff providing services meets the current credentialing standards in compliance with Attachment E of this Contract and the BOARD's MCO Policy Manual.

7. In order to ensure staffing remains compliant with applicable law, the AGENCY shall perform the following screening:

    i. Prior to hiring or contracting with any applicant, and on a monthly basis thereafter for employees and contractors, check the sanctioned provider list of the State Medical Services Administration, U.S. Health and Human Services OIG Exclusions list and the General Services Administration System for Award Management database to ensure that no direct and subcontracted workforce member is or has been excluded from participation in Federal or State healthcare programs, including Medicaid, Medicare, Children's Special

Healthcare Services and State Medical Program.

ii. Prior to hiring or contracting with any applicant, and not less than annually thereafter for employees and contractors, check the license status of each direct and subcontracted workforce member through all applicable databases including, but not limited to, the State of Michigan's Licensing and Regulatory Affairs (LARA) database, and the Michigan Secretary of State.

iii. Prior to hiring or contracting with any applicant, and regularly thereafter (at least every two years) for employees and contractors, perform a criminal background check. Criminal background checks must be completed by an organization, service, or agency that specializes in gathering the appropriate information to review the complete history of an individual, e.g., ICHAT. Use of the State of Michigan Offender Tracking Information System (OTIS) or a county level service that provides information on individuals involved with the court system, alone, is not acceptable for criminal background checks.

a. If the AGENCY wishes to use a state (MDHHS or State of Michigan) approved or federal (FBI) Rap Back subscription in lieu of affirmatively performing criminal background checks every two years, and is eligible to do so according to the guidelines enforced by the government entity that manages the Rap Back subscription, the AGENCY must: (i) retain documentary evidence of the initial subscription enrollment and continuing subscription for each eligible employee and contractor for the duration of the AGENCY's employment and/or contractual relationship with the individual, which documentation must be available for review immediately upon the BOARD's request; and (ii) immediately respond to any updates received through the Rap Back subscription.

b. Persons found to have any Excluding Conviction, and/or behavioral technician or aid level staff (chore, respite, CLS, and out of-home habilitation) found not to be in good standing with the law (i.e., a fugitive from justice, a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, not an illegal alien), are prohibited from providing any direct service or contact with individuals served by the BOARD.

c. For purposes of this provision, the following definitions will apply:

1. "Excluding Conviction" means:

a. Crimes described under 42 USC 1320a-7(a), until the individual is removed from the MDHHS Sanctioned Provider List:

i. Program related crimes;

ii. Crimes relating to patient neglect or abuse in connection with the delivery of a health care item or service;
iii. Felony conviction relating to health care fraud; or
iv. Felony conviction relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

b. Conviction for violating the Medicaid False Claims Act, the Health Care False Claims Act, a substantially similar statute, or a similar statute by another state or the federal government;

c. Federal or state felony conviction within the preceding 10 years of provider enrollment application, including but not limited to, any criminal offense related to:
i. Murder, rape, abuse or neglect, assault, or other similar crimes against persons;
ii. Extortion, embezzlement, income tax evasion, insurance fraud, and other similar financial crimes;
iii. The use of firearms or dangerous weapons; or
iv. Any felony that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct;

d. Federal or state misdemeanor conviction within the preceding five years of their provider enrollment application, including but not limited to, any criminal offense related to:
v. Any misdemeanor crime listed as a permissive exclusion in 42 USC 1320a-7(b);
vi. Rape, abuse or neglect, assault, or other similar crimes against persons;
vii. Extortion, embezzlement, income tax evasion, insurance fraud, or other similar financial crimes; or
viii. Any misdemeanor that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

2. “Conviction” means:

a. A judgment of conviction has been entered against the

individual or entity by a federal, state, tribal or local court regardless of whether there is an appeal pending;

b. There has been a finding of guilt against the individual or entity by a federal, state, tribal or local court; or

c. A plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, tribal, or local court.

8. The AGENCY shall immediately notify the BOARD through its Network Operations Contract Manager when it terminates, suspends, or declines a provider, subcontractor, practitioner, employee, or any member of its workforce from its organization as a result of fraud, integrity, a quality matter, or any criminal conviction described under Sections 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act, or assessment of civil monetary penalty under Section 1128A of the Act.

9. The AGENCY must immediately report to the BOARD all disciplinary actions taken by LARA against any employee, contractor or agent of the AGENCY.

10. Services delivered by direct or subcontracted workforce that are ineligible, pursuant to applicable law and/or Sections VI.G.4-7, are subject to denial of payment or payment recovery by the BOARD.

