CLINICAL RESIDENTIAL SERVICE PROVIDER AGREEMENT

BETWEEN

DETROIT WAYNE MENTAL HEALTH AUTHORITY

AND

«Provider_Name»

PROGRAM: Medicaid Healthy Michigan and General Fund Services

October 1, 2018 – September 30, 2019

CLINICAL RESIDENTIAL SERVICE PROVIDER AGREEMENT
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DETROIT WAYNE MENTAL HEALTH AUTHORITY
CLINICAL RESIDENTIAL SERVICE PROVIDER AGREEMENT

This Clinical Service Provider Agreement ("Agreement") is made and entered into **October 1, 2018** (the "Effective Date") by and between the **Detroit Wayne Mental Health Authority** ("Authority"), established and operating pursuant to the Michigan Mental Health Code, Act 258 of 1974, and **«Provider_Name», «Mailing_Address»** ("Service Provider"). The Authority and Service Provider, are each referred to as a "Party" and, collectively referred to as the "Parties".

BACKGROUND

The Authority is responsible for managing network providers of services to Wayne County residents suffering from severe and persistent mental illness, children and youth with serious emotional disturbance, individuals with intellectual or development disabilities or substance use disorders. (Here in after, "Members"), pursuant to its Prepaid Inpatient Health Plan contract, and its Community Mental Health Service Program contract (collectively, the "MDHHS Contracts"), with the Michigan Department of Health and Human Services ("MDHHS"). Service Provider has the capability to provide services to eligible individuals. The Authority Board of Directors approved funding for these services pursuant to Board Action 19-26 at its regular Board Meeting on September 19, 2019. In consideration of the mutual covenants, promises and undertakings herein and intending to be legally bound hereby, the Parties agree as follows:

1. COVERED SERVICES

1.1 Provision of Services. Service Provider shall provide "Covered Services" as further described in the Scope of Services attached hereto as Appendix A, to Members, either directly or through Authority-approved Subcontractors. Service Provider shall ensure timely and geographic access to Covered Services in accordance with Authority standards as provided in the Authority's Provider Manual (available on the Authority's Website, or upon request). Service Provider acknowledges and agrees that this Agreement is only for the provision of Covered Services to Members under the MDHHS Contracts. The Parties acknowledge that Appendix A may be supplemented as MDHHS issues policies, procedures, training and administrative materials. In the event of any inconsistency between the attached Scope of Service and the scope of service as defined by MDHHS Contracts policies and procedures, the MDHHS Contracts policies and procedures shall control.

1.1.1 Practitioners and Health Care Professionals may communicate with Members or their guardians about all treatment options, regardless of benefit coverage limitations which may not reflect the preferences of the Authority.

1.2 Standard of Care. Service Provider and its Subcontractors (as defined below) shall provide Covered Services to Members with at least the same degree of care and skill as customarily provided to recipients of behavioral health services and in accordance with generally accepted community and national standards and the terms of this Agreement. At all times this Agreement is in effect, Service Provider and its Subcontractors shall provide Covered Services in compliance with the Performance Measures, made available on the Authority's Website.

1.3 Person-Centered Planning, Family-Centered Planning, Choice and Self Determination. All Covered Services shall be provided in accordance with Person-Centered Planning practices ('PCP"), or family centered planning practices for children. Service Provider shall promote family support approaches for Members living with their natural family. The Service Provider must also assure that there are choices available to Members for Covered Services. Service Provider shall offer self-determination models for adults. The PCP process shall include both verbal and nonverbal translation of services where needed. Service Provider agrees to implement the PCP process and ensure that all Covered Services provided by the Service Provider or any of its Subcontractors shall be consistent with a PCP process as defined in the Mental Health Code and by the Authority, the MDHHS Behavioral Health and Developmental Disabilities Self-Determination Policy & Practice Guidelines (attached as Attachment P4.7.1/C.3.4.4) to the Authority's MDHHS Contracts, and made available for review on the Authority's Website or upon request, and any guidelines promulgated from time to time. Service Provider shall provide PCP training to its staff and to guardians of Members and other stakeholders. All Covered Services paid for by DWMHA are to be listed in a valid Individual Plan of Service ("IPOS") with amount, scope and duration of the Covered Service.

1.4 Standardized Assessment. Service Provider shall use the standards of assessment and corresponding tools that are approved by the Authority, MDHHS or Centers for Medicaid and Medicare Services ("CMS'). When applicable, Service Provider must enter Assessments of Members into MHWIN in order for any reimbursement for Covered Services rendered to a Member. In some instances, Service Provider will be required to have a staff member trained on assessments to train Service Provider's staff, e.g. CAFAS and PECFAS. Covered Services rendered to Members whose assessment identifies them as being a mild to moderately impaired individual at the time of service are not reimbursable, unless subject to an approved exception by the Authority.

1.5 Eligibility and Coordination of Services and Programs. Where feasible, Service Provider shall work collaboratively with programs serving Members, including but not limited to educational programs (i.e., preschool, school and community education), literacy programs, and health plans, and shall maintain a current list of available programs and community resources, and advise Members as to how to access as necessary.

1.6 Cultural and Linguistic Services. If Service Provider is unable to provide necessary Covered Services, it shall subcontract with and make referrals to providers from different cultural groups so that each Member who needs culturally appropriate Covered Services may receive Covered Services from a provider who shares the Member's cultural background, values and perspective. Service Provider shall provide access to interpreter services for Members to access Covered Services either through telephone language services or interpreters. Service Provider shall additionally participate in Authority and MDHHS efforts to promote the delivery of Covered Services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

1.7 Limited English Proficiency. Service Provider shall comply with the Office of Civil Rights Policy Guidance on the Title VI Prohibition against Discrimination as it affects persons with limited English proficiency, under Title VI of the Civil Rights Act of 1964.

1.8 Approvals. Service Provider agrees, at its sole expense, to be exclusively responsible for obtaining and maintaining throughout the term of this Agreement, any and all licenses, registrations, permits, qualifications, trainings and governmental authorizations necessary to conduct its business and perform all Covered Services required under this Agreement. Service Provider shall make available to Authority, as requested, copies of all such current licenses, permits and certificates.

1.9 Information/Marketing

1.9.1 Service Provider shall provide information to Members on the Your Choice program, managed care provider network options; plan administration, education and training, access to Services, Member rights and responsibilities, and complaint and appeal procedures.

1.9.2 Service Provider shall inform Members of Service Provider services through Authority-approved marketing strategies, which include health seminars, health fairs, community outreach programs, multimedia advertisements, mailers, and billboard advertisements.

1.9.3 Marketing materials must be evenly distributed throughout the service area and must be accurate and appropriate to the Covered Services and meet the cultural and linguistic requirements specified in this Agreement and MDHHS policies and guidelines.

1.10 Administrative and Clinical Personnel. Service Provider shall have sufficient administrative staff and organizational components to comply with the responsibilities reflected in this Agreement. Service Provider warrants that all employees assigned to the performance of Covered Services under this Agreement are qualified and authorized to perform the Covered Services under state and local laws and governing professional association rules. Whenever an employee assigned to this Agreement must be replaced for any reason, Service Provider must supply an acceptable replacement as soon as possible and agrees not to substitute a lower classified employee to perform the Covered Services without obtaining the Authority's prior written approval.

1.11 Member Involvement. Service Provider acknowledges that the Authority promotes Member involvement in all aspects of the Covered Service system. To that end, Service Provider agrees to make efforts to solicit and ensure Members' input and involvement regarding Service Provider, its community and population needs assessment, and service planning activities. Service Provider shall additionally make efforts to provide opportunities for Members to have an active role in the monitoring and evaluation of Services.

1.12 Verification of Member Eligibility/Prior-Authorization. Service Provider shall verify the eligibility and enrollment status of Members prior to providing Covered Services.

1.13 Medicaid Enrollment. Service Providers will prepare and submit information on Members who are on Medicaid, or have a Medicaid deductible (spend down), to DHS workers in order for the Members to maintain their Medicaid status. For Members who were capable of maintaining their Medicaid status but lost it, the Authority will withhold from subsequent claims paid to the Service Provider responsible for assisting the Member, in most instances either their Clinically Responsible Service Provider ("CRSP") or case manager, an amount of 10% for those Covered Services that were paid for with General Fund dollars during the time the Member lacked eligibility for Medicaid payment. Service Provider will be entitled to appeal the withhold under this section, pursuant to the terms of this Agreement.

1.14 Capacity. Service Provider agrees to call the Authority's Access Center when it has reached clinical capacity to accept new referrals. Service Provider will contact Access Center when it can begin accepting new referrals. Service Provider agrees that nothing in this section, or anywhere in this Agreement shall guarantee a number or volume of referrals of Members to Service Provider.

2. SUBCONTRACTING AND COORDINATION OF CARE

2.1 Subcontractors. Service Provider shall not delegate or assign of the rights, obligation or requirements in this Agreement without prior written approval of the Authority. In the event Service Provider contracts with a third parties ("Subcontractors") to ensure that the full array of Covered Services, benefits and/or extended coverage is available to Members, or for the delivery of any administrative/management services related to this Agreement, both of the following must first occur: (a) Service Provider must provide the Authority with a copy of its subcontract for review, and (b) Service Provider must ensure that all provisions of this Agreement containing obligations regarding Subcontractors are included in the subcontract. Such contract shall not relieve the Service Provider of any ultimate responsibility for its obligations hereunder. Service Provider agrees that to the extent the Service Provider does not itself directly provide the Covered Services, its Subcontractors, affiliates or other coordinating entities are capable and competent of providing all Covered Services contemplated hereunder.

Service Provider further agrees that MDHHS is not a party to this Agreement or to any agreement with its Subcontractors, and that the Authority and MDHHS are not a party to any employer/employee relationship with the Service Provider or its Subcontractors. Service Provider shall ensure that all subcontract arrangements specify that neither MDHHS nor the Authority is a party to any subcontract entered into by the Service Provider, and therefore not a party to any employer-employee relationship with any of Service Provider's Subcontractors.

2.2 Subcontractor Payment Arrangements. Service Provider shall comply with state rules and Authority policies for timely claims payment.

2.3 Service Provider and Subcontractor Credentialing. Service Provider shall at all times meet credentialing requirements in accordance with the procedures set forth by the Authority. Service Provider shall ensure that all Subcontractors meet the applicable credentialing requirements and provide related reports as requested by the Authority. To the extent neither prohibited by law nor violative of applicable privilege, Service Provider shall provide notice to Authority of, and shall

provide all information requested by Authority regarding, the nature, circumstances, and disposition of any actions or investigations which in any manner implicate credentials. Such notices shall be provided to the Authority within five (5) business days of the date that Service Provider acquires knowledge of the occurrence of an event requiring notice.

2.4 Coordination and Collaboration. As necessary, Service Provider shall coordinate and cooperate with other Service Providers contracted with the Authority, and other public interest and specialized focus groups, to enhance Covered Services and Member care generally. Service Provider shall also work with community-based organizations to meet the following outcomes for Members in the community: (i) the Member has access to the appropriate level of care; (ii) the Member and their family, when appropriate and authorized, are involved in the planning and provision of services and (iii) the services are individualized to meet each Member's treatment needs while allowing the Member to remain at home or close to home in the least restrictive environment possible. Appropriate releases of information will be completed upon initiation of Service Provider's Covered Services to the Member The provider identified as the CRSP for Covered Services shall ensure the coordination of care occurs between the Member's Primary Care Physician and Medicaid Health Plan. Coordination of care is also required with any other health care providers, agencies, natural or community support as specified in the Member's IPOS.

2.5 Subcontractor Performance Reviews. Service Provider shall conduct Subcontractor performance reviews, at least annually, and shall submit its written findings regarding the performance reviews to each Subcontractor for comment. Subcontractors shall submit correction plans, as necessary. Service Provider shall provide copies of Subcontractor performance reports to the Authority in a format specified by the Authority and MDHHS. Performance reports and any comments shall be maintained in Subcontractor files and made available for inspection by individuals, families, advocates, and the public.

3. RECIPIENT RIGHTS

3.1 Jurisdiction, Compliance and Statement of Policy. Chapters 7 and 7A of the Michigan Mental Health Code, titled "Rights of Recipients of Mental Health Services" provides specific rights to Members as recipients of mental health services. The Authority has established an Office of Recipient Rights ("ORR") to implement, administer and monitor the provisions of Chapter 7 and 7A of the Mental Health Code. Service Provider submits to the jurisdiction of the Authority's Office of Recipient Rights and any appropriate state or federal agency including, but not limited to MDHHS. Service Provider shall adopt and implement all the Authority's ORR policies and procedures, as included in the Authority's Provider Manual, and maintain the confidentiality of information regarding Members, including Protected Health Information ("PHI"), in compliance with Sections 748 and 750 of the Mental Health Code, and other statutes and regulations specified herein.

3.2 Access to Records and Personnel. In accordance with applicable state and federal rules and regulations governing the confidentiality of health information, Service Provider shall permit all requesting organizations with oversight authority relative to the Authority, the Service Provider or any of the Services including, but not limited to the Authority, state and federal agencies, immediate

and complete access to the following as they relate to the Services provided under this Agreement: (a) Member's Service records; (b) Service Provider's program/facility; (c) Service Provider's employees; (d) Service Provider's independent contractors; (e) Subcontractors; (f) Service Provider's financial records; (g) Service Provider's employee personnel, human resource and payroll records; (h) Service Provider's records involving independent contractors (including Subcontractors); (i) all electronically stored information related to the covered Services provided under this Agreement; and (j) other documentation determined necessary by any investigating authority. In furtherance of this, Service Provider acknowledges and agrees that it shall maintain no fewer than two (2) read only system access IDs and/or passwords available at all times for use by the Authority or regulatory agencies for access to Service Provider's records as provide herein and elsewhere within this Agreement.

3.3 Access to Sites. Service Provider shall ensure that the ORR has unimpeded access to each service site as determined by the ORR for the purpose of monitoring compliance with requirements of the Mental Health Code, administrative rules and Authority ORR policies. Service Provider shall further ensure that the identified, certified volunteer monitors of the ORR shall have access to each service site, and to Members and employees according to the policies of the ORR. Additionally, Service Provider shall ensure that, as applicable, the Authority has access, to the extent legally permissible, to both licensed and unlicensed group and individual homes of Members.

3.4 Determinations; Remedial Actions. Service Provider shall abide by determinations made by the ORR, or any, state or federal agency regarding Member rights. Service Provider shall promptly and diligently implement any corrective action requirements determined or approved by the Authority, state or federal agencies. Service Provider shall promptly implement any remedial action required by the Authority to correct and prevent recurrence of Member rights violations, including immediate removal of a Member from a program or Service Provider's care.

3.5 Service Provider Actions; Notices. Service Provider shall adhere to all applicable rules, policies and procedures of the ORR. Service Provider shall, at each service site:

3.5.1 Post in a conspicuous place a summary of all Member or Recipient rights guaranteed by the Mental Health Code;

3.5.2 Provide unrestricted access to Rights Complaint forms and Your Rights booklets to Members and others;

3.5.3 Post in a conspicuous place the MDHHS/ORR Reporting Requirements poster for staff;

3.5.4 Have the Mental Health Code and Administrative Rules of the Michigan Department of Human Services available for review by Members and others;

3.5.5 Post the Whistle Blower Act poster developed pursuant to Public Act 469 of 1980 in a conspicuous place for staff inspection;

3.5.6 Have readily available all applicable MDHHS policies, including those set forth in the MDHHS contracts with the Authority;

3.5.7 Post in a conspicuous place instructions on how to contact/access Authority Recipient Rights staff for Members and staff;

3.5.8 Post in a conspicuous place Abuse/Neglect Reporting Summary posters, and

3.5.9 Post in a conspicuous place Federal Medicaid Fair Hearing posters and provide for unrestricted access to corresponding brochures.

3.6 Notification and Reports.

3.6.1 Service Provider, its affiliates, and any Subcontractors servicing this Agreement shall notify all applicable state and federal agencies and accrediting organizations, as required by law or any Authority policies or guidelines under this Agreement, regarding any alleged or suspected abuse or neglect of any Member receiving any Services under this Agreement.

3.6.2 Without limiting Section 3.6.1, Service Provider shall immediately notify the Authority's ORR regarding any suspected or alleged abuse, neglect, or any other Member or Recipient Rights violation. Service Provider agrees to immediately report, by telephone, to the Authority's ORR (888-339-5595 Hotline) any abuse, neglect, serious injury, death, or unexpected absence of any Members. Within twenty-four (24) hours after any verbal or telephone report, or any other unusual incident specified by the ORR, Service Provider shall submit a written report to the Authority on such forms and in such format and detail as the Authority may require.

3.6.3 Service Provider shall comply with pertinent rules and regulations issued by the MDHHS for children and adults, including the reporting requirements for suspected abuse and/or neglect, assault, and other suspected misconduct as required by law, and shall adhere to the current agreement between the Authority and MDHHS.

3.6.4 Service Provider shall complete and submit all data and information requested by the Authority's ORR.

3.7 Training. Service Provider shall ensure all new Service Provider employees, Subcontractors, agents, and volunteers receive the Authority's New Employee Recipient Rights Orientation training within thirty (30) days of hire. If the newly hired employee has received the New Employee Recipient Rights Orientation training from the Authority or a reciprocal entity within three years prior to the date of hire, Service Provider shall provide documentation to the Authority's ORR. Failure to comply with this provision of the Agreement shall permit the Authority in addition to any sanctions available to it under Sections 12 and 15, impose the sanctions below:

3.7.1 Charge Service Provider a fee in an amount not less than $50.00 to cover the Authority's cost of providing training to Service Provider's employees, Subcontractors, agents, and

volunteers who receive training more than thirty (30) days after hire. Said fee may be deducted from payments otherwise owed to Service Provider; and/or

3.7.2 Prohibit the submission of encounters and/or claims for Covered Services provided by employees, Subcontractors, agents, or volunteers who have not received training within thirty (30) days of hire (with any Covered Services already inadvertently paid for being disallowed and recouped by the Authority).