11. The AGENCY shall ensure that any and all contracts, agreements, purchase orders, or leases funded under the MDHHS-MCCMH Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs Agreement are compliant with 42 C.F.R. §455.104-106.

12. The BOARD has delegated to the AGENCY those activities and obligations specified in Attachment "F" of this Contract. AGENCY agrees to perform all delegated activities and any related reporting responsibilities consistent with and in compliance with the BOARD's obligations under the relevant contract(s) attached as part of Appendix "X" to this Contract, and applicable BOARD policies, including but not limited to MCO Policy No. 3-010, "Evaluation and Monitoring of Delegated Functions."

H. **Provider Panel Requirements - Protected Health Information (PHI)**

The AGENCY shall:

1. Operate in full compliance with all applicable federal and state laws, rules, and regulations, and all applicable BOARD guidelines and requirements, concerning beneficiaries' health care information confidentiality rights, including without limitation the Health Insurance Portability and Accountability Act of 1996, the HIPAA Omnibus Rule and the Security Rule (collectively, "HIPAA"), the Health

Information Technology for Economic and Clinical Health Act ("HITECH"), the regulations and standards promulgated pursuant thereto, 42 CFR Part 2, the Michigan Mental Health Code, and the Michigan Public Health Code.

2. Sign the Business Associate Agreement attached hereto as Attachment "G", and, if applicable, the Qualified Service Organization Agreement attached hereto as Attachment "H". The parties acknowledge that they may be required by MDHHS or other regulatory agencies to enter into additional agreements regarding data usage, in order to promote greater data sharing between entities, and the parties agree to work cooperatively to ensure timely execution of any such necessary agreements.

3. Require compliance with HIPAA and HITECH in all of its subcontractor and business associate relationships and will provide documentation of same when requested by the BOARD. The AGENCY shall ensure that all staff members and contractors receive appropriate training regarding HIPAA and HITECH requirements and obligations.

4. Ensure that PHI is protected from unauthorized disclosure; is used or disclosed only for purposes directly connected with its performance and administration of this Contract; not further disclosed except as permitted under the contract or as allowed by law. Applicable State law, including by way of example and without limitation, the Michigan Mental Health Code, that is more stringent shall supersede as provided under HIPAA and HITECH. For purposes of this Contract, "Protected Health Information" (PHI) shall have the meaning given to such term under HIPAA and HITECH.

5. Have and maintain written policies and procedures for maintaining the confidentiality of all PHI; adhere to MCCMH MCO Policies pertaining to confidentiality and PHI; ensure proper safeguards to prevent use or disclosure of PHI other than as provided by this contract; report to the BOARD any known use or disclosure of PHI not provided for by HIPAA or this Contract immediately upon the AGENCY becoming aware of such disclosure, whether the disclosure is intentional or unintentional; comply with the breach notification requirements articulated in 45 CFR 164.404 – 164.414; ensure that any entity to which it provides PHI agrees to the same restrictions and conditions that apply to the AGENCY with respect to such PHI.

6. Afford individuals access to their protected health information, as required by HIPAA and the Michigan Mental Health Code; allow individuals to make amendments to their PHI and incorporate such said amendments as required by HIPAA and the Michigan Mental Health Code; make information available to individuals to provide an accounting of disclosures of their PHI in accordance with HIPAA and the Michigan Mental Health Code.

7. Make its internal practices, books and records relating to the use and disclosures of PHI received from, or created or received by the BOARD on behalf of the individual served available to the BOARD for the purposes of assessing the AGENCY's

compliance with the privacy regulations.

8. At the termination of this Contract and upon request by the Board, return to the BOARD copies of all PHI relating to individuals served by the AGENCY under this Contract, including but not limited to PHI created by the AGENCY or received from the BOARD or other sources on behalf of the individual served. Further, upon request by the BOARD, the AGENCY will make available to the BOARD all originals of all PHI.

9. In the event and to the extent of any conflict between any provision of this Contract relating to PHI and the provisions of HIPAA, HITECH or any other applicable federal or state statute or regulation, the terms of the applicable federal or state statute or regulation shall supersede and govern. In the event and to the extent of conflict between any provision of HIPAA or HITECH and any provision of any applicable Michigan statute or regulation, the statute or regulation providing more stringent protection for PHI shall supersede and govern.