3.8 No Retaliation. Service Provider shall not retaliate in any manner against its employees, Subcontractors, the Authority's Recipient Rights staff, Members, or any other person for any actions pertaining to the notification, reporting, or filing of required written reports, the investigation of, or the cooperation in an investigation of alleged or suspected Recipient Rights violations.

3.9 Dispute Resolution for Member Issues. Service Provider agrees to comply with all applicable Authority, state and federal guidelines, policies and laws regarding Member complaints, grievances, reconsiderations and appeals involving the Covered Services provided by Service Provider or its Subcontractors. Without limitation, such guidelines, policies and laws include the guidelines set forth in MDHHS: (a) Grievance and Appeal Technical Requirement (Attachment P.6.3.1.1, and (b) CMHSP Local Dispute Resolution Process (Attachment C6.3.2.1); both of which shall be made available on the Authority's Website. Additionally, Service Provider agrees to comply with the Authority's policies on dispute resolution grievance and appeals technical requirements (as provided in the Authority's Provider Manual); Medicaid Fair Hearing and appeals rights and procedures; Recipient Rights; rights to a second opinion; mediation; local/informal and alternate dispute resolution processes; rights to a review of an individual's treatment plan; and rights to request an independent plan facilitator. Service Provider shall report all Member grievances and appeals to the Authority on a monthly basis including date of initial grievance, date of resolution and a description of the resolution.

3.10 Advance Directives. Service Provider shall maintain written policies and procedures that meet the requirements for advance directives under 42 CFR Section 422.128 and 42 CFR Part 489, Subpart I. Service Provider shall inform and distribute written information to each Member regarding advance directives, including a description of (i) Member's rights to execute an advance written directive to physicians; (ii) Member's right to execute a durable power of attorney for health care; and (iii) Member's right to appoint an agent to make medical treatment decisions on his or her behalf.

3.11 Sanctions. In addition to the Authority's rights to impose sanctions under Sections 12 and 15 of this Agreement, the Authority shall have the broadest possible rights to monitor and take immediate remedial action in the event of breach of the provisions of Sections 3.1 through 3.10 including, but not limited to, the following: (i) any impediment to Member's access to the complaint and appeals procedures; (ii) any impediment to monitoring or investigation by rights officers employed by the Authority, or (iii) any harassment of, or retaliation against, any individual seeking to report, pursue or investigate a rights violation. The Authority shall take prompt action against Service Provider in the event of any such violation, including, without limitation:

3.11.1 Removal of Members from a service site or stopping of further Member referrals to the Service Provider as applicable;

3.11.2 Removal of Service Provider as a choice to Members;

3.11.3 Withholding all or a portion of Authority's payments to Service Provider;

3.11.4 Assessing monetary sanctions reflecting the severity of the violation;

3.11.5 Appointment of a receiver for Service Provider, and/or

3.11.6 Termination of this Agreement.

4. INFORMATION SYSTEMS, DATA, AND REPORTING

4.1 Information System.

4.1.1 System Components. Service Provider represents and warrants that at all times during the term of this Agreement it shall have in place an information system and related support staff and practices (collectively, the "IS") that are compatible with the Authority's MH-WIN System, and capable of performing the IS functions necessary to support the Covered Services provided under this Agreement, including but not limited to all functions set forth in the Authority's Provider Manual (available on the Authority's Website) and the following functions: (a) Monthly downloads of Medicaid eligible information, (b) Member registration and demographic information, (c) Service Provider enrollment, (d) Third party liability activity, (e) Claims payment system and tracking, (f) Grievance and complaint tracking, (g) Tracking and analyzing services and costs by population group, and special needs categories, as specified by MDHHS, (h) Encounter and or claims and demographic data reporting, (i) Quality indicator reporting, (j) HIPAA compliance, (k) Uniform Bill Project ("UBP") compliance, and (l) User access and satisfaction.

4.1.2 Service Provider's IS functions shall comply with all applicable laws, including but not limited to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") including HITECH revisions, shall allow accurate and timely reporting by the Service Provider of all data the Service Provider is obligated to report under this Agreement, and ensures compliance with all applicable laws and MDHHS and Authority policies and guidelines on confidentiality of data, as further described in Sections 4 and 8.

4.1.3 To the extent the Service Provider provides any of the Covered Services through Subcontractor agencies, it shall ensure that the Service Provider's IS and information exchange procedures with the Subcontractor agencies are capable of ensuring that all data required to be collected, maintained or reported by the Service Provider hereunder is provided by the Subcontractor to the Service Provider.

4.2 Reports. Service Provider shall submit data on an ongoing and regular basis in a format approved by the Authority to confirm Service Provider and Subcontractor compliance with Authority requirements. Service Provider shall provide summary reports on a timely basis. Failure to submit reports on a timely basis shall result in financial penalties as provided in Section 15. Service Provider agrees to provide the financial reports described in Section 5 below and/or in Appendix B, which must be prepared, as applicable, on the full accrual basis of accounting, according to Generally Accepted Accounting Principles. Service Provider shall submit additional reports as indicated in the Service Provider Reporting Grid, made available on the Authority's Website, as it may be amended from time to time by the Authority, and as may be required by the MDHHS Contracts (such reporting requirements are contained in Attachment P.7.7.1.1 and C.6.5.1.1, made available on the Authority's Document Website). In the event that reporting requirements are revised to reflect Authority policy and/or system modifications or amendments, and/or amendments to the MDHHS Contracts or applicable state funding models, the Authority shall, upon request, provide direction, guidance, and technical assistance to the Service Provider. Communication to the Service Provider regarding revisions shall be provided in the form of Authority bulletins, memoranda, and/or policies.

4.3 Data and Records Ownership. The Authority shall be and remain the sole and exclusive owner of any and all data (the "Authority's Data") pertaining to the operation of Service Provider. The Authority's Data includes all data entered into Service Provider's management information system ("MIS System"), including without limitation, all Covered Services and Member information, authorizations, eligibility data, claims reports, utilization reports, and any information from the Authority's present data processing and information system which shall be transferred and converted to operate on Service Provider's IS System. Service Provider shall notify the Authority and get permission in writing from the Authority's President & Chief Executive Officer ("CEO") before using any of the Authority's Data for any purpose other than to perform its obligations under this Agreement. Neither Service Provider nor any of its employees, agents, consultants, or assigns shall have any rights in any of the Authority's Data in any form including, but not limited to, raw data, stripped data, cumulated data, usage information, and statistical information derived from or in connection with the Authority's Data. The Parties agree that Service Provider shall promptly download for and provide to the Authority, at no cost to the Authority, all such Authority's Data in an electronically accessible form upon the termination of this Agreement. This provision shall survive the term or termination of this Agreement. Both parties recognize that they will be subject to HIPAA, including HITECH revisions, as provided in the Business Associate Agreement attached hereto as Appendix D. 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 time execution of necessary agreements.

4.4 Security. Service Provider shall implement tools to prevent unauthorized access and virus protection to its IS using planning, management, and system monitoring techniques. To ensure system security, Service Provider shall perform a HIPAA Security Audit of its internal data and access systems, once every two years. The Authority reserves the right to require review by a Third Party if the results are deemed unsatisfactory.

4.5 Remote Access. Service Provider shall maintain, no fewer than two (2) system access IDs and/or passwords available at all time for use by regulatory agencies, including the Authority, for read only access to Service Provider records as provided herein and elsewhere within this Agreement. Service Providers may be sanctioned monetarily for failing to provide this access as provided in Section 15 of this Agreement. In the event this Agreement is terminated, or not renewed, the Authority shall still have access to the system during the closeout process outlined in this Agreement.

5. FINANCIAL MANAGEMENT

5.1 Financial Management. Service Provider shall have in place at all times:

5.1.1 Fiscal policies, procedures and an IS that are consistent with appropriate accounting standards, including Generally Accepted Accounting Principles (GAAP), applicable to business enterprises and not-for-profit organizations as promulgated by the Financial Accounting Standards Board ("FASB") and the American Institute of Certified Public Accountants ("AICPA"), that require all financial reports be prepared using the full accrual basis of accounting according to GAAP and that meet applicable federal, and state statutory requirements and guidelines and the requirements of this Agreement;

5.1.2 A fiscal management system that assures that the Service Provider has the capacity to meet the financial and risk related requirements of this Agreement, including fiscal integrity, cost containment, timeliness of reporting, and fiscal monitoring and that requires the implementation of policies and procedures establishing internal controls and promoting the safeguarding of assets, and that provides accurate, current and complete disclosure of the financial status of the activity, including, but not limited to, generating regular financial status reports which indicate the dollar amount allocated for each activity (including any budget revisions), amount obligated, and the amount expended for each activity, and

5.2 Fiscal Integrity. The Service Provider agrees that at all times during the term of the Agreement it shall employ such day-to-day fiscal and management practices that ensure the fiscal stability and viability of the Service Provider, and shall meet such criteria as the Authority may reasonably determine from time to time. Such criteria may include:

a) Positive cash flow requirements;

b) Adequate ratio of current assets to current liabilities;

c) Access to lines of credit;

d) Adequate working capital;

e) Reserve funds in amounts reasonably determined by the Authority;

f) Commitment and ability to use data to manage utilization and enhance alternative funding;

g) Appropriate size and stability of budget, as reasonably determined by the Authority;

h) Appropriate diversity in revenues and funding sources, as reasonably determined by the Authority;

i) Appropriate budget development practices, as reasonably determined by the Authority;

j) Appropriate cost accounting practices, and

k) Appropriate contract management practices as reasonably determined by the Authority.

5.3 Audits. The Authority or any other applicable funding source (including, but not limited to CMS and MDHHS, may audit all books, records and operations of the Service Provider, its Subcontractors, and any other third party, related to its/their provision of the Covered Services. Service Provider agrees to and shall require its Subcontractors and any third party to cooperate with any such audit, including provision of all relevant books, records, electronically stored information and other information. Service Provider shall ensure that all files are available for review during these onsite visits and that all personnel responsible for this Agreement meet with the Authority'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 Service Provider's financial reporting and business activity. Consistent failure to meet these requirements will lead to sanctions as provided in this Agreement.

5.4 Independent Audit. Service Provider, shall at its sole expense, obtain an annual, independent financial audit by a certified public accountant acceptable to the Authority, or its designee. Additionally, Service Provider shall ensure annual independent financial audits by a certified public accountant acceptable to the Authority or their designee of all Subcontractors that receive more than $750,000.00 annually for Covered Services. Such audits of the Service Provider and its Subcontractors shall be made available to the Authority within one hundred twenty (120) days following the end of each fiscal year.

5.5 Non-Financial Reviews. The Authority, its delegated agents, MDHHS, CMS, and other state and federal agencies may conduct reviews and audits of the Service Provider regarding performance under this Agreement. These reviews and audits will focus on Service Provider's compliance with state and federal laws, rules, regulations, policies, and waiver provisions, in addition to contract provisions of this Agreement and/or with Authority policy and procedure. The Authority shall make good faith efforts to coordinate reviews and audits to minimize duplication of effort by the Service Provider, MDHHS, CMS, and/or any independent auditors conducting audits and compliance examinations.

6. SERVICE PROVIDER COMPENSATION AND BILLING

6.1 Payment. Subject to the provisions of Section 6.2, Authority shall pay Service Provider for Covered Services to Members in accordance with the payment methodology set forth in Appendix B.

Service Provider shall accept compensation in accordance with the payment terms of Appendix B as payment in full for Covered Services, and shall make no additional charge to Members for such Covered Services, except as provided in Sections 6.4 through 6.6. Service Provider shall notify Authority of any overpayments or payments made in error within thirty (30) business days of becoming aware of such overpayments or erroneous payments, and Service Provider shall return any such overpayment or payment made in error to the Authority.

6.2 Reduction in Authority Funding. This Agreement is, in all instances, contingent upon the continued availability of funding for Services derived from the MDHHS/PIHP Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s), the Healthy Michigan Program and/or the MDHHS/CMHSP Managed Mental Health Supports and Services and Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program, the MDHHS Contracts, or any grants or other arrangements between the Authority and MDHHS. In the event of a reduction in Authority funding from any source that, in the Authority's sole judgment, adversely impacts its ability to compensate Service Provider for Covered Services as provided herein, the Parties will have the lesser of thirty (30) days or the notice period afforded Authority regarding such reductions to discuss corresponding reductions in Covered Services reimbursement. If the Parties are unable to mutually agree upon such Covered Service reimbursement reduction by the end of the notice period, the reduced payments shall take effect, and the Service Provider may terminate the Agreement, without incurring any further liability, as described in Section 12.3.

6.3 Encounter and/or Claims Data and Authority Invoicing. Service Provider acknowledges that funds received shall not be used for any purposes other than the delivery of Covered Services and administrative work in connection herewith. Unless otherwise directed by the Authority, Service Provider shall deliver encounter and/or claims data regarding Services rendered to the Authority on a weekly basis. Additionally, Service Provider shall provide and/or confirm existing claims processing data in order to allow the Authority to accurately compensate Service Provide in accordance with the payment methodology set forth in Appendix B. Upon request, the Authority shall provide direction, guidance, and technical assistance to the Service Provider regarding the proper Authority procedures for provision of encounter and/or claims data and invoicing as outlined in Appendix E.

6.4 Billing of Members. Under certain programs, Members may be required to pay Copayments, Coinsurance or Deductibles for certain Covered Services. Service Provider shall collect any applicable Copayments, Coinsurance and Deductibles from Members. Copayments shall be collected at the time that Covered Services are rendered. Except for applicable Copayments, Coinsurance and Deductibles, Service Provider may bill Members only in the following circumstances. Subject to Authority's rules, policies and procedures, services that are not Covered Services may be billed to Members by Service Provider only if: (a) the Authority confirms that the services are not covered; (b) the Members were advised prior to the services being rendered that the specific services are not Covered Services; (c) the Members agreed in writing to pay for such services, and (d) such services are pre-approved by the Authority as services that may be delivered to Members. Nothing in this section is intended to prohibit or restrict Service Provider from billing individuals who were not Members at the time that services were rendered. Nothing in this section shall prohibit Practitioners and Health Care Professionals from freely communicating with

Members or guardians about all treatment options, regardless of benefit coverage limitations, which may not reflect the preferences of the Authority.

6.5 Coordination of Benefits. With respect to all payments from the Authority and funding available through other programs, as further addressed in Section 6.7, the Service Provider shall coordinate benefits, including coordination with primary health care providers, and shall make ability to pay determinations and billing determinations as to first and third parties. The Service Provider shall ensure that payments from the Authority are payments of last resort and that the best use of community resources and supports are explored for each Member receiving services. If at any time it is determined, after Covered Services claims reimbursement to Service Provider has been made by Authority, that Service Provider received monies directly for the Covered Services from another funding source or from another party that provides for, reimburses, offsets, or otherwise covers payment retroactively, currently, or subsequently for such Covered Services, Service Provider shall refund to Authority an amount equal to the sums reimbursed by third party payors and/or paid by any other source. Service Provider shall notify Authority immediately of any such payments. Alternatively, the Authority may, upon notice to Service Provider, withhold from future payments due to Service Provider those funds which should be refunded to the Authority. The inability to submit claims and be reimbursed by first and third party payors is not justification for reimbursement of Covered Services by the Authority and those claims will be denied.

6.6 Holding Members Harmless. Service Provider hereby agrees that in no event including, but not limited to, non-payment by the Authority or breach of this Agreement, shall Service Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against Members or persons acting on their behalf (other than the Authority) for Covered Services, except as otherwise permitted by law. This provision shall not prohibit collection of Copayments, Coinsurance, Deductibles, and non-Covered Services. Service Provider further agrees that: (a) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members, and (b) this provision supersedes any contrary verbal or written agreement now existing or hereafter entered into between Service Provider and Members or persons acting on their behalf.

6.7 Additional Funds. Service Provider agrees to use its best efforts to solicit, qualify for, secure and/or receive any and all federal, state, local or private benefits, entitlements of any kind, and any other available funding amounts for any Members served by the Service Provider under this Agreement. To the extent that the Authority requests Service Provider and/or Subcontractor cooperation and compliance with MDHHS and other funding source programs that may increase Authority funding for Covered Services, the Parties agree to cooperate in good faith attempts to implement such additional funding programs.

6.8 Service Provider Loans, Fund Transfers, Liens and Encumbrances Prohibited. Service Provider shall not lend, transfer, create or permit to be created, a lien or encumbrance, or grant a security interest in, or with respect to any funds provided in whole or in part by the Authority, to any third party for any purpose without the express written consent of the Authority.

7. COMPLIANCE AND RELATED MATTERS

7.1 Compliance Responsibilities. Service Provider warrants that it, its Subcontractors, employees, agents, and volunteers, and the Covered Services provided under this Agreement, shall be consistent with:

7.1.1 Applicable law, including, but not limited to the federal and state false claims acts, Medicare, Medicaid, federal and state anti-kickback laws and the Stark laws;

7.1.2 All pertinent policies of accrediting agencies that accredit Service Provider;

7.1.3 Requirements of third-party payers responsible for payment of Covered Services to Members;

7.1.4 The applicable clinical standard of practice for clinical staff, including the principles and professional ethical requirements applicable to the profession of each staff member assigned to perform Covered Services, and

7.1.5 All applicable written policies and protocols of Service Provider (including medical staff bylaws and rules, as applicable) regarding the performance of Covered Services.

7.2 Compliance Plan. Service Provider shall develop, implement and monitor a compliance plan that is approved by the Authority, and incorporates the Authority's Compliance Plan (available on the Authority's Website or upon request).

7.3 Applicable Laws. This Agreement is governed by the Mental Health Code and performed in accordance with all applicable local, state and federal laws. This includes laws and regulations regarding human subjects' research and data projections set forth in 45 CFR and HIPAA. Service Provider and its Subcontractor shall comply with all applicable federal, state, and local laws and all applicable state, and Authority rules, administrative directives, guidelines, procedures and/or policies, as promulgated and as updated or amended from time to time. Applicable laws, include, but are not limited to Chapter III of the MDHHS Medical Services Administrative Policy Manual for Specialty PIHPs; and CMS, Title VI and VII of the Civil Rights (42 U.S.C.S. 2000d), and the United States Department of Justice Regulations (28 C.F.R. Part 42) issued pursuant to those Titles; the Age Discrimination Act of 1985 (42 U.S.C. 6101-07); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794); the Americans with Disabilities Act (42 U.S.C. 12101 et seq.) and its associated regulations; the Michigan Civil Rights Act (P.A. 1976 No. 453) and the Persons with Disabilities Civil Rights Act (P.A. No. 220 of 1976); the Anti-Lobbying Act, 31 USC 1352 as revised by the Lobbying Disclosure Act of 1995; 2 USC 1601 et seq.; Section 503 of the Departments of Labor, Health and Human Services and Education, and Related Agencies Appropriations Act (Public Law 104-208); and rules delineated in 67 Federal Register 40989 et seq. dated June 14, 2002. Service Provider agrees to abide by all requirements of the current MDHHS Contracts. Further, specified applicable laws may be incorporated into this Agreement by notice, mailing, or sending of specified substitute pages of the Agreement to better comply with law or statute.

7.4 Non-Discrimination. Service Provider shall not discriminate against any employee, applicant for employment, Member or other person, or any applicant for Services, with respect to hiring, tenure,

terms, conditions or privileges of employment, programs or Services provided, or any matter directly, or indirectly related to employment, Services, or Service delivery and access, due to a person's race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, or physical or mental disability unrelated to the individual's ability to perform the duties of the particular job or position, in accordance with the Elliott-Larsen Civil Rights Act, Public Act 453 of 1976, as amended, (MCL 37.2101 et seq.), the Michigan Handicappers' Civil Rights Act, Public Act 220 of 1976, as amended, (MCL 37.2201 et seq.), and the Persons with Disabilities Civil Rights Act, 1976 PA 220, as amended, MCL 37.1101 et seq., and Sections 504 of the Federal Rehabilitation Act 1973, PL 93-112, 87 Stat. 394, any other federal, state or local law forbidding discrimination against any individual in employment, public accommodation, housing, or the receipt of public services. Any breach of this provision shall be regarded as a material breach of this Agreement**.**

7.5 No Inducements. Subject to any applicable federal, state, or local laws or ordinances relating to any conflict of interests for public employees, Service Provider shall not grant, give, allow, pay, reimburse, compensate, or otherwise provide any benefits, privileges, gifts, equipment, personal property, supplies, entitlement, consideration (monetary or otherwise) or give or loan any other thing of value, either directly or indirectly, to, for the use by, or on behalf of, any individual or group of persons included within the definition of Authority agents, except as expressly provided in this Agreement. This Agreement is subject to any policy adopted by the Authority on inducements, and conflicts of interest.

7.6 Conflicts of Interest. Service Provider shall not knowingly hire, employ, become associated with, or enter into any contract for any work or service with any Authority agent. Service Provider shall comply with all applicable state statutes, including but not limited to Public Act 317 of 1968, as amended, MCL 15.321, et seq., and Authority policies regarding contracts with public employee(s), public employee conflicts of interest, or public employee ethics. Service Provider shall accurately disclose conflicts, prior to contracting, consistent with the Authority's Ethics in Contracting Policy. To avoid any real or perceived conflict of interest, Service Provider shall identify any Service Provider employee or director or any relative of any Service Provider employee or director employed by the Authority. Further, Service Provider shall disclose ownership and governance board information, as required in Section 7.7.

7.7 Identification of Governance/Ownership. Members of the Service Provider's governing board shall not be owners, governing board members, or employees of any Subcontractor, with the exception of Member peers. Service Provider shall inform the Authority immediately of any change in its governance board members. In accordance with 42 CFR Part 455 Subpart B and the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s) Agreement, the Authority must collect specific information on "owners, agents, board of directors and managing employees for all providers within its network". Accordingly, Service Provider shall complete the Authority's Disclosure Statement for the Authority to maintain on file regarding this Agreement and any other agreements for Medicaid services between the Authority and Service Provider. Service Provider shall update this form within thirty-five (35) days of any change in ownership, and within thirty-five (35) days of any request for such information by the Authority, MDHHS, CMS, or any regulatory agency. Further, Service Provider shall provide the Authority with notice of any change in ownership of five percent (5%) or greater within seven (7) days of such change becoming effective. In the event that any change in ownership results in a change in Service Provider's

majority ownership, the Authority shall have the right, in its sole discretion, to terminate this Agreement for cause as provided in Section 12.5.

7.8 Medicare and Medicaid Participation. Service Provider represents and warrants that neither it nor any affiliate (i.e., any entity that Service Provider holds at least twenty-five percent ownership or control of), nor to the best of its knowledge after due inquiry and investigation, has Service Provider, its employees, or Subcontractors, or their respective majority-owned or controlled affiliates, been (i) excluded, debarred, or suspended from participation in any program under Title XVIII or Title XIX under any of the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. Section 1320 a-7) (ii) have not within a three-year (3) period preceding this Agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (iii) are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state or local) with commission of any of the offenses enumerated in (ii) above; and (iv) have not within a three-year (3) period preceding this Agreement had one or more public transactions (federal, state or local) terminated for cause or default. Service Provider agrees that it shall notify the Authority within three (3) days of the date it receives notice that any action is being taken against the Service Provider or any persons defined under the provisions of Section 1128(a) or (b), or against any Subcontractor, which could result in exclusion, debarment, or suspension from the Medicare or Medicaid programs, or any other governmental health care program. Service Provider shall develop, maintain and follow procedures for identifying excluded providers and terminating their ability to deliver Covered Services in a timely manner. Service Provider shall execute a Debarment and Suspension Agreement and Certification (attached hereto as Appendix C), and shall ensure that its Subcontractors providing Covered Services hereunder complete the same form(s), and shall execute and deliver such forms as Authority requires confirming the Service Provider representations and warranties.

7.9 Public Notice. Service Provider must publicly post, including via website notification, and update no less frequently than annually, information regarding the make-up of its governing board. Additionally, Service Provider must publicly post, including via website notification, and update no less frequently than annually, its IRS Form 990 (where applicable), and information regarding the salaries, including any bonuses, of its executive administrative staff.

7.10 Fraud, Waste, and Abuse. Authority has responsibility and authority to make fraud and/or abuse referrals to the Office of the Michigan Attorney General, Health Care Fraud Division, the Office of Inspector General ("OIG"), and MDHHS. If Service Provider has any suspicion or knowledge of fraud and/or abuse within any of the Authority's programs, including within Service Provider or any of its Subcontractors, Service Provider must report directly to the Authority by contacting the Authority's Compliance Officer at (313) 344-9099. Service Provider shall not attempt to investigate (beyond an initial basic internal inquiry) or resolve the reported alleged fraud and/or abuse without first contacting the Authority. Any unreasonable delay in reporting known or suspected fraud or abuse to the Authority, shall be considered a material default of this Agreement, which may result in sanctions up to and including termination of this Agreement, at the Authority's sole discretion.

Service Provider shall ensure that its Subcontractors reasonably cooperate and assist the Authority and any state or federal authority charged with identifying, investigating, sanctioning or prosecuting suspected fraud and abuse, ensuring Members' rights, or any other oversight of the Services in this Agreement.

7.11 Holder of Record. The Authority shall delegate to the Service Provider a mutually agreeable, limited authority as holder of the record, as recognized in this Agreement, to allow the Service Provider to comply with and fulfill the requirements of the Mental Health Code. Notwithstanding the above, the Service Provider shall recognize the Authority under Michigan law, as the holder of the record for any and all Member records relative to this Agreement and maintained by the Service Provider. Unless and then only to the extent expressly prohibited by federal or state law, Service Provider agrees that the Authority and its authorized agents shall have complete access to, and at the Authority's option, the right to obtain copies of all personnel, clinical, medical, treatment or finance records held by the Service Provider. The Authority may at its option determine whether the Authority will be the holder of the record under federal law, after a specific determination of the facts.

7.12 Notices and Reporting. To the extent neither prohibited by law nor violative of applicable privilege, Service Provider shall provide notice to the Authority within ten (10) business days of the date that Service Provider acquires knowledge of the occurrence of an event requiring notice, or earlier if otherwise required by this Agreement, and shall provide all information requested by Authority regarding the nature, circumstances, and disposition of:

7.12.1 Any litigation brought against Service Provider or any of its employees or Subcontractors which is related to the provision of Covered Services to Members;

7.12.2 Any action taken or investigation initiated by any accrediting body or any government agency or program against or involving Service Provider or any of its employees or Subcontractors, that does or could adversely affect Service Provider or Subcontractor accreditation status, licensure, or certification to participate in the Medicare, Medicaid of federal payor programs; and

7.12.3 Any material change in services provided by Service Provider or licensure status related to services that affect the Service Provider's ability to provide Covered Services.

All such notices shall be provided to Authority within ten (10) business days of the date that Service Provider acquires knowledge of the occurrence of an event requiring notice, or earlier if otherwise required by this Agreement. However, the Service Provider must immediately inform the Authority of material changes in its operation, ownership or financial condition. Material changes include, but are not limited to:

A. Reduction or change in staffing assigned to the Agreement;

B. Decrease in, or cancellation of, insurance coverage;

C. Delinquent payment, or nonpayment, of tax obligations;

D. Delinquent payment, or nonpayment, of payroll obligations;

E. Delinquent funding, or non-funding, of pension or profit sharing plans;

F. Delinquent payment, or nonpayment, of subcontractors;

G. Termination of, or changes in, subcontracts;

H. Transfer, sell, assignment or delegation to an entity other than the Service Provider, of ownership or administrative services; or

I. Delinquent payment or non-payment of loan and or note payable obligations and/or material violation of debt covenants.

7.13 Consent for Treatment. Service Provider shall comply with all federal and state statutory and regulatory requirements regarding consent to treatment. Service Provider shall maintain written consent forms and upon request from the Authority make them available on a timely basis. In this regard, Service Provider shall cooperate with the Authority and MDHHS as necessary in the development and implementation of the state Standard Form Consent for Sharing Your Health Information (DCH-3927), available at http://www.michigan.gov/mdch/0,4612,7-132-2941_58005_70642---,00.html ("Standard Release Form"). For all non-electronic Health Information Exchange environments, Service Provider shall use, accept, and honor the Standard Release Form.

7.14 Criminal Background Check. Service Provider and all Subcontractors providing Covered Services in this Agreement, shall have effective methodologies to perform initial criminal background checks on potential employees in order to avoid employment of those who do not pass such background check in accordance with federal, state laws, and Authority rules and policies. Service Provider and all Subcontractors shall perform annual criminal background checks on employees providing Covered Services pursuant to this Agreement.

7.15 Pro-Children Act. Assurance is hereby given to the Authority that the Service Provider will comply with Public Law 103-227, also known as the Pro-Children Act of 1994, 20 USC 6081 et seq., which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by the Service Provider 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. Service Provider also agrees that this language will be included in any contracts with Subcontractors that contain provisions for children's services.

7.16 Ethics in Contracting. Service Provider will comply with the Authority's Procurement Ethics Policy (available on the Authority's Website or upon request), and shall execute an Ethics in Contracting Form, attached hereto as Appendix F.

7.17 Sanctions for Violation. A failure by Service Provider, or any of its Subcontractors, to comply with any of the laws or other requirements detailed in this Section 7, shall be considered a material default of this Agreement and shall permit the Authority, in addition to other sanctions which may be imposed under Section 15 hereof, to terminate this Agreement for cause, pursuant to Section 12.4.

7.18 Clean Air Act and Federal Water Pollution Control Act. If this Agreement is in excess of $100,000.00, Service Provider shall comply with all standards, orders and regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401 et seq.), and the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.), as amended. Service Provider shall require its Subcontractors performing Services in excess of $100,000.00 pursuant to this Agreement to comply with the requirements of this provision. Violations shall be promptly reported to the Authority and the Regional Office of the Environmental Protection Agency (EPA).

7.19 Anti-Lobbying Act. Service Provider shall comply with the Anti-Lobbying Act, 31, USC 1352 as revised by the Lobbying Disclosure Act of 1995, 2 USC 1601 et seq., and Section 503 of the Departments of Labor, Health and Human Services and Education, and Related Agencies Appropriations Act (Public Law 104-208), with respect to any federal funds received or utilized pursuant to this Agreement. Additionally, Service Provider shall ensure that it includes this provision in all subcontracts for Services under this Agreement, and that if applicable, its Subcontractors include this provision in all sub-awards.

7.20 Section 1915 and Other Waivers. The Service Provider agrees that it shall, and shall ensure its Subcontractors shall, at all times this Agreement is in effect, meet all requirements, terms and conditions for participation in the program (and any successor or additional related programs developed by MDHHS or CMS and communicated by Authority to Service Provider).

8. CONFIDENTIAL INFORMATION

8.1 Confidential Information. Each Party and its affiliates shall, and shall cause its respective officers, trustees, employees, agents, consultants and representatives (the officers, trustees, employees, agents, consultants and representatives of a Party and its affiliates are referred to collectively herein as "Representatives") to keep confidential and not disclose or release to any person or entity, any proprietary or other sensitive information, documents, agreements, reports, work product or other data disclosed to such Party by the other Party or its affiliates in connection with this Agreement, or the actions of the Parties in furtherance thereof, including any discussions or negotiations of the Parties (all of the foregoing is hereinafter referred to collectively as "Confidential Information"), other than to: (i) those of its Representatives working on or otherwise having a need to know about such services, or (ii) to other appropriate persons legally or practically necessary in order to obtain consents or approvals or otherwise necessary to provide the Covered Services contemplated under this Agreement. As used herein, "Confidential Information" shall not include information that: (i) is or becomes generally available to the public other than as a result of a voluntary disclosure or release by a recipient Party or its Representatives, or (ii) was available to a recipient Party on a non-confidential basis prior to the disclosure in connection with the transactions contemplated hereby, or (iii) is lawfully obtained by the recipient Party from a third party under no duty of confidentiality to the disclosing Party, or is otherwise disclosable to the

public under the State or Federal Freedom of Information Acts, or under the Open Meetings Act. "Affiliate of a Party," for purposes of this Section, shall mean an entity controlling, controlled by or under common control with a Party. Each Party and its affiliates will take all necessary steps to inform each of its Representatives of, and to cause each of its Representatives to comply with, the obligations set forth herein. Confidential Information shall be utilized solely for purposes of negotiating this Agreement or providing the Covered Services contemplated under this Agreement.

8.2 Remedies. The Parties agree that any breach of the confidentiality obligations of this Agreement may result in irreparable damage to the disclosing Party for which it may have no adequate remedy at law. Therefore, it is agreed that the disclosing Party may be entitled to equitable relief, including an injunction enjoining any such breach by any court of competent jurisdiction, and the recipient Party agrees to pay reasonable attorneys' fees and other costs incurred by the disclosing Party in successfully securing such injunction. Such injunction shall be without prejudice to any other right or remedy to which the disclosing Party may be entitled, including but not limited to any damages resulting from a Party's breach of the confidentiality obligations under this Agreement. Failure or delay to exercise any right, power or privilege hereunder (unless waived in writing) shall not operate as a waiver, nor shall any single or partial exercise thereof preclude the exercise of any other right, power or privilege hereunder.

9. QUALITY IMPROVEMENT AND UTILIZATION MANAGEMENT

9.1 Quality Improvement Plan. Service Provider agrees that it shall have in place at all times during the term of the Agreement a written quality improvement plan (the "QI Plan") approved by the Authority that addresses all Services provided by the Service Provider and/or the Subcontractors. Service Provider shall submit the QI Plan to the Authority for its approval at least annually, and shall incorporate all revisions requested by the Authority. The QI Plan shall satisfy all applicable Authority, MDHHS, state and federal requirements including, but not limited to the Balanced Budget Act of 1997 ("BBA") requirements, and rules promulgated thereunder, and the Centers for Medicare and Medicaid Services' ("CMS") Quality Improvement System in managed care guidelines. Service Provider shall cooperate with the Authority's QI activities, including collection of performance measurement data and participation in the Authority's clinical and service measure QI programs to improve the quality of care and services and member experience. Cooperation includes, but is not limited to, collection and evaluation of data and participation in the organization's QI programs.

9.2 Performance Improvement Projects. Service Providers shall cooperate with the Authority on any Performance Improvement Projects ("PIP") that the Authority is involved in conducting. Service Providers shall not perform any PIPs involving Authority Members and/or data or Protected/Confidential Health Information of Authority Members without the Authority's knowledge and written consent. Failure to comply with this section may result in monetary sanctions against Service Providers as provided in Section 15 of this Agreement.

9.3 Utilization Management. Service Provider agrees that it shall have in place at all times during the term of the Agreement a utilization management plan as part of the QI Plan (the "UM Plan") which has been approved by the Authority. The UM Plan shall include comprehensive, written utilization management policies and procedures in alignment with the Authority's Policies and Procedures

that evaluate the appropriateness and effectiveness of Services provided by the Service Provider and its Subcontractors. The UM Plan shall utilize systems of utilization review/quality improvement/peer review consistent with applicable federal and state laws to promote adherence to accepted services standards and to encourage Service Provider and its Subcontractors to efficiently utilize resources consistent with sound delivery of Services. In addition, Service Provider shall cooperate with the Authority, or its UM Designee, in Authority or UM Designee oversight of the UM Plan. To this end, Service Provider agrees to the following, and shall ensure that the Subcontractors agree to the following:

9.3.1 To participate, as requested, and to abide by Authority's or UM Designee's utilization review, Member management, quality improvement programs, any programs mandated by applicable State law, and all other related programs (as modified from time to time) and decisions with respect to all Persons. This includes, but is not limited to, the Behavioral Health Treatment committee.

9.3.2 To participate in the implementation of the Authority's UM Program including DWMHA's clinical and administrative Policies, Procedures, and Protocols.

9.3.3 To provide notice to Authority or UM Designee, in format specified by Authority, of all admissions of Persons, and of all Services or events for which Authority requires notice, upon occurrence admission or prior to the provision of such Services.