I. **Provider Panel Requirements - Additional Laws and Regulations**

The AGENCY shall:

1. Comply with all applicable federal, state and local laws, ordinances, rules, and regulations, including but not limited to: (i) the Michigan Mental Health Code and the Michigan Public Health Code and the rules and regulations promulgated thereunder; (ii) MCL 15.342 Public officer or employee; prohibited conduct; (iii) federal and state Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions, and including the Balanced Budget Act; (iv) OSHA/MIOSHA requirements; (v) Americans with Disabilities Act; (vi) Title VI of the Civil Rights Act of 1964; (vii) Title IX of the Education Amendments of 1972; (viii) the Age Discrimination Act of 1973; (ix) the Rehabilitation Act of 1973; (x) Section 1557 of the Affordable Care Act (ACA); (xi) all applicable standards, orders and regulations issued pursuant to the Clean Air Act of 1970 (42 USC 7401 et seq.) and Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738 and Environmental Protection Agency regulations (40 CFR Part 15) if the amount of this Contract is over $100,000.00; (xii) and, as applicable (with respect to Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 19 21 services rendered under the MIChild program), statutory and regulatory provisions related to Title XXI (The Children's Health Insurance Program).

2. Comply with the Anti-Lobbying Act, Title 31 USC, Section 1352 (added under Section 319 of Public Law 101-121), as revised by the Lobbying Disclosure Act of 1995 (P.L.104-65) and Section 503 of the Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act (Public Law 104-208). The AGENCY shall include the language of this assurance in all subcontracts for services covered by this Contract.

3. As applicable based on the contracted service line(s), comply with Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through state or local governments, by Federal grant, contract, loan or loan guarantee. The Act also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The Act 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 WIC coupons are redeemed. Failure to comply with the provisions of the Act 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. The AGENCY shall include this language in any subcontracts which contain provisions for children's services.

   The AGENCY, in addition to compliance with Public Law 103-227, shall ensure that any service or activity funded in whole or in part through this Contract 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 the AGENCY. If activities or services are delivered in facilities or areas that are not under the control of the AGENCY, (e.g., a mall, restaurant or private work site), the activities or services shall be smoke-free.

4. Comply with the Hatch Act (5 USC 1501-1508) and Intergovernmental Personnel Act of 1970, as amended by Title VI of the Civil Service Reform Act (Public Law 95-454 Section 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.

5. If any law or administrative rule or regulation that becomes effective after the date of execution of this Contract substantially changes the nature and conditions of this Contract, it shall be binding to the parties, but the parties retain the right to exercise any remedies available to them by law or other provisions of this Contract.

J. **Provider Panel Requirements - Liability Coverage**

The AGENCY shall:

1. Procure, maintain in force and supply to the BOARD evidence of professional liability (malpractice) insurance protection and with coverage and limits of at least $200,000.00 per occurrence, $600,000.00 annual aggregate or such higher limits as reasonably required by the BOARD for the type of services performed by the AGENCY. Evidence of such insurance will be verified through the submission of Provider Profile and in the form of a certificate of insurance. The AGENCY shall

provide thirty (30) days prior written notice of any material change or cancellation of professional liability insurance to the Macomb County Community Mental Health, Chief Network Officer, 22550 Hall Road, Clinton Township, Michigan, 48036.

2. Procure, maintain in force and supply to the BOARD evidence of a commercial general liability policy with coverage and limits of at least $1,000,000.00 per occurrence, $2,000,000.00 annual aggregate limit, and providing the BOARD with indemnification for any liability arising out of AGENCY's performance or breach of this Contract.

3. If the AGENCY is a residential provider, procure, maintain in force and supply to the BOARD evidence of "All Risk" property insurance and coverage protecting against sprinkler damage, vandalism, and malicious mischief, all of which must cover damage to or loss of any personal property and coverage for the full replacement cost, including business interruption. If the property of AGENCY's invitees (including but not limited to residents) is to be kept on the premises, the insurance should include bailee insurance for the full replacement cost of the property belonging to invitees and located on the premises.

4. If the AGENCY operates a motor vehicle in the transport of individuals served, then, the AGENCY shall procure, maintain in force and supply to the BOARD evidence of Michigan No-Fault Motor Vehicle Liability Insurance with coverage and limits required by law or such higher limits as reasonably required by the BOARD for the type of services performed by the AGENCY.

5. Procure, maintain in force and supply to the BOARD evidence of Workers' Compensation insurance in compliance with the State of Michigan Worker's Compensation statute.

6. Notify the BOARD immediately when there is any litigation initiated against the AGENCY or when any individual served asserts any claim against the AGENCY.

K. **Provider Panel Requirements - Record Retention**

1. The AGENCY shall comply with the record retention requirements outlined by the Michigan Department of Technology, Management, and Budget, by the BOARD's MCO Policy Manual, and other applicable State and Federal law, including but not limited to those further described below.

2. The AGENCY is required to retain enrollee grievance and appeal records (42 CFR 438.416), base data (42 CFR 438.5(c)), MLR reports (42 CFR 438.8(k)), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

3. The AGENCY shall comply with the record retention requirements described in any

agreement included in Appendix "X" to this Contract.

4. In the event of a conflict between any of record retention authorities described in this Contract, the AGENCY shall be required to comply with the more stringent requirement.

L. **Provider Panel Requirements - Federal E-Verify Policy**

1. The AGENCY shall comply with the Macomb County Federal E-Verify Program Policy as adopted by the Macomb County Board of Commissioner in 2009, and as applicable to all contractors and sub-contractors of the BOARD.

2. A copy of the Federal E-Verify Policy is located in the BOARD'S MCO Policy Manual.

M. **Provider Panel Requirements - Recipient Rights**

The AGENCY shall:

1. Demonstrate adherence to the BOARD's MCO Policy 9-100 and all accompanying MCCMH MCO Recipient Rights Policies as contained in Chapter 9 - Recipient Rights Protection requirements contained in Attachment "C" of this Contract. Repeated failure or non-compliance shall subject continuation of the AGENCY's Contract to review, possible revocation, and/or denial of re-contracting.

2. Monitor the safety and welfare of individuals served while they are under the AGENCY's service supervision pursuant to this Contract. If the health or safety of any individual served is in jeopardy, the AGENCY shall cooperate in the immediate transfer of the individual(s) served to another services provider.

VII. BOARD RESPONSIBILITIES

A. **Managed Care Organization Assurances**

The BOARD shall:

1. Provide payment of Clean Claims submitted for the Contracted Services designated in Attachment "B" of this Contract in accordance with Attachment "D" of this Contract and within thirty (30) days after receipt of such Clean Claims.

2. Monitor the AGENCY's compliance with the requirements of this Contract, and the AGENCY's adherence to federal, state and local laws, guidelines, rules, and regulations. This monitoring may include but is not limited to conducting fiscal and/or program audits, as required by contract with the Michigan Department of Health and Human Services.

3. Provide assistance and guidance related to delegated program integrity / corporate compliance related activities (e.g., audits, investigation), upon request of the AGENCY.

4. Designate a Recipient Rights Officer as required by BOARD policy and as referenced in the BOARD's MCO Policy Manual. The Recipient Rights Officer shall respond to and investigate all alleged violations of recipients rights, as delineated in chapter seven (7) of the Michigan Mental Health Code and provided in applicable BOARD MCO Policies.

5. Designate a Corporate Compliance Officer, Privacy Officer and Security Officer to implement Corporate Compliance and HIPAA policies of the BOARD. The Corporate Compliance Officer, Privacy Officer and Security Officer shall respond to reports and inquires as provided in applicable MCO policies of the BOARD.

6. Determine the effective date for compliance with modified or updated policies, regulations or contractual requirements with a minimum advance written notice to the AGENCY of thirty (30) days, or such lesser period of time as may be required for compliance with applicable federal and state law.

7. Provide the AGENCY with notice of any reduction or restriction of its funding allocation for performance of this Contract at least thirty (30) days in advance of such reduction or restriction, unless the BOARD receives a shorter period of notice of the cause for such reduction or restriction in which case, such shorter period of notice shall be given.

8. Maintain responsibility for a Quality Assessment and Performance Improvement Program (QAPIP), including performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcome and satisfaction of individuals served.

9. Perform Utilization Management and assure that service eligibility and medical necessity determination decisions are conducted using defined criteria and standardized service selection guidelines, where available, and shall assure that utilization management of services are instituted as a formal process for ongoing monitoring of care determination decisions with mechanisms to correct for under and over utilization of services. The AGENCY shall assure that individuals served that are located in the service area have clear and identifiable access to needed supports and services for which they are eligible, in an amount, scope and duration that is consistent with the principals delineated in the Michigan Medicaid Provider Manual, and shall ensure that supports and services are of high quality and delivered according to established regulations, standards, and practice guidelines.

10. Evaluate and monitor the AGENCY's performance on an ongoing basis and subject

the AGENCY to formal review of any functions delegated to AGENCY including, but not limited to, Coordination of Care, Credentialing and Privileging, Corporate Compliance, and Customer Satisfaction, in order to ensure performance consistent with applicable law and industry standards.

11. Promptly inform the AGENCY upon any determination that the AGENCY's performance of any delegated function has been deemed to be inadequate. In any such case, the AGENCY shall take corrective action. Should AGENCY's performance remain inadequate, the BOARD may revoke any delegation of responsibilities to the AGENCY and/or may impose other sanctions.