9.3.4 To provide any requested data and information to Authority or UM Designee as is necessary to permit Authority to conduct utilization management function.

9.3.5 To allow Authority or UM Designee to conduct concurrent on-site or telephonic review of any Services delivered.

9.3.6 To provide Authority or UM Designee with requested utilization management information in a timely manner.

9.4 Critical and Sentinel Events.

9.4.1 Service Provider shall, and shall cause all its Subcontractors to, prepare and file critical incident reports on Members actively receiving services within 24 hours of the incident occurrence, and in accordance with the Authority's Critical/Sentinel Event Policy. Such reports must include the following components:(a) determination by the Subcontractor and/or Service Provider as to whether a critical incident has occurred, (b) performance of a root cause analysis or investigation, (c) development and implementation of a plan of action to prevent further occurrence of the critical/sentinel event (including identification of who is responsible for implementing the plan and how implementation will be monitored), and (d) performance of a subsequent review to determine patterns and trends, and implementation of any actions needed to correct adverse actions and prevent them from occurring.

9.4.2 Reporting**.** Service Provider shall ensure that it and all Subcontractors have in place policies and procedures for immediate response and reporting of relevant information

about Sentinel Events (as defined by MDHHS) to the Authority and that they shall promptly and accurately report any Sentinel Event to the Authority in accordance with applicable state and Authority policies and guidelines. Failure to report Sentinel Events shall result in penalties as described in the Performance Measures made available on the Authority's Website, and at Authority's sole discretion, other sanctions in accordance with Sections 12 and 15 hereof.

9.4.3 Support. Service Provider and its Subcontractors are expected to support the Authority with the implementation of MDHHS' Quality Strategy for Specialty Services and Supports regarding Critical/Sentinel events, including, but not limited to ensuring the safety of Members served.

9.5 Policies and Procedures. Authority shall provide Service Provider with access to all of its policies, procedures, and protocols applicable to the Program and this Agreement; which may be amended from time to time. The Authority shall endeavor to ensure that all such policies, procedures, and protocols are made available upon its website for ease of access and review by Service Provider staff.

9.6 Quarterly Case Record Reviews. Service Provider shall engage in quarterly case record reviews in accordance with the policies and procedures of Authority. In the event that Service Provider identifies a measurement below 95% for two (2) consecutive quarters, Service Provider shall implement and monitor an internal plan of correction regarding such measurement. Service Provider shall submit evidence of the satisfaction of any such plan of correction to Authority upon completion.

9.7 Caseload Monitoring Process. Service Provider shall development and implement a caseload monitoring process for supports coordinators and case managers and shall ensure that such persons are adequately trained regarding access procedures for community resources. Service Provider shall submit evidence of the caseload monitoring process for review and approval of Authority annually.

10. DISPUTE RESOLUTION, INSURANCE, AND INDEMNIFICATION

10.1 Dispute Resolution.

10.1.1 Non-Clinical Service Provider Complaints. Controversies or claims between the Authority and Service Provider, arising out of or relating to this Agreement, but not of a clinical nature, shall be resolved as provided below.

A. Service Provider shall provide written notification to the Authority requesting the engagement of the dispute resolution process. In this written request, Service Provider shall identify the nature of the dispute, submit any documentation regarding the dispute, and state a proposed resolution to the dispute. First contact for requesting Dispute Resolution shall be the Authority's Director of Managed Care Operations ("MCO Director"). The MCO Director shall timely

respond to Service Provider's request, which time for response shall not exceed ten (10) days subsequent to the MCO Director's receipt of Service Provider's written request. If the dispute is not resolved in a timely manner, or to the satisfaction of the Service Provider, then Service Provider is permitted to appeal pursuant to the following Dispute Resolution step; provided Service Provider takes the actions described in subsection 10.1.1 B within ten (10) days of receipt of the MCO Director's decision.

B. Service Provider shall provide written notification requesting appeal of the MCO Director's response to the Authority's Chief Network Officer ("CNO"). The CNO shall thereafter provide both Service Provider and the MCO Director with a written decision regarding the dispute within ten (10) days following the CNO's receipt of written notification of appeal. Any corrective action plan required of Service Provider by the Authority pursuant to the MCO Director's response shall be on hold pending the CNO's decision regarding the dispute. If the dispute is not resolved in a timely manner, or to the satisfaction of the Service Provider, then Service Provider is permitted to appeal the CNO's decision pursuant to the following Dispute Resolution step; provided Service Provider takes the actions described in subsection 10.1.1 C within ten (10) days of receipt of the MCO Director's decision.

C. Service Provider shall provide written notification requesting appeal of the CNO's decision to the Authority's CEO. The CEO shall thereafter provide both Service Provider, the MCO Director, and the CNO with a written decision regarding the dispute within ten (10) days following the CEO's receipt of written notification of appeal. Any corrective action plan required of Service Provider by the Authority pursuant to the MCO Director's response shall be on hold pending the CEO's decision regarding the dispute. Subject to the provisions of Section 17.12 below, the CEO's decision is final.

10.1.2 Clinical Disputes. The Authority has developed and implemented a grievance and appeal system regarding disputes of a clinical nature. Information related to this is located in the Provider Manual (available on the Authority's Website). Additionally, brochures containing this information are available upon request.

10.2 Insurance. Unless otherwise agreed to in writing by the Authority, Service Provider shall at all times during this Agreement, and at its sole cost and expense, maintain policies of general liability and professional liability insurance or self-insurance with minimum limits of liability of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) in annual aggregate per year, or such other limits as may be required by state or federal law or regulation or as may be required by a state or federal regulatory body, covering the Authority, its agents and employees against any claims for damages arising out of any act or omission by Service Provider, its agents, and employees during the terms of this Agreement. Service Provider shall also maintain the following insurance coverages, as applicable to the scope of Covered Services provided directly or indirectly for the Authority:

10.2.1 Workers' Compensation Insurance. Service Provider shall procure and maintain during

the term of this Agreement Workers' Compensation Insurance, including Employers' Liability Coverage, in accordance with all applicable statutes of the state of Michigan.

10.2.2 Motor Vehicle Liability. If the Service Provider, or its employees, owns, leases, or uses vehicles in the transportation of Members served or the provision of other Services funded through this Agreement, Service Provider shall maintain Motor Vehicle Liability Insurance in the minimum amount of $1,000,000.00 per occurrence combined single limit, including coverage for hired and leased vehicles, and owned and non-owned vehicles, with No-Fault coverage as required by law. If no vehicles are owned or leased by the Service Provider, non-owned and hired vehicle coverage shall be required in lieu of auto fleet coverage.

10.2.3 Property Insurance. If the Service Provider has furnishings or equipment provided to it by either the Authority or the State and/or purchased with Authority or State funds, Service Provider shall procure and maintain Property Insurance coverage with replacement-cost endorsement for furnishings and equipment, and where applicable, such coverage shall also include coverage for all personal property of Members under the Service Provider's care and supervision. The certificates shall maintain limits, at minimum, equal to the value of the property.

All coverages shall be with insurance carriers licensed to do business in Michigan and acceptable to the Authority. At its sole discretion, the Authority, with prior written permission, may allow alternate insurance carriers. Service Provider shall require all providers and Subcontractors, to the extent reasonably feasible, to provide the insurance required in section 10.2. Unless notified otherwise, the Authority shall be named as additional insured under all of the policies described above.

10.3 Cancellation Notice. Service Provider shall ensure that all insurance required hereunder shall include an endorsement stating the following: "Thirty (30) days' Advance Written Notice of Cancellation, Non-Renewal and/or Limits Reductions shall be sent to: Detroit Wayne Mental Health Authority, 707 W. Milwaukee, 5th Floor, Detroit, Michigan 48202, Attn: Risk Management." Service Provider shall additionally make reasonable efforts to ensure that the Authority is named as an additional insured on all policies described above.

10.4 Additional Insurance Requirements.

10.4.1 If any insurance policy required herein is written on a "claims made" basis, each policy shall have a retroactive date which is not later than the Agreement effective date. Service Provider shall extend claims made coverage from the Agreement expiration date or termination date of this Agreement, for a minimum period of three (3) years, plus the statute of limitations for bringing any claim in the state of Michigan.

10.4.2 Any and all deductibles or self-insured retentions on insurance coverages shall be borne by the Service Provider.

10.4.3 If the Service Provider or Subcontractors desire additional insurance coverages, Service Provider and Subcontractor shall be responsible for the acquisition and cost of such additional protection.

10.5 Indemnification.

12.5.1 Service Provider agrees to indemnify, defend and hold the Authority harmless against, and from any and all liabilities, obligations, damages, penalties, claims, costs, charges and expenses (including, without limitation, reasonable fees and expenses of attorneys, expert witnesses and other consultants) which may be imposed upon, incurred by or asserted against the Authority because of any negligent or tortious act, error, or omission attributable in whole or in part to the Service Provider, or any of its personnel, employees, consultants, agents, or any entities associated, affiliated (directly or indirectly) or subsidiary to the Service Provider now existing, or to be created, their agents and employees for whose acts any of them might be liable, or any failure by the Service Provider, or any of its employees to perform its obligations either expressed or implied under this Agreement.

10.5.2 Service Provider agrees that it is its responsibility, and not the responsibility of the Authority, to safeguard the property and materials used by Service Provider's employees performing the Services in this Agreement. Service Provider must hold the Authority harmless for costs and expenses resulting from any loss of the property and materials used by its employees pursuant to the performance of the Service Provider under this Agreement.

10.5.3 Nothing in this article shall be deemed to relieve the Service Provider of its duty to defend the Authority, as specified, pending a determination of the respective liabilities of the Service Provider, and the Authority, by legal proceeding or agreement. The Authority shall cooperate with the Service Provider in the defense against the suit. In no event shall the Service Provider make any admission of guilt or liability on behalf of the Authority without the Authority's prior, written consent.

10.5.4 This indemnity applies without regard to whether the claim, damage, liability or expense is based on breach of contract, breach of warranty, negligence, strict liability, or other tort. This indemnity survives the termination of this Agreement regardless of the reason for termination.

10.5.5 This indemnity must not be construed as a waiver of any governmental immunity the Authority, its agencies, or employees, has as provided by statute or modified by court decisions.

10.6 Reserves and Fiscal Management. The Service Provider shall abide by the fiscal management requirements delineated in this Agreement and Authority policies and procedures.

11. INSPECTION OF RECORDS AND DATA ACCESS

11.1 Inspection of Records and Data Access. Service Provider agrees that Authority, on behalf of Service Provider and on behalf of its Subcontractors, shall have timely access to all data and information obtained, created, or collected by Service Provider related to Members ("Information"); provided, however, that all information listed in Section 3.2 shall be immediately available. All requested Information shall be supplied at no cost to the Authority. Service Provider shall not enter into any contract or arrangement whereby Authority does not have unlimited free and equal access to the Information in electronic or other form or would be required to pay any access, transaction or other fee to obtain such Information in electronic, written or other form. Service Provider agrees to provide Authority and federal, state, and local governmental authorities having jurisdiction, upon request, access to all books, records and other papers (including, but not limited to, medical and financial records) and information relating to this Agreement and to those Covered Services rendered by Service Provider to Members, and to maintain such books, records, papers and Information for the longer of ten (10) years after termination of this Agreement, or the period required by applicable state or federal law, including, but not limited to, the periods set forth in the state of Michigan's Records Retention and Disposal Schedule for CMHSPs available at https://www.michigan.gov/documents/hal/mhc_rm_gs20_195724_7.pdf).

11.1.1 Service Provider agrees that representatives of the Authority are entitled to make periodic inspections to ascertain that the Service Provider is properly performing the Covered Services. The inspections may be made at any time during Service Provider's normal business hours. If, in the course of the inspections, the Authority's representatives note any deficiencies in Service Provider's performance of the Covered Services, or any other mutually agreed upon performance deficiencies, the alleged deficiencies must be reported promptly to the Service Provider, in writing. Service Provider agrees to promptly remedy and correct any reported deficiencies within 10 days of notification by the Authority.

11.1.2 If, as a result of any audit conducted by the Authority, State of Michigan or federal authority relating to the Service Provider's performance under this Agreement, a discrepancy should arise as to the amount of compensation due the Service Provider, the Authority may retain the amount of compensation in question from any funds allocated to the Service Provider but not yet disbursed under the Agreement. Should a deficiency still exist, the Authority may offset such a deficiency against the compensation to be paid the Service Provider in any successive or future Agreements between the Parties.

11.2 Medical Records. Service Provider shall maintain information in a current, detailed, organized and comprehensive manner and in accordance with customary medical practice, applicable state and federal laws, Authority policies, and applicable accreditation standards. Individual Member records shall include all information regarding Covered Services provided to such individuals and medical records including reports from referred and/or referring providers, discharge summaries, records of emergency care received by the Members and such other information as Authority requires. Service Provider shall make these records available to: (i) Authority or its agents or designees for the purpose of assessing quality of care, conducting medical evaluations and audits, and determining, on a retrospective basis, the medical necessity and appropriateness of care provided

to Members; and (ii) applicable state and federal authorities and their agents involved in assessing the quality of care or investigating Member grievances or complaints.

11.3 Government Access to Records. Until the expiration of ten (10) years after the furnishing of Covered Services under this Agreement, Service Provider shall make available upon request by the Authority, State of Michigan, MDHHS or Auditor General, Secretary of the U.S. Department of Health and Human Services, the U.S. Comptroller General, and their duly authorized representatives, this Agreement and all other books, documents and records that are necessary to certify the nature and extent of costs incurred by Service Provider in furnishing Covered Services under this Agreement. If Service Provider carries out any of its duties through a subcontract with a value or cost of ten thousand dollars ($10,000.00) or more over a twelve (12) month period, with a related organization, such subcontract shall contain a clause permitting access to the Subcontractor's contract, books, documents and records to the Parties listed above until the expiration of ten (10) years after the furnishing of Covered Services pursuant to the subcontract. Service Provider shall include a similar covenant allowing for audit by the Authority, and or other governmental authorities, in any contract it has with a consultant or agent whose services will be charged directly or indirectly to the Authority. The Authority may delay payment to the Service Provider pending the results of any such audit without penalty or interest.

12. TERM AND TERMINATION

12.1 Term. The term of this Agreement shall be for the period commencing on the Effective Date and ending on September 30, 2019. The Parties may mutually agree in writing to extend this Agreement for up to two (2) terms of one (1) year in length upon the expiration of the initial term; provided that such extension(s) shall be at the sole option of the Authority and shall be made effective by the Authority giving written notice of its intent to extend this Agreement to Service Provider not less than thirty (30) calendar days prior to the expiration of the then current Agreement term; and further provided that the Parties acknowledge and agree that the Authority may adjust the specific scope of services and administrative standards required hereunder based on any directives or guidance from MDHHS. This Agreement is contingent upon the Authority's MDHHS Contracts. In the event the MDHHS Contracts are not awarded to the Authority, or terminate during the term of this Agreement, then this Agreement shall terminate and be of no force and effect.

12.2 Mutual Termination. The Parties may mutually agree to terminate this Agreement at any time prior to the expiration of the term set forth herein.

12.3 Termination without Cause. Either Party may terminate this Agreement without cause at any time, without incurring any further liability other than as stated in this Section, by giving written notice to the other Party of the termination as provided in this Section. The notice must specify the effective date of termination which shall be not less than thirty (30) days after the date of the notice, and this Agreement shall terminate upon expiration of such notice period.

12.4 Termination for Cause. Provided that a request for a meeting with the other Party has been made before the issuance of the relevant default notice, either Party may terminate this Agreement if the other Party defaults under any material provision of this Agreement and, upon written notice to that

effect from the non-defaulting Party, the defaulting Party fails to cure such default within thirty (30) days. A failure by the Authority to provide such written notice, or to request a meeting prior to the issuance of such notice, shall not limit any right it may have under this Agreement other than this right of termination as set forth in this section 12.4; and provided further, that such notice or meeting shall not be required for any default for which section 12.5 specifically grants an immediate right of termination or suspension to the Authority.

12.5 Authority Immediate Termination, Reduction, or Suspension. Any of the following events shall result in the immediate termination, reduction or suspension of this Agreement by Authority, upon notice to Service Provider, at Authority's sole discretion at any time:

12.5.1 The withdrawal, expiration or non-renewal of credentialing and/or empanelment of Service Provider based on the Authority's standards;

12.5.2 The dissolution of Service Provider as a corporate entity or the filing of a petition in voluntary bankruptcy or an assignment for the benefit of creditors by a party, or upon other action taken or suffered, voluntarily or involuntarily, by Service Provider, under any federal or state law for the benefit of insolvents, except for the filing of a petition in involuntary bankruptcy against Service Provider with the dismissal thereof within thirty (30) days thereafter.

12.5.3 The inability of the Service Provider to fulfill this Agreement due to the bankruptcy or receivership of Service Provider, or an assignment by Service Provider for the benefit of creditors;

12.5.4 The loss or limitation of Service Provider's liability insurance;

12.5.5 A reasonable determination by Authority that Service Provider's continued management and delivery of the Covered Services could result in harm to Members including, but not limited to, disruption or interruption of Covered Services;

12.5.6 The debarment or suspension of Service Provider from participation in any governmental sponsored program, including, but not limited to Medicare or Medicaid;

12.5.7 The indictment or conviction of an executive officer, chief or principal employee of the Service Provider for any crime;

12.5.8 Change of control of Service Provider to an entity not acceptable to Authority; or

12.5.9 Disapproval of the Service Provider by CMS or any other governmental entity, to the extent such approval is required in connection with the funding for Covered Services delivered hereunder. Service Provider shall provide immediate notice to Authority, upon Service Provider's actual knowledge of any of the aforesaid events.

The Authority reserves the right to make changes, including reductions, holds (temporary or permanent), or eliminations to: funding, scope of services, allowed program services, delegated

responsibilities, targeted population, or any other program or program component that, in the sole discretion of the Authority, will better align either the Covered Services performed by Service Provider, or the Authority's current or future performance objectives as a whole. Notification of such changes shall be in writing from the Authority and such reductions shall take effect upon the date stated in the written notification.