12. As appropriate, recover payments based on audit exceptions, overpayment, inadequate documentation of services provided, non-compliance with contractual staffing expectations or failure to comply with all applicable service and billing requirements. BOARD's recovery may include full extrapolation of dollars based on audit sample findings. The methodology used for sample selection (random sample with 95% confidence and 1% materiality) allows the audit exceptions to be extrapolated to the entire claims population. For purposes of illustration, a five percent exception (error) rate found in the audited sample would be applied to the entire population of claims dollars. In circumstances of suspected fraud, audit findings may be reported to the State Attorney General, the Michigan Department of Health and Human Services Office of Inspector General and/or other applicable investigation and enforcement agencies and personnel.

VIII. CONTRACT ADMINISTRATION

A. The parties agree that the BOARD will monitor and review the AGENCY's compliance with the terms of this Contract, including but not limited to the AGENCY's attainment of program outcome measures, the AGENCY's corporate compliance and program integrity activities, quality improvement, financial compliance, recipient rights performance, and measured satisfaction of individuals served, and will consider all as factors in its re-contracting determination

B. If the BOARD identifies deficiencies or areas for improvement following an evaluation of the AGENCY's performance, including the performance of delegated Managed Care functions, clinical service delivery or documentation, the AGENCY must take corrective action. BOARD may take progressive corrective action of a type and nature it deems appropriate, up to and including termination of this Contract. Should performance remain inadequate following corrective action, delegation of responsibilities to the AGENCY under this Contract may be revoked and other sanctions imposed, up to and including contract termination.

C. At the time of contracting, re-contracting, when there is a change in ownership, or upon request of the BOARD, AGENCY shall submit full disclosures identified in 42 C.F.R. Part 455 Subpart B. Disclosures statements shall include

1. Name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include primary business address, every business location, and P.O. Box location.

2. Date of birth and Social Security number of each person with an ownership or control interest in the disclosing entity.

3. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five percent or more interest.

4. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with an ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child, or sibling.

5. The name or any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.

6. The name, address, date of birth, and Social Security number of any managing employee of the disclosing entity.

7. The identity of any individual who has an ownership or control interest in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

D. Both parties shall provide and facilitate ready access to information for referrals and for transmittal of information, as required between the AGENCY and other appropriate services, to assure continuity of services to the individual served.

E. In the event of a dispute related to the administration of this Contract (i.e., disputes that are <u>not</u> related service authorizations, denial or reductions of services, or denial of payment), the resolution will be managed as follows.

Step # 1: The AGENCY must provide written notification to their assigned Contract Manager within thirty (30) days after the AGENCY becomes aware, or should have become aware, with reasonable diligence, of the issue or dispute. The Contract Manager will promptly provide a written summary of the issue to the MCCMH Chief Network Officer.

Step # 2: Within fourteen (14) calendar days after receiving written notification of the issue/dispute from the AGENCY, the assigned Contract manager will communicate with the AGENCY supervisor in attempt to resolve the dispute.

Step # 3: If still unresolved, the Contract Manager will provide a summary of the remaining issues to the MCCMH Chief Network Officer, who will meet with the AGENCY Chief Operations Officer within twenty-one (21) additional days, in attempt to bring resolution to the dispute. If unresolved, the MCCMH Chief Network Officer and AGENCY Chiel Operations Officer will, within fourteen (14) additional calendar days, submit written recommendations to the MCCMH Chief Operations Officer for resolution.

Step # 3: The MCCMH Chief Operations Officer will meet with the AGENCY within fourteen (14) calendar days after receipt of written recommendations to determine resolution of the dispute.

Step # 4: If the BOARD or AGENCY is dissatisfied with the resolution of the MCCMH Chief Operations Officer, either party may initiate termination of the Contract in accordance with Section X.

Refer to the BOARD's MCO Policy 2-006 "Service Provider Appeals" for a description of the appropriate process to resolve disputes related to service authorizations, denials or reductions of services, or denial of payment.

IX. SUBCONTRACTING AND DELEGATION

A. The AGENCY may not subcontract or delegate Contract Services without first receiving express written approval of both the subcontracting arrangement and the subcontract agreement from the BOARD, and only in strict accordance with the terms of this Contract. If the BOARD consents to any subcontract or delegation, the AGENCY shall ensure that for any such subcontracted service or activity:

1. A written subcontract is executed between the AGENCY and its subcontractor/delegate, and is approved by the BOARD, prior to the initiation of subcontracted activities;

2. Any subcontract funded in part or whole by this Contract must (i) require the subcontractor to comply with the terms and conditions herein; and (ii) clearly state that neither MDHHS nor the BOARD is a party to the subcontract, and therefore not a party to any employer-employee relationship with any of the AGENCY's subcontractors;

3. AGENCY shall maintain records to demonstrate compliance by the subcontractor with the terms of this Contract;

4. Copies of each subcontract and/or delegation agreement shall be available for review by authorized BOARD or MDHHS representatives. Upon request of the BOARD or MDHHS, AGENCY shall forward copies of requested subcontracts or delegation agreements for review; and

5. The AGENCY shall at all times remain responsible for full compliance with the terms

of this Contract and shall ensure that each of its subcontractors also complies with the terms of this Contract.

B. The AGENCY shall not sub-delegate any activities and/or obligations specified in Attachment "F" of this Contract.

C. The BOARD will withhold funding for any subcontracted/delegated work that has not been pre-approved and/or is not covered by appropriate, properly executed contracts.

X. TERM AND TERMINATION

A. **Term**. The initial term of this Contract shall be for a two (2) year period commencing on October 1, 2019, and ending on September 30, 2021 (the "Initial Term"), unless it is sooner amended to revise the term, terminated in accordance with its terms or replaced by execution of a new contract between the parties. Notwithstanding the foregoing: (i) the Initial Term of this Contract may be extended by mutual agreement of the parties for a period of no more than one (1) year (the "Renewal Term"); and (ii) the BOARD may extend the Initial Term and/or the Renewal Term for a period of one-hundred-eighty (180) days, provided that such extension shall be at the sole option of the BOARD and shall be made effective upon notice from the MCCMH Network Operations Division to the AGENCY of its intent to extend this Contract. Such notice shall be sent by the MCCMH Network Operations Division not less than thirty (30) calendar days prior to the expiration of the initial term.

B. **Termination**

1. This Contract may be terminated by either party at any time, with or without cause, upon sixty (60) days' prior written notice to the other party.

2. Either party may terminate this Contract if the other party materially breaches this Contract and such breach is not cured within sixty (60) days after the breaching party receives from the non-breaching party written notice specifying the claimed material breach and including sufficient factual detail to permit the breaching party to clearly identify and investigate the claimed breach.

3. Anything in this Contract to the contrary notwithstanding, the BOARD my revoke any delegated function and/or terminate this Contract effective immediately upon written notice to the AGENCY in the event of any of the following:

   i. a serious violation of this Contract by the AGENCY including but not limited to any violation that places the life or safety of any individual served in jeopardy or failure to properly perform any delegated function;

   ii. the AGENCY fails to maintain all licenses, certifications, permits, accreditations, certificates of authority or registrations required by law;

   iii. the AGENCY is excluded, suspended or terminated from any federal program or any state or federal health care program;

iv. the AGENCY is convicted of or pleads no contest to a felony of any kind or a misdemeanor related directly or indirectly to the provision of health care services;

v. the AGENCY is required to terminate this Contract pursuant to the directive of an applicable regulatory agency;

vi. the AGENCY files a certificate of dissolution;

vii. any insurance required by this Contract to be maintained by the AGENCY is terminated or reduced below the minimum levels required by this Contract without immediate replacement by insurance of the type and levels required by this Contract;

viii. the AGENCY applies for or consents to the appointment of a receiver, trustee or liquidator of all or substantially all of its assets, or files a petition or an answer seeking reorganization or to otherwise take advantage of any insolvency law;

ix. the AGENCY files a voluntary petition in bankruptcy, admits in writing its inability to pay its debts as they become due, or makes a general assignment for the benefit of creditors;

x. the AGENCY is adjudicated bankrupt or insolvent by a court of competent jurisdiction or is the subject of such a court's order, judgment or decree approving a petition seeking its reorganization; or

xi. the AGENCY has a receiver or trustee appointed by a court of competent jurisdiction to manage its assets, and such receiver or trustee has not been discharged within forty-five (45) days after appointment;

Provided, however, that the AGENCY shall be required to continue to furnish Contracted Services to individuals served to the minimum extent required by law or by order of any court of competent jurisdiction.

4. Upon the expiration or termination of this Contract for any reason, the AGENCY shall cooperate with the BOARD in the orderly transfer of individuals to other providers so that individuals served will have timely access to medically necessary services and appropriate continuity of care.

5. No expiration or termination of this Contract shall affect the obligations of either party under this Contract accruing prior to such expiration or termination if such obligations remain unsatisfied at the date of expiration or termination. If either party breaches this Contract, the other party's termination of the Contract for that reason shall not limit such other party's rights to obtain damages or enforcement of those obligations which continue after termination.