12.6 Duties of Parties upon Termination. Upon termination of this Agreement, the Parties agree that they shall meet following obligations:

12.6.1 If the Agreement is terminated, the Authority shall pay the Service Provider for the Covered Services rendered in accordance with the terms of this Agreement prior to termination. The Authority shall compute the amount of the payment based on the payment methodology set forth in Appendix B through the final month of service. The Authority's final payment under this Agreement constitutes full payment for the Service Provider's Covered Services hereunder.

12.6.2 Notwithstanding anything to the contrary in this Agreement, in the event this Agreement is terminated by the Authority as a result of the default of the Service Provider for any or no reason, including but not limited to misappropriation, fiscal mismanagement or nonperformance, the Service Provider shall immediately return to the Authority any funds that have been paid by the Authority that are unexpended or that have been misappropriated.

12.6.2 Upon termination of this Agreement, all records, data, notes, reports, and documents prepared by the Service Provider for the Authority under this Agreement shall become the Authority's exclusive property, whether or not in the possession of the Service Provider. The Service Provider agrees that such documents are free from any claim or retention of rights on the part of the Service Provider except as specifically provided in this Agreement. The Authority agrees that it shall promptly return all the properties of the Service Provider in its possession to the Service Provider and the Service Provider agrees that it shall promptly return all properties of the Authority in its possession or the possession of the Subcontractors to the Authority.

12.6.3 Upon termination of this Agreement for any reason, each Party agrees that it shall assist the other Party in the orderly termination of this Agreement and the transfer of all aspects, tangible or intangible, including equipment and furnishings, as may be necessary for the orderly, non-disrupted business continuance of each Party and continuous provision of high quality service to Members. Service Provider and its Subcontractors shall use best efforts to ensure an orderly transfer of Members to other service providers, as needed. At the expiration or termination of this Agreement, the Service Provider agrees that it shall cooperate with any subsequent contractors and the Authority personnel performing the Covered Services previously provided by the Service Provider. The Authority may recoup capitated payments to Service Provider if the Authority reasonably determines that the Service Provider is not cooperating in transition activities as required under this Section. This obligation to cooperate shall be binding for a period not to exceed ninety (90) business days following the termination of this Agreement.

12.6.4 Members will be notified of any closures/contract terminations within thirty (30) calendar days of the notice, by letters, posting on websites, meetings with case managers and/or therapists, forums, and consumer fairs. If Service Provider notifies the Authority of the termination less than thirty (30) calendar days prior to the effective date, Members will be notified as soon as possible, but no later than thirty (30) calendar days after receipt of notification. Members will continue to receive services per their IPOS for the current period of active treatment, or ninety (90) calendar days, whichever is less. The Authority will work with Service Provider to develop a reasonable transition plan for each Member in active treatment. If Members do not choose another provider they will be passively assigned by zip code to a new provider.

12.7 Effect of Termination. The expiration, cancellation, or termination of this Agreement shall be without prejudice to any rights of either Party against the other and shall not relieve either Party of any obligations which, by their nature, survive expiration or termination of this Agreement. Any terms and conditions herein which are intended to survive the termination of this Agreement shall survive and continue in full force and effect, without interruption, beyond any expiration, cancellation, or termination of this Agreement.

12.8 Close Out. If this Agreement is canceled or not renewed, the following shall take effect:

12.8.1 Within forty-five (45) days (interim), and ninety (90) days (final), of the date of termination, the Service Provider shall provide to the Authority all financial, performance and other reports required by this Agreement.

12.8.2 Payment for any and all valid claims for Covered Services rendered to Members after the date of termination of this Agreement shall be the Service Provider's responsibility and not the responsibility of the Authority.

12.8.3 The portion of all reserve accounts, inclusive of interest thereon, maintained by the Service Provider that were financed in whole or in part by Authority funds must be paid to Authority within ninety (90) days of the date of termination, unless otherwise directed in writing by the Authority.

12.8.4 Should additional statistical or management information be required by the Authority when this Agreement terminates, Service Provider shall deliver such information to the Authority within forty-five (45) days of the date of termination.

12.8.5 At the Authority's sole discretion, it may withhold all or part of any funds otherwise due to Service Provider from Authority until the later of: (a) the date on which Service Provider has met all close-out duties described in this Section, or (b) the date on which payment would otherwise be due in accordance with this Agreement.

13. RELATIONSHIP OF THE PARTIES

13.1 Independent Contractor Status. The relationship between Authority and Service Provider, as well as their respective employees and agents, is that of independent contractors, and neither shall be considered an agent or representative of the other Party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose. Authority and Service Provider shall each be solely liable for its own activities and those of its agents and employees, and neither Authority nor Service Provider shall be liable for the activities of the other Party or the other Party's agents or employees, including, without limitation, any liabilities, losses, damages, injunctions, suits, actions, fines, penalties, claims or demands of any kind or nature by or on behalf of any Members, party or governmental authority arising out of or in connection with: (a) any failure to perform any of the agreements, terms, covenants or conditions of this Agreement; (b) any negligent act or omission or other misconduct; (c) the failure to comply with any applicable laws, rules or regulations; or (d) any accident, injury or damage. Service Provider acknowledges that all decisions relating to the clinical care of Members are the sole responsibility of Service Provider, and that Authority's procedures, protocols and policies do not dictate or control Service Provider's clinical decisions with respect to the care of Members.

13.2 Use of Names.

13.2.1 Service Provider agrees that the Authority may use the Service Provider's address, phone number, picture or logo, type of practice or other professional services offered, applicable practice restrictions, in any communication from the Authority to Members regarding Covered Services.

13.2.2 Service Provider also agrees to acknowledge the Authority as a funding source in its publications and communications, in accordance with Authority policy.

13.3 Cooperation. The Authority and Service Provider agree that to the extent compatible with each separate and independent management, they shall maintain an effective liaison and close cooperation with the goal of providing Covered Services to Members at reasonable costs consistent with high standards of medical care. The Parties shall exchange information about matters related to this common interest. To the extent that MDHHS or other regulatory agencies require the participation of the Authority, Service Provider, or its Subcontractors, in programs regarding the development of new lines of service or guidelines and guidance regarding Covered Services, the Parties agree to cooperate with one another and with MDHHS, and participate in applicable aspects of MDHHS' transition plan.

14. NON-COMPETITION

14.1 Scope. The Parties agree that the Service Provider, directly or indirectly, itself or through or in connection with any employee, partner, representative, Subcontractor or other entity, is prohibited, throughout the term of this Agreement, from competing with the Authority on any State of Michigan bid for public mental health services covering the same populations as this Agreement for which the Authority may elect to submit a bid.

14.2 Reasonableness. The Parties agree that the nature, scope and duration of the non-competition provisions set forth herein are expressly represented and agreed to be fair, reasonable and necessary. If however, any court determines that the foregoing restrictions are not reasonable, the restrictions shall be modified, rewritten or interpreted to include as much of their nature and scope as shall render them enforceable. In the event of the Service Provider's breach of any provision of this Section 14, the Parties agree that monetary damages shall be inadequate to compensate the Authority and that the Authority shall be entitled, in accordance with law but without the posting of a bond, to an injunction restraining the Service Provider from the action constituting the breach.

15. AGREEMENT REMEDIES

15.1 Available Remedies At the Authority's sole discretion, it may, in addition to or as an alternative to pursuing its termination rights in accordance with Section 12, impose any one or more of the sanctions described below for Service Provider's default under this Agreement. If monetary sanctions are imposed, the Authority may reduce the amount of any payments otherwise due to the Service Provider by the amount of the monetary sanction.

15.2 Informal Remedies. The Authority may respond to Service Provider's potential or actual contract breach by taking any one or more of the following actions:

15.2.1 Sending informal notices to Subcontractors and Members;

15.2.2 Conducting telephone and mail inquiries;

15.2.3 Requesting Service Provider to respond in writing to identified problems;

15.2.4 Referring Authority or other program staff on site to Service Provider’s office for further investigation;

15.2.5 Sending warning letters to the Service Provider;

15.2.6 Requiring corrective action:

15.2.7 Referral moratorium;

15.2.8 The withholding of payment;

15.2.9 Monetary sanctions in amounts reasonably related to the severity of the violations; or

15.2.10 Termination of Agreement.

15.3 Suspension of Choice Availability for New Members. The Authority may suspend Service Provider's availability as an option for Members under this Agreement. The Authority shall give Service Provider ten (10) days written notice of intent to suspend such choice availability. The suspension date will be calculated as ten (10) days following the date that the notice of intent to suspend choice availability is received by Service Provider. Service Provider shall be given an opportunity to cure the default during the ten (10) day notice period if the Authority determines in its sole discretion that a cure is possible. The suspension of choice availability may be for any

duration up to the termination date of the Agreement. The Authority shall impose a duration of suspension based upon the type and severity of the default and the Service Provider's ability to cure the default.

15.4 Authority-Initiated Change in Member Choice. The Authority may initiate a change in a Members' choice, or reduce the total number of Service Provider's Members through initiating a Member's change from Service Provider to another provider of Member's choice if Service Provider fails to provide medically necessary Covered Services to a Member or if the Authority determines that Service Provider has a pattern or practice of failing to provide necessary Covered Services to Members. Unless exigent circumstances require otherwise, the Authority shall give Service Provider thirty (30) days written notice of intent to initiate a Member's change or to reduce the total number of Service Provider's Members through initiating a Member change from Service Provider to another provider of the Member's choice. The date of change will be calculated as thirty (30) days following the date that the notice of intent to initiate change is received by Service Provider. Service Provider will be given an opportunity to be heard by the Authority as to the default; however, the Authority, in its discretion, may deny an opportunity to cure. The Authority may continue to initiate change of Service Provider's Members until Service Provider demonstrates that it can and/or will provide Covered Services as required under this Agreement.

15.5 Removal of Members. Service Provider agrees that the Authority may unilaterally remove Members from the Service Provider's care with only verbal notice if the Authority, in its sole discretion, determines that a Member's health or safety is in imminent jeopardy, and upon written notice to the Service Provider, if the Authority reasonably determines that such removal is in the best interest of the Member.

15.6 Revocation of Delegated Responsibilities. Consistent with 42 CFR 438.230, to the extent that the Authority has delegated any of its decision-making responsibilities to Service Provider pursuant to this Agreement, the Authority may revoke any delegation made hereunder, and/or impose other sanctions, as described in sections 3 and 15 in this Agreement. The Authority retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision-making.

15.7 Withholding Payments. The Authority may withhold payments to Service Provider until any defaults are cured. If the Authority has provided or paid for a requested Covered Service pending an appeal to the Authority, and the Authority's determination is adverse to the Service Provider, the Authority will withhold the entire amount the Authority paid for the Covered Service. Additionally, should the Service Provider owe the Authority a receivable, Service Provider grants a right of set-off to all funds that are ultimately to be paid or credited to Service Provider either directly or indirectly (an example of indirectly would be Service Provider's share of all types of payments made pursuant to a subcontracting arrangement). Service Provider authorizes Authority to request an accounting of expected payments, communicate with Service provider or Subcontractors about such a receivable after it has been on the Authority's books for thirty (30) days, to withhold funds from payments in the amount of indirect and direct payments to Service Provider, to withhold funds on the basis of the Authority's estimates of direct and indirect payments should cooperation on establishing an agreed-upon amount of indirect and direct payments not be

forthcoming from Service Provider, and further, Service Provider agrees to hold harmless other parties involved in collection of unpaid receivables to the Authority.

15.8 Liquidated Damages. The Authority may assess Service Provider liquidated money damages for default under this Agreement, in addition to other remedies and sanctions provided herein. The liquidated damages set out in this section are not intended to be penalties but are intended to be reasonable estimates of the Authority's financial loss and damage resulting from Service Provider's default. Liquidated damages will be forfeited and will not be subsequently paid to Service Provider upon compliance or cure of default. Liquidated damages imposed shall be as follows:

15.8.1 Failure to Provide Necessary Services. If the Authority determines that Service Provider failed to provide a necessary Covered Service to a Member, the Authority will, for each failure, order Service Provider to provide the Covered Service and/or impose money damages up to two percent (2%) of the payment due and owing to Service Provider based on calculations from Appendix B, and up to twenty percent (20%) of the total payment due based upon continued non-compliance. Additionally, failure to provide a necessary Covered Service may be considered a breach of this Agreement.

15.8.2 Data Reporting Penalties. The Authority may assess Service Provider liquidated damages for its failure to submit complete, accurate and properly formatted data, information or reports by the due date required in this Agreement. Such failures may result in the Authority withholding a portion of Service Provider's payment due, up to one-half percent (0.5%) per day that such information is deemed late, until such late documentation is received.

16. SERVICE PROVIDER REPRESENTATIONS

16.1 Organization and Good Standing. Service Provider is an entity duly organized, validly existing, and in good standing under the laws of the state of Michigan. Service Provider has the requisite legal power and authority to own all of its properties and assets, and to meet all of the Service Provider obligations provided herein.

16.2 Authorization. Service Provider has the requisite legal power and authority to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance by Service Provider of this Agreement has been duly authorized by all necessary legal action of Service Provider, and no other corporate act or proceeding on the part of Service Provider is necessary to authorize the execution, delivery or performance by Service Provider of this Agreement. This Agreement is the legal, valid and binding obligations of Service Provider enforceable in accordance with its terms against Service Provider and each Service Provider member/owner, except as may be limited by applicable bankruptcy, insolvency, reorganization, moratorium or other similar laws affecting the rights of creditors generally and the availability of equitable remedies.

16.3 Debarment and Suspension

a) Service Provider hereby affirms that it shall comply with Federal Regulation 45 CFR Part 76 and Service Provider certifies to the best of its knowledge and belief, after reasonable due diligence and inquiry, that

i) The Service Provider, its principals and its Subcontractors are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Authority;

ii) The Service Provider, its principals and its Subcontractors have not, within a three-year period preceding this Agreement, been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of federal or ftate antitrust statutes, or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

iii) The Service Provider, its principals and its Subcontractors are not presently indicted or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the offenses enumerated in 16.4 a (i-iii) above; and;

iv) The Service Provider, its principals and its Subcontractors have not, within a three-year period preceding this Agreement, had one or more public transactions (federal, state or local) terminated for cause or default.

b) The certification in this clause is a material representation of fact upon which reliance was placed. When the Authority determines that the Service Provider knowingly rendered an erroneous certification, in addition to other remedies available to the Authority, the Authority may terminate this Agreement for cause or default.

c) The Service Provider shall provide immediate written notice to the Authority if, at any time, Service Provider learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

d) The terms “covered transaction”, “debarred”, “suspended”, “ineligible”, “lower tier covered transaction”, “Grantee”, “person”, “primary covered transaction”, “principal”, “proposal”, and “voluntarily excluded”, as used in this clause, have the meaning set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76.

e) The Service Provider agrees that it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Authority.

f) The Service Provider further agrees that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transaction", provided by the Authority, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

g) A Service Provider may rely upon a certification of a participant in a lower tier covered transaction, unless it knows that the certification is erroneous. A Service Provider may decide the method and frequency by which it determines the eligibility of its principals. Each Service Provider may, but is not required to, check the Non-procurement List (of excluded parties).

h) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a Service Provider is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

i) If a Service Provider is in a covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Authority, the Authority may terminate this Agreement for cause or default.

17. MISCELLANEOUS

17.1 Entire Agreement. The agreement consists of and incorporates by reference, this written Agreement, including appendices and attachments; the Authority's PIHP and CMHSP contracts with MDHHS; Michigan Mental Health Code and Administrative Rules; Michigan Public Health Code and Administrative Rules; MDHHS Appropriations Act in effect during the term of this Agreement; Medicaid Policy Manuals and subsequent publications; all applicable federal and state statutes, rules and regulations, all final MDHHS guidelines and technical requirement and Authority policies and procedures. Additionally, if the selection of the Service Provider was determined by a procurement process, the following documents are incorporated by reference into this Agreement: (a) written materials provided to or by the Service Provider as part of its procurement application, interview or questioning process, and (b) all applicable Authority, state and federal forms or applications pertaining to the Covered Services provided under this Agreement, including, but not limited to the RFP and Service Provider's RFP Response. This constitutes the entire agreement of the Parties.

17.2 No Verbal Modification or Amendments. There shall be no verbal modifications or amendments to any provision in this Agreement. No changes, amendments or alterations shall be effective unless written and signed by authorized representatives of both Parties, except as expressly provided in this Agreement, and more specifically, with respect to funding modifications, as expressed in Section 6.2. Notwithstanding the foregoing, at Authority's discretion, Authority may amend this Agreement upon written notice to Service Provider to comply with applicable law or regulation, or any order or directive of any governmental authority.

17.3 Waiver. The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as or be construed as a waiver of any subsequent breach. To be effective, all waivers must be in writing and signed by the Party to be charged.

17.4 Severability. Any determination that any provision in this Agreement is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement.

17.5 Headings and Terms. The headings contained in this Agreement are included for purposes of convenience only, and shall not affect in any way the meaning or interpretation of any of the terms or provisions of this Agreement. When used in this Agreement, and not otherwise defined herein, all capitalized terms shall be as defined in the Authority's Provider Manual (available on the Authority's Website), the Mental Health Code (MCL 330.1 *et seq.*), in the MDHHS Contracts, or as defined by CMS or other regulatory agencies acting with respect to the subject matter of this Agreement in the ordinary course of their respective duties.

17.6 Notices. Any notice required to be provided pursuant to the terms and provisions herein shall be effective only if provided in writing and sent by overnight delivery service with proof of receipt, or by certified mail return receipt requested. Notices shall be sent to the Service Provider at each address indicated on the signature page hereto, and to the Authority at:

Detroit Wayne Mental Health Authority
707 W. Milwaukee, 5th Floor
Detroit, Michigan 48202
Attn: Chief Network Officer

With a mandatory copy to:

Office of General Counsel
Detroit Wayne Mental Health Authority
707 W. Milwaukee, 5th Floor
Detroit, Michigan 48202

1.7 Consent to Alternate Service of Process. The Parties hereby waive personal service of process and agree that any summons and complaint commencing an action or proceeding against the Authority or the Service Provider shall be properly served and shall confer personal jurisdiction on the Authority or Service Provider, if served by registered or certified mail to the other Party in accordance with Section 17.6.

17.8 Successors and Assignment. The Parties agree that this Agreement shall be binding upon each of them and, to the extent permitted by law, upon their administrators, contractors, Subcontractors, representatives, executors, trustees, successors and assigns, and all persons acting by, through, under or in concert with any of them. Service Provider may not assign or delegate this Agreement to any other party without the Authority's express, written consent.

17.9 No Third-Party Beneficiaries. Except as expressly provided herein for the benefit of the Parties, and the limited third-party beneficiary rights granted to Members hereunder, this Agreement does not, and is not intended to create, by implication or otherwise, any direct or indirect obligation, duty, promise, benefit, right to be indemnified (i.e., contractually, legally, equitably, or by implication) and/or any right to be subrogated to any Party's rights in this Agreement, and/or any other right of any kind, in favor of any person, including, but not limited to any persons served or their legal representative, any organization, any alleged unnamed beneficiary or assignee, or any other Members.

17.10 Previous MCPN Agreements. Service Provider acknowledges that it previously had an agreement or agreements with Managers of Comprehensive Provider Networks ("MCPNs"), (collectively the "MCPN Agreements"), to provide Covered Services for Authority Members and knowingly and willingly gives the Authority the ability to enforce the terms of the MCPN Agreements. Service Provider acknowledges that the Authority, MDHHS, CMS and other regulatory agencies may audit the services rendered under the MCPN Agreements and seek recoupment of money that was paid for Covered Services that were inappropriate.

17.11 No Assumption of Obligations by Authority. The Parties agree that this Agreement does not, and is not intended to transfer, delegate, or assign to the Authority and/or any Authority agent any civil or legal responsibility, obligation, duty of care, or liability associated with the ownership, maintenance, or operation of the Service Provider's entity, facilities or enterprise, or the provision of Covered Services. Service Provider agrees that under no circumstances shall the Authority be responsible for any costs, obligations, and/or civil liabilities associated with Service Provider's program/facility. Service Provider agrees that no provision in this Agreement shall in any way superintend, limit, or relieve the Service Provider of any responsibility or consequence of its neglect or carelessness nor that of its Subcontractors, employees, agents or representatives.

17.12 Reservation of Rights. The Authority reserves to itself any and all rights and obligations relating to the implementation and operation of a comprehensive Community Mental Health System for the residents of Wayne County or any other eligible Members as provided by law, and this Agreement does not, and is not intended to diminish, delegate, divest, impair, or contravene any constitutional, statutory, or other legal right, privilege, power, obligation, duty, capacity, immunity, or character of office of the Authority. The Authority reserves the right to revoke any and all delegated authority if, in its sole opinion, the Service Provider's performance under this Agreement is deemed inadequate. In addition to Service Provider's Covered Services rendered pursuant to this Agreement, the Authority, in its sole judgment and discretion and subject to its fiscal and staffing constraints, reserves the right to supplement any Service Provider Covered Services to any Members, as solely deemed appropriate by the Authority. The Service Provider agrees to cooperate in all regards with the Authority or any Authority agents, including any other possible Authority contractors, in the provision of any Authority authorized supplemental Covered Service or treatment efforts.

17.13 Governing Applicable Law. This Agreement is made and entered into in the state of Michigan and shall in all respects be interpreted, enforced and governed under the laws of the state of Michigan. The language of all parts of this Agreement is intended to and under all circumstances shall be construed as a whole according to its fair meaning and not construed strictly for or against either

Party.

17.14 Consent to Jurisdiction and Venue. Service Provider and the Authority agree that in any claim, action, suit, or proceeding brought or initiated by either Party to enforce, interpret, or decide any claim or issue arising under or otherwise related to this Agreement, shall be initiated, raised, or brought only in the 3rd Judicial Circuit Court of the state of Michigan, and/or in the United States District Court for the Eastern District of Michigan, Southern Division. The Parties each hereby consent and submit, in advance, to jurisdiction and that venue shall be proper in these courts on any such matter. The choice of forum set forth in this section shall not be deemed to preclude the enforcement of any judgment obtained in such forum, or the taking of any action under this Agreement to enforce such judgment in any appropriate jurisdiction.

17.15 Non-Exclusivity. This Agreement is not exclusive, and nothing herein shall preclude either Party from contracting with any other person or entity for any purpose. Authority makes no representation or guarantee as to the number of Members who may select or be assigned to Service Provider.

17.16 Waiver of Jury Trial**.** The Parties acknowledge that the Right to Trial by Jury is a constitutional one, but that it may be waived. Each Party, after consulting (or having had the opportunity to consult) with counsel of its choice, knowingly and voluntarily, and for their mutual benefit, waives any right to trial by Jury in the event of litigation regarding performance or enforcement of, or in any way related to, this Agreement.

17.17 Counterparts. This Agreement may be executed in counterparts, and counterpart signatures may be furnished by email scan. If so executed, this Agreement shall be fully valid and binding.

[Signatures on next page]

EXECUTION PAGE

WHEREFORE, the undersigned Parties have executed this Agreement, intending to be bound hereby.

«Provider_Name»

By: _____ Date: _____

Title: _____

Address: _____

_____

DETROIT WAYNE MENTAL HEALTH AUTHORTY

By: _____ Date: _____

Eric Doeh
Chief Network Officer

Reviewed by the Office of General Counsel

By: _____ Date: _____

Print Name:_____

APPENDIX A

Scope of Service

SCOPE OF SERVICES
RESIDENTIAL SERVICE PROVIDERS

SERVICE PROVIDER shall follow the authorization and referral procedures set forth in the Provider Manual, and shall furnish only such General Fund services, and Medicaid services below for which it has been credentialed and empaneled to provide by the AUTHORITY, if and when applicable, is listed in their Service Agency Profile on file with the AUTHORITY, and to which the rendering professional is legally qualified to provide and whose training is up to date. SERVICE PROVIDER shall only be reimbursed for Covered Services rendered at an approved site that is on its current Service Agency Profile on file with the AUTHORITY.

SERVICE PROVIDER shall consult with, and seek further authorization from, the AUTHORITY if it is believed that additional treatment or tests are needed beyond those initially authorized. SERVICE PROVIDER understands and agrees that AUTHORITY's authorization of services does not constitute a guarantee of AUTHORITY's payment for such services. Covered Services under this contract are those services that are delineated in the AUTHORITY's Pre Paid Inpatient Health Plan agreement with the Department of Health and Human Services and the Community Mental Health Services Program agreement.

The provision of Medicaid services must be consistent with the applicable sections of the Social Security Act, the Code of Federal Regulations (CFR), the CMS/HCFA State Medicaid & State Operations Manuals, Michigan's Medicaid State Plan, and the Michigan Medicaid Provider Manual: Mental Health -Substance Abuse section. These services are identified in Part II Section 2 of the PIHP Agreement between the Authority and MDHHS.

SERVICE PROVIDER shall provide Members those medically necessary Covered Services listed in Fig. A, included in the benefits array applicable to the Funding Program for which such Member is eligible at the time, and authorized by AUTHORITY. SERVICE PROVIDER shall provide such Covered Services in accordance with the service delivery, documentation and billing requirements of the AUTHORITY.

Fig. A[1]

CPT CODE	COVERED SERVICE DESCRIPTION	REPORTING PROCEDURE/REVENUE CODE DESCRIPTION	DETAIL
H2016	Community Living Supports	Licensed Specialized Residential setting	Per Day
T1020	Personal Care Services	Licensed Specialized Residential setting	Per Day

SERVICE PROVIDER agrees that the specific identity, scope and procedure coding of Covered Services to be provided under this agreement shall be in accordance with the Medicaid Manual.

[1] The times listed in Column four of Fig A, above, constitute the amount of time each service must be provided to constitute a unit of service.

- SERVICE PROVIDER shall provide Covered Services to Members in a manner similar to and within the same time availability in which SERVICE PROVIDER provides such services to any other individuals, and SERVICE PROVIDER will not differentiate or discriminate against any Persons as a result of his/her enrollment or coverage, or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for services, status as a Medicare of Medicaid beneficiary, sexual orientation, or any other basis prohibited by law. SERVICE PROVIDER will not be required to provide any type or kind of service to Members that it does not customarily provide to others.
- Service Provider shall immediately send written notice to AUTHORITY of any legal, governmental, or other action involving SERVICE PROVIDER which could materially impair the ability of SERVICE PROVIDER to carry out the duties and obligations of this Agreement including but not limited to suspension, termination or revocation of license or licensee, insurance and accreditation, any material change in ownership or legal status or SERVICE PROVIDER's ability to continue to provide all contracted Covered Services.
- AUTHORITY shall have sole authority to determine whether a service is a Covered Service and whether an individual is a Member.
- SERVICE PROVIDER shall receive payment only for those Covered Services provided in accordance with the terms and conditions contained in AUTHORITY's utilization management and service authorization program as described in AUTHORITY's Provider Manual and applicable AUTHORITY policy.
- AUTHORITY reserves the right to establish a separate service provider network or other service provider referral panel which has its own set of selection criteria. If SERVICE PROVIDER does not meet the selection criteria, SERVICE PROVIDER understands and agrees that it will cooperate in the transfer of the Members to a service provider within the separate service provider network.
- All Covered Services shall be provided in accordance with Person-Centered Planning practices ("PCP"), as defined in the Mental Health Code, MDHHS Contracts and any guidelines the AUTHORITY or MDHHS may publish from time to time.
- SERVICE PROVIDER agrees to adopt network principles regarding self-determination and semi-independent living.
- It is the SERVICE PROVIDER's responsibility to maintain a current authorization for services provided. Failure to do so may result in denial of claims submitted.
- SERVICE PROVIDER agrees to comply with provisions of the Medicaid Home and Community-Based Settings requirement as developed by MDHHS and AUTHORITY, including protections regarding discharge and complaints. SERVICE PROVIDER agrees to enter into appropriate residential care agreements as required under the rule.

SPECIALIZED RESIDENTIAL SERVICES- Service Provider Responsibilities

Specialized Residential SERVICE PROVIDER shall further comply with the terms and conditions listed below.

a. As a condition of entering into this Agreement, SERVICE PROVIDER agrees to provide or has provided AUTHORITY with the following:

    1. If requested, a copy of SERVICE PROVIDER's Admission and Discharge Criteria detailing who the SERVICE PROVIDER will admit, serve and under what conditions the SERVICE PROVIDER will discharge a Member.
    2. SERVICE PROVIDER agrees that admission to the Residential Facility will not be denied solely on the basis of a Member having a chronic medical condition or if an Emergency Room Physician determines

that a Member does not immediately require medication and is stable enough for discharge and follow-up with primary care physician.

3. Upon each instance that a SERVICE PROVIDER needs to issue a 30 day eviction notice due to a health and safety concern, SERVICE PROVIDER agrees to send the notice to the designated AUTHORITY department email as well as to the Clinically Responsible Service Provider on the day that the notice is provided to the Member. In addition, SERVICE PROVIDER agrees to provide the rationale for the notice.
4. If requested, a census of the available open beds at the frequency determined by AUTHORITY and in the format determined by AUTHORITY.
5. If requested, a statement of program services to be provided to the Member.
6. If requested, a statement delineating which functions/services will be subcontracted in the delivery of Covered Services purchased under this Agreement.
7. If requested, a list of current Board of Directors with their titles and phone numbers. SERVICE PROVIDER agrees to submit, within 5 business days, written notification to AUTHORITY when any changes occur (i.e. license, insurance, legal status, ownership, etc.).
8. A copy of current Certificates of Insurance.
9. A copy of all applicable licenses and certification as required for the performance of SERVICE PROVIDER'S contractual duties.

b. SERVICE PROVIDER agrees that the first proactive measure in the case of a Behavioral Health Crisis that does not involve health and safety issues is to contact AUTHORITY's Crisis Service Vendor in an attempt to divert a full blown crisis.

c. SERVICE PROVIDER agrees that designated representatives of the AUTHORITY shall have access to the home, Members, Member records, contract records and employees of SERVICE PROVIDER upon request and as necessary to monitor and manage this Agreement and maintain the health and safety of the Members in the home.

d. SERVICE PROVIDER agrees that organizations authorized by statute and/or by AUTHORITY, including but not limited to the Michigan Protection and Advocacy Services, Adult & Child Protective Services, the Arc of Michigan or its local affiliates, the responsible County, the State, the Federal Government, and any agents of any of the foregoing shall have access to the home, the Members, the Member's records and the employees of SERVICE PROVIDER.

e. SERVICE PROVIDER agrees to assist the Member and/or AUTHORITY, in securing State, Federal, private benefits, or entitlements for all eligible Members of service who are receiving supports from SERVICE PROVIDER including Social Security Income and Title XIX benefits as appropriate. Furthermore, SERVICE PROVIDER agrees to assist Members with obtaining appropriate documents such as appropriate identification (picture ID), social security information, etc.

f. SERVICE PROVIDER agrees to assist Members as necessary to apply for and regularly receive food stamps.

g. SERVICE PROVIDER agrees to maintain the home(s) and provide the Members with a safe and clean environment in accordance with AUTHORITY Policies, Standards and Protocols as from time to time, may be amended

- SERVICE PROVIDER shall not make structural/mechanical system changes to the home(s), and obligate the AUTHORITY for repairs, without the prior written approval of AUTHORITY. In emergency situations, oral approval from AUTHORITY must be obtained.
- Damage caused by SERVICE PROVIDER or its staff as a result of negligence, omission, or commission shall be SERVICE PROVIDER'S responsibility.
- AUTHORITY will consider contract adjustments only under circumstances that significantly alter or affect the funding level of the Agreement.

h. SERVICE PROVIDER shall ensure that vehicles used for transportation are maintained in safe operating condition and maintains liability insurance as required by AUTHORITY.

i. SERVICE PROVIDER agrees that AUTHORITY will not be made a secured party on the title of all vehicles or purchased in whole or in part with AUTHORITY funds.

j. SERVICE PROVIDER agrees to maintain sufficient trained staff to ensure the health and safety of the Members residing in the home(s) and to carry out each Member's IPOS as funded under the Agreement. SERVICE PROVIDER agrees to provide all Covered Services identified as SERVICE PROVIDER'S responsibility in each Member's person centered plan as funded under the Agreement.

k. The current support plan for each Member shall be retained at the home. Furthermore, SERVICE PROVIDER agrees to maintain on the home premises, complete and current Member records and any other records required to document the delivery of service in accordance with each Member's plan, including personal care services or Habilitation Support Waiver Services (if appropriate), on forms approved by AUTHORITY including Form 3803. These records shall be maintained for ten (10) years. SERVICE PROVIDER also agrees to keep current copy of guardianship records in the Members medical record.

l. SERVICE PROVIDER agrees to make a good faith effort to provide the supports identified and agreed upon in the Member's person-centered plan as required by the Michigan Mental Health Code.

m. SERVICE PROVIDER agrees to confirm with AUTHORITY or its designee, regarding any vacancies. SERVICE PROVIDER further agrees to notify AUTHORITY, Case Manager/Supports Coordinator and AUTHORITY or its designated placement agency immediately by telephone in the event of a Member's vacancy from the home.

n. SERVICE PROVIDER agrees to notify the AUTHORITY immediately by telephone in the event SERVICE PROVIDER receives a notice of deficiency from any regulatory entity. Deficiencies include citations that affect the health, safety and well-being of the Members, the environment, and/or the fiscal integrity of SERVICE PROVIDER. SERVICE PROVIDER shall submit within three (3) days of any such event a written report on forms provided by AUTHORITY.

o. SERVICE PROVIDER agrees not to charge a fee for acting as representative payee for a Member.

p. If SERVICE PROVIDER is the representative payee, the SERVICE PROVIDER agrees to maintain separate bank accounts and auditable records on behalf of each Member for whom personal funds are received with respect to revenue (including date received and source of funds) and expenditures (including purpose and date expended) received or expended by or in the name of the individual Member.

q. SERVICE PROVIDER agrees to provide access to such accounts and records by the MDHHS, Department of Human Services the AUTHORITY or authorized designee, upon request, and understands that failure to maintain such accounts and records in accordance with MCL 400.731-400.737, (The Adult Foster Care Facility Licensing Act) and MCL 750.145 (the Vulnerable Adult Act/Varga Act) is a violation of Michigan statutes.

r. Included as a part of the Member's funding entitlement are monies designated as personal allowance. Personal allowance includes funds received as a result of a Member's participation in a day program or supported employment, the personal allowance included in any funds provided by the AUTHORITY's federal funding programs, social security, or made available by the family or guardian on behalf of a recipient. Access to these funds will be limited only if the Member's plan so provides.

s. SERVICE PROVIDER agrees to designate to the AUTHORITY, and to SERVICE PROVIDER'S in-home staff a person(s) responsible for the administration of the residential services. SERVICE PROVIDER further agrees that the designee(s) will be available to their in-home staff and AUTHORITY 24 hours per day and will be able to take any necessary actions on behalf of SERVICE PROVIDER.

t. SERVICE PROVIDER agrees that SERVICE PROVIDER'S state license to provide foster care services, state certification to provide specialized residential services and continuing certification and enrollment under the Title XIX Medicaid program (if applicable) are dependent covenants of this Agreement. Failure to maintain such licensure and/or certification shall cause this Agreement to be immediately canceled.

u. Upon expiration or cancellation of this Agreement SERVICE PROVIDER agrees to:

    1. If requested, give to AUTHORITY within 24 hours, the Member'' clinical records, Member's personal funds, and Member's personal fund records. AUTHORITY shall provide SERVICE PROVIDER with a receipt for the records provided. Any original records forwarded by SERVICE PROVIDER will be returned to SERVICE PROVIDER by AUTHORITY within fourteen (14) days of receipt. In the event there is an emergency removal of Members from the home, SERVICE PROVIDER or the Member chooses to move from the residence, SERVICE PROVIDER must cooperate with the AUTHORITY in Member moves.