6. Immediately upon expiration or termination of this Contract (and/or to the extent of the partial expiration or termination of this Contract – i.e., termination or expiration of any service site or any type of service provided under this Contract while the

remainder of the Contract remains intact), the AGENCY shall:

i. Cooperate and supply the BOARD with any and all information necessary for the reimbursement of outstanding Medicaid or private third party insurer claims arising out of services provided under this Contract and billed to Medicaid or a private insurer;

ii. Complete and submit to the BOARD all outstanding documentation, which shall require, among other things: (i) ensuring that all documentation is properly signed, as required; (ii) completing all required FOCUS entries and discharge summaries; and (iii) submitting all reports required by this Contract and/or applicable law for the final monthly/quarterly/annual reporting period (e.g., financial, compliance, etc.);

iii. Surrender to the BOARD copies of any records of relevant individuals served, any medications prescribed to and owned by such individuals, all personal property including personal funds (unless the AGENCY is payee of the individual served) belonging to such individuals, and all BOARD funds held by the AGENCY that are not obligated in the performance of this Contract; and

iv. Ensure the orderly wrap-up of all other administrative aspects of the AGENCY's relationship with the BOARD, which shall require, among other things, ensuring that FOCUS access is terminated for the AGENCY and all AGENCY staff.

C. **Amendment**

1. The BOARD may amend the MCO Policy Manual and initiate and implement Executive Directives and Compliance Alerts from time to time during the term of this Contract and shall give notice of such amendments, Executive Directives, and Compliance Alerts in writing or by positing same on the BOARD or MCCMH website. All such amendments, Executive Directives, and Compliance Alerts shall constitute a part of this Contract and shall be deemed to be incorporated herein.

2. This contract shall be amended to comply with State and Federal statutes and regulations. Any such amendment of the contract must be approved in writing by only the BOARD. Schedules, appendices and attachments to this Contract relevant to State and Federal statutes and regulations can be amended in writing by the BOARD without necessity of AGENCY approval or signature.

3. Anything in this Contract to the contrary notwithstanding, if the funding to the BOARD, in its capacity as the Prepaid Inpatient Health Plan (PIHP), is terminated or materially reduced by State action, then by written notice to the AGENCY the BOARD may terminate payment under this Contract and require that the AGENCY continue to provide all or some designated portion of the Contracted Services in return for payment by the BOARD in its CMHSP capacity, under an alternative reimbursement methodology the financial terms of which shall be dependent upon the funding received by the CMHSP from the State of Michigan directly or through an

intermediary including, but not limited to, a State-contracted health plan.

XI. GENERAL PROVISIONS

A. Governmental Immunity. Nothing in this Contract shall be construed as a waiver of any governmental immunity of the County, the BOARD, its agencies, elected officials or employees, as provided by statute or modified by court decisions.

B. Non-Interference. The AGENCY may freely communicate with individuals served, including advocating on behalf of an individual in any grievance or utilization management procedure, or discussing treatment options with an individual that may not reflect the BOARD's position or be paid for by the BOARD. Furthermore, the AGENCY may at any time advise or advocate on behalf of an individual served for their health status, medical care, or treatment options including medication treatment options; for any information the individual needs to decide among treatment options; for the risks, benefits, and consequences of treatment versus non-treatment; or for the individual's right to participate in decisions regarding his or her health care, including the right to refuse treatment or express preferences about treatment.

C. Governing Law & Venue. This Contract shall be governed by and interpreted in accordance with the laws of the State of Michigan without regard to its principles of conflict of laws. Each provision of this contract shall be interpreted in a way that is valid under applicable law. Any lawsuit arising directly or indirectly out of the contract will be litigated in the Circuit Court for Macomb County, Michigan or, if original jurisdiction can be established, in the United States District Court for the Eastern District of Michigan.

D. Merger Clause. All schedules, appendices and attachments referred to herein are incorporated by reference as though fully set forth herein. All references in the schedules, appendices and attachments to "the Contract" shall be deemed to refer to this Contract. This Contract, including the schedules, appendices and other attachments hereto, and the statutes, regulations, policies, procedures and manuals referenced herein constitutes the entire agreement between the parties and supersedes any and all prior agreements and understandings, oral and written, relating to the subject matter hereof.

E. Amendments. This Contract may be amended only by a written document signed by duly authorized representatives of both parties. Notwithstanding the foregoing, the BOARD retains the right in all cases to unilaterally amend this Contract in the following circumstances:

   i. To the extent such right is expressly reserved in any provision of this Contract, including but not limited to Sections V.B. (with respect to Fee for Service Rates), X.A. (with respect to the term), and X.C. (generally);

   ii. To the extent necessary, as determined in the sole and absolute discretion of the BOARD:

      a. In order for the BOARD to discharge any of its obligations pursuant to

applicable law and/or any of the contracts attached as part of Appendix X; and/or

b. In order for the BOARD to adjust to changes in funding sources or amounts; and/or

iii. In any way with respect to program descriptions and/or requirements, or any other aspect of Attachment "B".