    2. Immediately surrender to AUTHORITY all medications and personal property belonging to the Members, and

    3. Immediately surrender to AUTHORITY all fixed assets with a value in excess of $500 that were purchased in whole or in part by AUTHORITY funds.

    4. Immediately thereafter vacate the premises, if applicable.

v. The SERVICE PROVIDER agrees to not discriminate against a Member of services or an applicant for receipt of services in keeping with any applicable federal, state, or local law prohibiting employment discrimination and any applicable federal state, or local act prohibiting discrimination in services to the public. This includes but is not limited to Section 504 of the Rehabilitation Act of 1973 (27 USC sec 794); Americans with Disabilities Act of 1990; Fair Housing Act Amendments of 1988 (42 USC sec 3601 et seq.) Michigan Handicapper Civil Rights Act, PA 121 of 1990 (MCL Sec. 37.1102 et seq.) Education for All Handicapped Children Act of 1972 (20 USC sec 1400 et seq.) and the Michigan Mandatory Special Education Act (MCL sec 380.1 et seq.)

w. SERVICE PROVIDER must follow AUTHORITY'S placement process for placement of Members in appropriate settings to be eligible for possible reimbursement from AUTHORITY for Covered Services provided. SERVICE PROVIDER cannot independently place Members in the home and seek reimbursement from the AUTHORITY. Members placed in the home where the SERVICE PROVIDER has not followed the AUTHORITY's placement protocol may be removed from the home if appropriate. SERVICE PROVIDER will not be reimbursed for Covered Services rendered to Members if inappropriately placed in the home.

x. SERVICE PROVIDER agrees to abide by all "Independent Living" principles as required by and adopted by the AUTHORITY and in accordance with the AUTHORITY'S contract with MDHHS

y. SERVICE PROVIDER must attend all service provider meetings by the AUTHORITY. SERVICE PROVIDER is solely responsible for the information disseminated at the service provider meetings. If SERVICE PROVIDER is not able to attend a service provider meeting, it is the SERVICE PROVIDER'S responsibility to follow up with the AUTHORITY regarding information distributed. If SERVICE PROVIDER fails to consistently attend service provider meetings, this will become a plan of correction for the SERVICE PROVIDER and subject to the network's scope and severity protocol.

- SPECIFIED SERVICES- Environmental

SERVICE PROVIDER is responsible for assuring the completion of all routine maintenance, repairs and replacement of the residence so as to provide safe and clean environment and to meet all regulatory requirements and network standards and protocols.

Additionally, these responsibilities may be limited or expanded to include specific lessee/tenant responsibilities as specified in any lease agreement for this residence, if applicable.

SERVICE PROVIDER shall retain records relating to the upkeep/repair/remodeling done at the home, and retain these records for ten (10) years (beyond the end of the lease) or forward a copy of those records to at AUTHORITY's request when a home closes. These records should include copies of payments for furnace inspections, gutter cleaning general repairs etc.

SERVICE PROVIDER Responsibilities:

- Annual heating/air conditioning systems inspection and cleaning.
- Complete exterior yard upkeep tasks:
    - mow lawns weekly (less often during hot/dry weather)
    - control weeds in the lawn and flower/shrub beds - add mulch as needed
    - trim shrubs twice yearly
    - remove leaves/debris from yard
    - clean oil spills off driveways
- Clean gutters and downspouts as needed.
- Clean siding as required.
- Pump septic tanks annually or more often if required.
- Wash, repair and/or paint walls as needed. Walls must be reasonably clean
- Regularly clean floors; professionally clean as needed.
- Complete routine maintenance/repair/replacement of appliances.
- Complete routine maintenance/repair of electrical, mechanical, and plumbing systems.
- Keep home clean of offensive odors
- Clean furniture as appropriate
- Maintain clean bathrooms including sufficient hand soap (or sanitizer), paper towels and toilet paper
- Maintain clean linens and replace as needed
- Maintain clean, sanitary kitchen, utensils, etc.
- Maintain clean bedrooms
- Keep all harmful supplies out of harms way from the consumers

Notify the owner/lessor and the AUTHORITY, Inc. of serious/emergency/regulatory agency citations of physical plant concerns; take actions to have the situation corrected/repairs completed to protect the persons living in the home and/or to prevent further damage and to satisfy regulatory standards.

All repairs and replacements must be completed to industry and professional standards.

SPECIFIED SERVICES- Personal Property

Residential Care SERVICE PROVIDER

PURPOSE:

This section sets forth the minimum standards of accountability for personal property, including funds of Members receiving support services from the AUTHORITY. The purpose is to ensure that funds are expended consistent with Members' choices identified in the person-centered planning process, unless limited by provisions of law, while at the same time safeguarding the property and funds against theft, loss, or misappropriation.

POLICY:

Residential SERVICE PROVIDERs shall have established procedures to: accept and account for an Member's personal property and/or funds; provide Members with easy access to property and funds; and safeguard personal property, including funds against theft, loss, or misappropriation.

Based upon a determination of financial liability processed by the AUTHORITY, and in accordance with the AUTHORITY's rules and regulations, part of a Member's income, entitlements, and/or assets may be utilized as a contribution to his/her cost of care. This sum may be paid directly to the residential SERVICE PROVIDER, or may be used to purchase goods and services such as rent, utilities, food, etc. Any income or assets exceeding the cost of care is considered as the Member's personal allowance and/or property.

Money remaining in a Member's account or possession may be used to purchase goods and services which are not part of the contract budget. Supporting justification shall be documented in the Plan of Service/Support Plan for any exceptions.

Definitions:

Personal Property/Property: all of a Member's possessions (whether purchased with his/her own money or received as gifts), also includes funds.
Personal Funds: all of a Member's income, entitlements, and assets.
Personal Allowance Funds: Money stipulated by the state/county as a Member's personal funds when he/she receives SSI and/or SSDI.

Responsibilities:

Residential SERVICE PROVIDER:

1. Property or Funds belonging to a Member that are turned over to SERVICE PROVIDER for safekeeping shall be properly accounted for and protected, and shall be treated as a trust obligation. When money remains in the possession of a Member consistent with his/her plan of service or guardianship, the individual shall be informed that he/she is responsible for it.

2. All of a Member's Funds, including bank accounts, shall be kept separate and apart from all funds of SERVICE PROVIDER. In addition, SERVICE PROVIDER will complete appropriate forms approved by AUTHORITY to support this responsibility.

3. Funds exceeding **$200.00 per Member** which are entrusted to SERVICE PROVIDER for safe keeping shall be deposited in separate accounts on behalf of the Member. Any interest earned shall be credited to the Member's account. SERVICE PROVIDER shall be prohibited from having any ownership interest in a Member's account.

   SERVICE PROVIDER may keep up to **$200.00** of a Member's Funds available in the home (kept in a secure area) as **"cash on hand",** and shall be responsible for replacing any money that is lost, stolen, or unaccounted for.

4. SERVICE PROVIDER shall be responsible for the appropriate management of Property and Funds entrusted into its care and shall be accountable for said property and funds. The residential SERVICE PROVIDER shall ensure that the Member receives the merchandise or services purchased on his/her behalf.

5 SERVICE PROVIDER agrees to maintain personal property insurance for the personal property owned by the Members residing in the home. The coverage shall be on a replacement cost basis to the extent that such insurance is available.

6. Prior to making expenditures on behalf of a Member from the Member's Funds for any single item exceeding $200.00, SERVICE PROVIDER shall obtain approval from the legal guardian where the guardian has the authority to control the ward's funds. A guardian has the option of requesting either more or less restrictive limitations on spending per the authority granted in the legal guardianship papers. Expenditures made by SERVICE PROVIDER without this approval may be disallowed, and restitution required.

   SERVICE PROVIDER is encouraged to have a guardian stipulate a dollar amount in writing for which prior approval may be required.

7. For all purchases of more than $2.00 made on behalf of the Member residing in the home, itemized receipts or other suitable documentation shall be maintained by the SERVICE PROVIDER and available for review and audit. Exceptions to the receipt requirement shall be stipulated in the Plan of Service/Support Plan.

8. Each Member shall have access to his or her Funds and shall be entitled to spend it as he or she desires without restriction, unless restricted lawfully by guardianship authority or through a specific written plan developed in conjunction with SERVICE PROVIDER's support team.

Access shall be defined as, having access to and use of Funds that belong to a Member, in reasonable amounts, including immediate access to no less than twenty dollars ($20.00) and access to any and all other monies within five days after the request for the funds. (The exception to this would be if documented, reasonable attempts to contact the guardian for authorization when necessary have been unsuccessful).

9. Residential Service Providers case managers and support coordinators may make decisions regarding appropriateness of expenditures using the following guidelines:
    a. Consideration for the Member's personal choices and interests, level of comprehension, and physical abilities.
    b. Whether or not the expenditure would improve the Member's daily living conditions, personal comfort, or provide better medical care.
    c. Consideration of therapeutic value, or benefit from item or service.
    d. Whether or not it would provide training to help him or her enhance living skills and become more self-sufficient.

    Expenses generally considered appropriate for the Member may include:
    - The cost of trips, outings, recreation, leisure time activities, program items, snacks, and occasional meals out.
    - School tuition, book expenses, and costs associated with employment, such as uniforms and work shoes (transportation when indicated in the Plan of Service/Support Plan).
    - The difference in cost to upgrade an item when a Member chooses or elects to purchase personal possessions or clothing above the level supplied.

    Expenses generally considered not appropriate may include:
    - Use of a Member's Funds to supplement the home's consumables budget.
    - Cost of tickets, meals or travel expenses for residential SERVICE PROVIDER's staff who accompany Members on trips or outings.
    - Reimbursement for damages to property or personal possessions of others unless it has been previously determined to be appropriate and documented in the Plan of Service/Support Plan.
    - Purchases from. SERVICE PROVIDER employees, or other service providers and their employees. (Inexpensive fund-raising items such as candy or baked goods, inexpensive T-shirts, etc. may be permitted).

10. SERVICE PROVIDER, administrators and their employees, shall not use, take, or borrow money from a Member, even with his/her consent, except as provided.

11. Upon discharge or transfer of a Member or upon contract termination of SERVICE PROVIDER, SERVICE PROVIDER shall immediately relinquish the balance of the Member's money. If AUTHORITY determines that there is insufficient documentation or incomplete personal fund records, reconciliation for the previous twelve months may be requested to be provided to the support coordinator or contract manager within five working days.

SPECIFIED SERVICES- Finance

1. SERVICE PROVIDER shall be paid a rate for Community Living Supports and/or Personal Care Services as authorized by the AUTHORITY and/or designee for each resident.
2. SERVICE PROVIDER's accounting procedures shall conform to Generally Accepted Accounting Principles. All revenue and expenditures under this Contract must be recorded in accounts separate from the SERVICE PROVIDER's other business or corporate expenditures.
3. SERVICE PROVIDER shall maintain all fiscal records relating to this Contract for ten (10) years. These records shall be made readily available to AUTHORITY, or its designee at any reasonable time for examination or audit.
4. To provide the assurance required under the Medicaid/Medicare programs (Code of Federal Regulations, 42 CFR, Sections 413.9 and 413.24) that costs are reasonable, SERVICE PROVIDER agrees to submit, if requested, a complete report of all revenue and expenditures utilizing the accrual basis of accounting. The revenue section of the report shall categorically identify AUTHORITY revenues and all other revenues.
5. SERVICE PROVIDER agrees that payroll taxes required by federal, state and local law shall be maintained on a current basis.
6. SERVICE PROVIDER assures that all hours and wages charged to direct care will be supported by contemporaneous time records and home work schedules.
7. All home furnishings and equipment if purchased in whole or in part with funds provided by ConsumerLink, CareLink, Integrated Care Alliance or AUTHORITY remain the property of the AUTHORITY. Disposition shall be subject to the discretionary approval of the AUTHORITY.
8. In accordance with requirements defined by AUTHORITY, SERVICE PROVIDER shall commission an independent financial audit of SERVICE PROVIDER'S financial statements annually, and forward audited financial statements to AUTHORITY no later than one hundred and twenty (120) days following the end of SERVICE PROVIDER's fiscal year end.
9. SERVICE PROVIDER understands and agrees, under penalty of law that the funds received under this Agreement are to be used solely in providing the specialized residential services identified herein. All charges to the contract must be in the provision of consumer care.
10. SERVICE PROVIDER shall seek to minimize costs and agrees that actual costs will not exceed what a prudent and cost-conscious buyer pays for a given item or service.

APPENDIX B

Financial Information

BILLING OF AND PAYMENTS FOR VALID SERVICE REIMBURSEMENT CLAIMS

The parties hereto agree that a primary purpose of this Agreement is to provide for reimbursement by Authority to Service Provider for Covered Services provided to any of Authority's Members. Therefore, it is agreed by the parties hereto that Service Provider shall bill Authority and Authority shall reimburse Service Provider only for services to such Members pursuant to the service, service recipient, billing, and payment requirements and limitations specified and delineated in the Agreement and in this Appendix B, as follows:

A. **Determination of Financial Status and Benefits Status of Enrollees**. Service Provider shall inform Authority immediately regarding any change in Authority status/coverage for any of Authority's Members. Authority shall have access upon request to any Service Provider information and documentation regarding said matters.

Service Provider agrees that it shall initiate application for, charge, bill, and diligently seek to collect all third party benefits as applicable from insurers and government agencies for Authority-authorized services rendered to Authority's Members hereunder for whom reimbursement may be available, including (but not by way of limitation) public and private insurance plans, entitlements or other assistance, and other health benefit plans.

Pursuant to this Agreement, Service Provider agrees to comply with the Third Party Liability requirements in federal regulations and interpretive state policy for Medicaid.

To insure the maximum third-party reimbursement and verified county of residency, as required by the Mental Health Code, Service Provider shall provide Authority with:

(1) Access to screening and financial records for Members under this Agreement; and

(2) Access to any such Member when necessary to obtain additional information needed in Authority's monitoring of the financial liability determination process.

B. **Coordination of Benefits**. For the purposes of this Agreement, Service Provider shall be responsible for the coordination of public and private benefits of each Member hereunder. Service Provider acknowledges that Authority shall be the payor of last resort for Authority-authorized services to Authority-authorized Members under this Agreement subject to the terms and conditions herein. The payments from Authority to Service Provider under this Agreement are intended only to cover the allowable costs of the services net of, and not otherwise covered by, payments provided by other funding, entitlements or benefits and by liable third parties, as applicable, for which each recipient of services hereunder may be eligible. If Service Provider fails to coordinate benefits the Service Provider shall not be reimbursed for the services, and monies paid by the Authority to the Service Provider for the services shall be recouped.

C. **Third Party Liability Requirements**. Service Provider shall be responsible under this Agreement for seeking service reimbursements, if applicable, from third party liability claims for Enrollees hereunder, pursuant to federal and State requirements.

Service Provider shall not seek or collect any service fee payments directly from Enrollees, legal guardians, parents or relatives, etc. or any reimbursement fee payments from Medicaid and/or the State of Michigan, for Service Provider's services rendered hereunder, unless authorized to do so, in writing, by Authority.

D. **Preauthorized Service Periods and Reimbursements.** The initial preauthorized service period for reimbursement by Authority to Service Provider for services to Enrollees, shall be per the determination of Authority's CEO or his or her designee.

E. **Requirements and Limitations for Billing of Claims and Payments of Claims**. Service Provider shall provide a billing statement with valid claims for Authority-authorized services rendered to Members hereunder. In order to be considered valid claims for which payments from Authority may be made, Service Provider's billing of a service claim (as defined in the Authority's Provider Manual) must be received by Authority within:

(1) sixty (60) calendar days from the date in services were rendered for a Member whose eligibility status has been established without pending third party approval; or

(2) ninety (90) days after Member eligibility status is no longer pending third party approval for services rendered by Service Provider.

All claim resubmissions must be received by the Authority, with necessary supporting documents, within thirty (30) days of Service Provider's receipt of an Authority denial. In no event shall any claims be accepted by the Authority in excess of one hundred twenty (120) days from the date upon which services were rendered.

Authority's CEO or his or her designee shall authorize and process valid service claims payments to Service Provider within thirty (30) days following receipt of complete and accurate billing statement from Service Provider. Only those services in which appropriate authorizations were obtained and appropriate documentation completed and submitted shall be reimbursed by Authority. The Authority shall conduct verification reviews to substantiate claims received by Service Provider.

F. **Contractual Account Reconciliation.** Upon termination of this Agreement, a contractual account reconciliation shall be completed wherein the claims billed by Service Provider and the claims paid by Authority shall be reviewed in order to assure that payments made by Authority or still outstanding during the term hereunder have been in accordance with the provisions of this Agreement and have been identified appropriately and accounted for separately by Service Provider and Authority as to the benefit status of the Members.

Said contract reconciliation shall be completed in full compliance with the Mental Health Code, the MDHHS Rules, the MDHHS Contract and applicable State and federal laws, including Medicaid regulations.

The contractual account reconciliation shall be completed in accordance with the following procedures:

(1) Service Provider shall submit a preliminary reconciliation proposal to Authority no later than **sixty (60)** calendar days after the end of this Agreement. Service claims occurring during this Agreement period for which denial or approval is pending as to eligibility also shall be identified and accounted for separately, in completing the preliminary reconciliation proposal;

(2) After considering Authority's preliminary reconciliation response, Service Provider shall submit a final reconciliation proposal, including updated data on eligibility determinations, to Authority no later than **ninety (90)** calendar days after the end of this Agreement. Thereafter, Authority shall make a final determination of a contractual account reconciliation; and

(3) The amount due to Authority or to Service Provider as a final contract account reconciliation for the current fiscal year shall be paid within **thirty (30)** days after notification of Authority's final determination.