To the extent reasonably practicable, the BOARD will provide the AGENCY with at least thirty (30) days' advance written notice of any unilateral amendment; however, in the event that the BOARD fails to provide such thirty (30) days' advance notice, the amendment will not be ineffective and the AGENCY will not be relieved of the amendment's binding effect.

F. Non-Exclusivity. It is expressly understood and agreed that this Contract is not intended to be exclusive. Either party may enter into agreements with other persons or entities for the provision of services that are the same or similar to those provided under this Contract.

G. Waiver. The failure of either party at any time to require performance by the other party of any provision hereof shall not affect in any way the full right to require such performance at any time thereafter. The waiver by either party of a breach of any provision hereof shall operate as a waiver of the provision itself, nor of any other provision of this Contract, unless each such waiver is made in writing.

H. Remedies. Except as specifically provided in this Contract with respect to dispute resolution, all rights and remedies provided to either party under this Contract are cumulative, are not exclusive, and are in addition to other rights and remedies provided by Law.

I. Severability. If any provision of this Contract is determined by a court of competent jurisdiction to be void or unenforceable to any extent, such part or provision shall be deemed severable and the remaining provisions shall continue in full force and effect, unless severance would materially adversely affect the obligations or rights of a party, in which case the party may terminate this Contract in accordance with Article VIII.

J. No Third-Party Beneficiaries. The BOARD and the AGENCY are the only parties to this Contract. This Contract does not create and shall not be construed to confer any rights or benefits upon any other person as a third-party beneficiary of this Contract. This contract shall inure in all particulars to the benefit of the parties hereto, and to their respective agents, successors, and permitted assigns, to the fullest extent permitted by law.

K. Relationship of the Parties (Independent Contractor). The relationship between the BOARD and the AGENCY is solely that of independent contractors and nothing in this Contract or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency, partnership or joint venture.

L. Assignment and Delegation. The AGENCY cannot assign or delegate this Contract or any right or obligation hereunder without the prior written consent of the BOARD and the COUNTY. Any attempted assignment or delegation without first obtaining such consent shall be deemed void and of no effect. Any such consent given in one instance shall not relieve the AGENCY of its obligation to obtain prior written consent of the BOARD and the COUNTY to any further assignments or delegations.

M. Counterparts. This Contract may be executed in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. A signed copy of this Agreement delivered by facsimile, e-mail or other means of electronic transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this Agreement.

N. Miscellaneous. The headings herein are inserted as a matter of convenience and for reference only and in no way define, limit or describe either the scope of this Contract or the intent of any of the provisions hereof. When required by the context, the singular number used in this Contract includes the plural. The word "including" or "includes" used in this Contract means including without limitation. This Contract is the subject of negotiation and contribution by both parties. No presumption shall exist that either party is the drafter of the Contract, or of any specific language in the Contract, and no presumption shall be permitted against either party if a dispute, disagreement or litigation develops over the intent, terms or language of this Contract.

Signature Page and Contract Review Signature Page follow.
Remainder of this page intentionally blank.

FISCAL YEAR 2019/2021

SIGNATURE PAGE FOR SPECIALTY SERVICES CONTRACT

MACOMB COUNTY COMMUNITY MENTAL HEALTH BOARD **AGENCY: _____**

Signature:	**Signature:**
Print Name:	**Print Name:**
Title:	**Title:**
Date:	**Date:**

COUNTY OF MACOMB
OFFICE OF THE COUNTY EXECUTIVE

Signature:
Print Name:
Title:
Date:

PANELED PROVIDER APPROVED BY THE MACOMB COUNTY MENTAL HEALTH SERVICES BOARD ON: _____

FISCAL YEAR 2019/2021
SIGNATURE PAGE FOR CONTRACT REVIEW

Initial and Date each section.

By initialing and dating each area below, you are agreeing with the language and content for each area.

_____ Specialty Services Contract

_____ Attachment "A" – Provider Profile Application

_____ Attachment "B" – Specialty Services Requirements / Documentation Grid

_____ Attachment "C" – Recipient Rights Protection Requirements

_____ Attachment "D" – Reimbursement Rates

_____ Attachment "E" – Privileging Clinical Staff by License and Payer Coverage

_____ *Attachment "F" – Delegated Functions (Signature Required)

_____ *Attachment "G" – Business Associate Agreement (Signature Required)

_____ *Attachment "H" – Qualified Service Organization Agreement (Signature Required)

_____ Appendix "X" – Incorporate BOARD Contracts

AGENCY: _____

Signature:
Print Name:
Title:
Date:

* If Attachment "F", "G", and/or "H" is a part of this Contract, they will require additional signatures from both the BOARD and the AGENCY.