G. **Unallowable Services/Cost Claims and Financial Paybacks.** Should Service Provider fail to fulfill its obligations as required under this Agreement, thereby resulting in unallowable services and/or cost claims, it shall not be reimbursed by Authority hereunder for any such services and/or cost claims. Service Provider shall repay to Authority for such unallowable services and/or cost claims. This requirement shall survive the termination of this Agreement and such repayment shall be made by Service Provider to Authority within sixty (60) calendar days of Authority's final disposition notification to Service Provider that financial payback is required.

H. **Disallowed Expenditures and Financial Repayments.** In the event that CMS, MDHHS, Authority, the State of Michigan, or the federal government ever determines in any final revenue and expenditure reconciliation and/or any final finance or service audit that Service Provider has been paid inappropriately per Authority's expenditures of federal or State funds pursuant to this Agreement for services claims and/or cost claims which are later disallowed, Service Provider shall fully repay Authority for such disallowed payments within sixty (60) calendar days of Authority's final disposition notification of the disallowances, unless Authority authorizes, in writing, additional time for repayment.

I **Refunding of Payments.** In the event that the Service Provider bills Authority for services rendered hereunder in any instances in which Service Provider received monies directly from another funding source or from another party that provides for, reimburses, offsets, or otherwise covers payment retroactively, currently, or subsequently for such services, Service Provider shall repay to Authority an amount equal to the sums reimbursed by such third party payors and/or paid by any other source within thity (30) days. Service Provider shall notify Authority immediately of any such payments. Alternatively, the Authority may, upon notice to Service Provider, withhold from future payments due to Service Provider those funds which should be repaid to the Authority.

J. **Compensation.** The Authority shall reimburse the Service Provider at the rates identified in the Authority's Rate Summary Sheet ("Rate Sheet") in place for the date on which the services were provided to the Member. The Rate Sheet is available on the Authority's website at www.dwmha.com. If you are having trouble accessing the Rate Sheet and need a copy sent to your organization, please contact the Authority. It is the Service Providers responsibility to maintain a current authorization. Failure to do so may result in a denial of claims submitted for services that are not paid on the fee schedule and require an alternative billing method for Members e.g. client budgeting, self-determination & other unique situations the Authority may provide a rate sheet under separate cover.

K. **Claims Appeal or Request for Adjustment**. Any claim appeal, or request for adjustment of a payment, by Service Provider must be made in accordance with applicable provisions of the Provider Manual and Authority policies and procedures and, in any case, must be received by Authority within thirty (30) days of the original payment or denial. Service Provider may not bring legal action on claims which have not been appealed through Authority appeal mechanisms.

APPENDIX C

Debarment/Suspension Agreement and Certification & List of Subcontractors

APPENDIX D

Business Associate Agreement

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT ("BAA") is entered on the last date of signature below ("Effective Date") by and between **DETROIT WAYNE MENTAL HEALTH AUTHORITY,** an independent governmental entity established and operating pursuant to the Michigan Mental Health Code, Act 258 of 1974 ("Covered Entity") and «Provider_Name» ("Business Associate"). Individually, Covered Entity and Business Associate are referred to as a "Party," and collectively, as the "Parties".

RECITALS

A. The Parties have entered into one or more agreements under which Business Associate provides certain services to Covered Entity ("Services").

B. The Health Insurance Portability and Accountability Act of 1996 and applicable privacy and security regulations, Pub. L. 104-191, Subtitle F, Administrative Simplification; and 45 CFR Parts 160, 162 & 164 (collectively "HIPAA") were enacted to prohibit the use and disclosure of Protected Health Information ("PHI"), and "Electronic PHI or ePHI," as is defined at 45 C.F.R. § 160.103 as amended (collectively "PHI"), except under limited circumstances.

C. HIPAA was amended by enactment of the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, Title XIII, Subtitle D of PL 111-5, 123 Stat 115 ("HITECH"). HITECH and the applicable regulations expanded HIPAA's enforcement provisions; extended certain HIPAA privacy and security requirements to business associates; defined notification requirements for data breaches; and amended certain provisions related to the use of PHI.

D. Business Associate may receive, maintain, or transmit certain information to Covered Entity or create certain information on behalf of Covered Entity, which may constitute PHI as those terms are defined in HIPAA.

For these reasons, the Parties agree:

Article 1
Definitions

The following terms have the meanings described in this Article for purposes of the BAA, unless the context clearly indicates another meaning. Any terms used, but not otherwise defined, in this BAA shall have the same meaning as those terms have under HIPAA and HITECH.

1.1 Business Associate

"Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103.

1.2 CFR

"CFR" means the Code of Federal Regulations.

1.3 Covered Entity

""Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the Party to this Agreement, shall mean the Detroit Wayne Mental Health Authority.

1.4 Designated Record Set

"Designated Record Set" has the same meaning as the term "Designated Record Set" in 45 CFR 164.501.

1.5 Electronic Health Record

"Electronic Health Record" has the same meaning as the term "electronic health record" in 45 CFR 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

1.6 Individual

"Individual" has the same meaning as the term "individual" in 45 CFR 160.103 and includes a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

1.7 Privacy Rule

"Privacy Rule" means the privacy rule of HIPAA as set forth in the privacy, security, breach notification and enforcement rules at 45 CFR part 160, part 162 and part 164.

1.8 Protected Health Information

"Protected Health Information/PHI" has the same meaning as the term "protected health information" in 45 CFR 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

1.9 Required By Law

"Required By Law" has the same meaning as the term "required by law" in 45 CFR 164.103.

1.10 Secretary

"Secretary" means the Secretary of the Department of Health and Human Services.

1.11 Security Incident

"Security Incident" has the same meaning as the term "Security Incident" in 45 CFR 164.304.

1.12 Security Rule

"Security Rule" shall mean the security standards and implementation specifications at 45 CFR Part 160 and Part 164, subpart C.

Article 2
Obligations and Activities of Business Associate

Business Associate agrees to perform the obligations and activities described in this Article.

2.1 Business Associate understands it is subject to the Privacy and Security Rules in a similar manner as the rules apply to Covered Entity. As a result, Business Associate agrees to take all actions necessary to comply with the Privacy and Security Rules for business associates including, but not limited to, the following: Business Associate shall establish policies and procedures to ensure compliance with the Privacy and Security Rules, Business Associate shall train its workforce regarding the Privacy and Security Rules, Business Associate shall enter into a privacy/security agreement with its subcontractors that perform functions relating to Covered Entity involving PHI, and Business Associate shall conduct a security risk analysis.

2.2 Business Associate agrees to not use or disclose PHI other than as permitted or required by this BAA, agreements between Business Associate and Covered Entity for Services, or as Required by Law.

2.3 Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this BAA. Business Associate shall implement administrative, physical and technical safeguards (including written policies and procedures) that reasonably and appropriately protect the confidentiality, integrity and availability of PHI that it creates, receives, maintains or transmits on behalf of Covered Entity as required by the Security Rule.

2.4 Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this BAA, or any Security Incident.

2.5 Business Associate agrees to report to Covered Entity any use or disclosure of the PHI not provided for by this BAA of which it becomes aware, and/or any Security Incident of which it becomes aware, within ten (10) calendar days after discovery.

In addition, Business Associate agrees to the following in connection with the breach notification requirements of HITECH.

> **(a)** If Business Associate discovers a breach of unsecured PHI, as those terms are defined by 45 CFR 164.202, Business Associate shall notify Covered Entity without unreasonable delay and within five (5) calendar days after discovery. For this purpose, discovery means the first day on which the breach is known to Business Associate or by exercising reasonable diligence would have been known to Business Associate. Business Associate shall be deemed to have knowledge of a breach if the breach is known or by exercising reasonable diligence would have been known to any person, other than the person committing the breach, who is an employee, officer, subcontractor or other agent of Business Associate. The notification must include identification of each individual whose unsecured PHI has been, or it has reasonably believed to have been, breached and any other available information in Business Associate's possession which the

Covered Entity or Business Associate is required to include in the individual notice contemplated by 45 CFR 164.404.

(b) Notwithstanding the immediately preceding paragraph, Business Associate shall assume the individual notice obligation specified in 45 CFR 164.404 on behalf of Covered Entity where a breach of unsecured PHI was committed by Business Associate or its employee, officer, subcontractor or other agent of Business Associate or is within the unique knowledge of Business Associate as opposed to Covered Entity. In such case, Business Associate will prepare the notice and shall provide it to Covered Entity for review and approval at least five calendar days before it is required to be sent to the individual. Covered Entity will promptly review the notice and will not unreasonably withhold its approval, but may in its sole discretion make a determination to amend the notice or assume responsibility for distribution of the notice. In the event, Covered Entity does not provide a timely response, the Business Associate may proceed with distribution.

(c) If there is a breach involving the PHI of 500 or more Individuals committed by the Business Associate or its employee, officer, subcontractor or other agent, or is within the unique knowledge of Business Associate as opposed to Covered Entity, Business Associate shall provide notice to the media pursuant to 45 CFR 164.406. Business Associate will prepare the notice and shall provide it to Covered Entity for review and approval at least five (5) calendar days before it is required to be sent to the media. Covered Entity shall promptly review the notice and shall not unreasonably withhold its approval, but does retain discretion to amend the notice or assume control of media distributions. In the event, Covered Entity does not provide a timely response, the Business Associate may proceed with distribution.

(d) Business Associate shall maintain a log of breaches of unsecured PHI with respect to Covered Entity and shall submit the log to Covered Entity within thirty (30) calendar days following the end of each calendar year so that the Covered Entity may report breaches to the Secretary in accordance with 45 CFR 164.408.

2.6 Business Associate agrees to ensure that any agent, including the subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity, agrees in writing to the same restrictions and conditions that apply through this BAA to Business Associate with respect to such information. Business Associate shall ensure that any such agent or subcontractor agrees to implement reasonable and appropriate safeguards to protect Covered Entity's electronic PHI.

2.7 Business Associate agrees to provide reasonable access, at the written request of Covered Entity, to PHI in a Designated Record Set, to Covered Entity or, as directed in writing by Covered Entity, to an Individual in order to meet the requirements under 45 CFR 164.524.

2.8 Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs in writing or agrees to pursuant to 45 CFR 164.526 at the written request of Covered Entity or an Individual.

2.9 Following receipt of a written request by Covered Entity, Business Associate agrees to make internal practices, books, and records including policies and procedures and PHI relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity reasonably

available to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

2.10 Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528

2.11 Following receipt of a written request by Covered Entity, Business Associate agrees to provide to Covered Entity or an Individual, information collected in accordance with Section 2.10 of this BAA within fifteen (15) calendar days, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

Article 3
Permitted Uses and Disclosures by Business Associate

3.1 Except as otherwise limited in this BAA, Business Associate may use or disclose PHI to perform functions, activities or services for, or on behalf of, Covered Entity as specified in the underlying service agreement Covered Entity and Business Associate, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity. Business Associate may use or disclose PHI to perform functions, activities or services for, or on behalf of, Covered Entity for the purposes of payment, treatment or health care operations as those terms are defined in the Privacy Rule, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

3.2 Except as otherwise limited in this BAA, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

3.3 Except as otherwise limited in this BAA, Business Associate may disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that disclosures are Required by Law, or Business Associate obtains reasonable assurances in writing from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

3.4 Except as otherwise limited in this BAA, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 CFR 164.504(e)(2)(i)(B).

3.5 Business Associate may use PHI to report violations of law to appropriate Federal, State and local authorities, consistent with 45 CFR 154.502(j)(1).

3.6 Business Associate will limit the use, disclosure, or request of PHI, to the extent practicable, to the Limited Data Set or, if needed by Business Associate, to the minimum necessary to accomplish the intended purpose of such use, disclosure, or request, except to the extent a broader use, disclosure, or request of PHI is allowed by the Privacy Rule.

3.7 Except as otherwise authorized by the Privacy Rule, Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI of an Individual unless Covered Entity has received a valid authorization from the Individual that includes a specification of whether the PHI can be further exchanged for remuneration by the entity receiving PHI of that Covered Individual.

3.8 Business Associate may not use or disclose PHI regarding an Individual with respect to a communication about a project or service that encourages recipients of the communication to purchase or use the product or service unless the communication is made to the Individual: (i) to describe a health-related product or service (or payment for such product or service) that is provided by, or included in, the Plan, including communications about the entities participating in a health care provider network or health plan network, replacement of, or enhancements to, the Plan, and health-related products or services available only to Individuals that add value to, but are not part of, the Plan; (ii) for treatment of the Individual; or (iii) for case management or care coordination for the Individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the Individual. Notwithstanding the foregoing, except as allowed by the Privacy Rule, Business Associate may not use or disclose PHI regarding an Individual with respect to a communication described above if Covered Entity receives direct or indirect payment in exchange for making such communication.

3.9 With respect to PHI that Business Associate creates or receives on behalf of Covered Entity, Business Associate will not use or further disclose the PHI other than as permitted or required by this BAA or as Required by Law.

3.10 In the event the Business Associate transmits or receives any electronic transaction on behalf of Covered Entity, it shall comply with all applicable provisions of HIPAA and HITECH and the applicable regulations and shall ensure that any agents and subcontractors that assist Business Associate in conducting electronic transactions on behalf of Covered Entity agree in writing to comply with all applicable provisions of HIPAA and HITECH and the applicable regulations to the extent Required by Law.

Article 4
Obligations of Covered Entity

4.1 Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices in accordance with 45 CFR 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

4.2 Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

4.3 Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

4.4. Covered entity shall not request or direct Business Associate to create, maintain, receive, or transmit Electronic PHI in any manner that would not be permissible under the Security Rule.

Article 5
Term and Termination

5.1 Term

The Term of this BAA shall be effective as of the Effective Date, and shall terminate either pursuant to Section 5.2 below, or when all of the PHI provided by Covered Entity to Business Associate is destroyed or returned to Covered Entity, or, if it is not feasible to return or destroy PHI, protections are extended to such PHI and it is maintained for a period of seven (7) years.

5.2 Termination

Either Party may terminate this BAA at any time by written notice to the other Party, without being required to state a cause.

Article 6
Miscellaneous

6.1 Notice

Any notice or other written communication required or permitted to be given to the other party under this BAA must be addressed to the attention of the other party in care of the contact person identified below.

Written notice may be delivered by certified mail or overnight mail to Business Associate, at the address listed beneath its signature below, and to the Covered Entity as follows:

Detroit Wayne Mental Health Authority
Attn: Chief Clinical Officer
707 W. Milwaukee Street, 5th Floor
Detroit, Michigan 48202

With a copy to:

Detroit Wayne Mental Health Authority
Attn: HIPAA Privacy & Security Officer(s)
707 W. Milwaukee Street, 5th Floor
Detroit, Michigan 48202

6.2 Regulatory References

A reference in this BAA to a section in the Privacy Rule or Security Rule means the section as in effect or as amended.

6.3 Amendment

This BAA may only be amended in a written document signed by an authorized representative of each Party. The Parties agree to take such action as is necessary to amend this BAA from time to time as is necessary for Covered Entity to comply with the Privacy and Security requirements of HIPAA and HITECH. If the Business Associate refuses to sign such an amendment, this BAA shall automatically terminate.

6.4 Survival

The respective rights and obligations of Business Associate and Covered Entity under this BAA shall survive the termination of this BAA and any related services agreement.

6.5 Interpretation

Any ambiguity in this BAA shall be resolved to permit each party to comply with the Privacy Rule and the Security Rule.

6.6 Successors

This BAA is binding on each Party's legal successors.

6.7 Indemnification

Business Associate agrees to indemnify and hold harmless Covered Entity, and its directors, officers and employees against any and all claims, lawsuits, settlements, judgments, costs, penalties and expenses including attorney fees resulting from or arising out of or in connection with a use or disclosure of PHI by Business Associate or its subcontractors or agents in violation of this BAA.

To the extent permitted by law, Covered Entity agrees to hold harmless Business Associate and its directors, officers and employees against any and all claims, lawsuits, settlements, judgments, costs, penalties and expenses resulting from or arising out of or in connection with a use or disclosure of PHI by Covered Entity or Plan Sponsor, or agents of Covered Entity or Plan Sponsor, in violation of this BAA.

6.8 No Beneficiaries

Nothing expressed or implied in this BAA is intended to confer, nor shall anything confer, upon any person other than the Covered Entity and Business Associate, and their respective successors or assigns, any rights, remedies, obligations or liabilities.

The Parties have executed and delivered this BAA on the date indicated on the following Execution Page.

EXECUTION PAGE

WHEREFORE, the undersigned Parties have executed this Agreement, intending to be bound hereby.

«Provider_Name»

By: _____ Date: _____

Printed Name: _____

Title: _____

Address: _____

_____

Detroit Wayne Mental Health Authority

By: _____ Date: _____

Eric Doeh
Chief Network Officer

Reviewed by the Authority's Office of General Counsel

By: Date:

Print Name:_____

APPENDIX E

Claims Submission Protocols and Requirements

Claims Submission Protocols and Requirements

PROTOCOLS & REQUIREMENTS

Claims/Encounters

All claims are to be submitted by direct entry into the Mental Health Wellness Information Network (MHWIN) web-based information system unless otherwise authorized.

Refer to Provider Manual for further details.

Format

Electronic transfer is via a secure web-site protocol.

Electronic Claims & Encounters

- 837 format only and Direct Data Entry into the designated website address.

Submission Protocol

Electronic Claims

To set up Electronic Claims Entry

- *pihpclaims@dwmha.com or call (313) 344-9099 (ask for Claims Unit)*
- *For 837 file submitters contact Information Services Department*

- Indicate your **agency business name** and for your agency **e-mail address of the person submitting electronic claims**
- An electronic file, containing instructions for submitting claims, including file formats, file naming protocol and web-site protocols will be returned to you, along with contact information for help with set-up.

Frequency & Timeliness

- All primary claims and encounters must be received no later than 60 days from date of service.
- When Detroit Wayne Mental Health Authority is a secondary payer, (i.e., when C.O.B. is involved), claims and encounters must be received within 60 days of provider's receipt of payment advice from the primary payer.
- Claims & encounters may be submitted at any time and on any day. Weekly submissions are encouraged.

Adjustments

- *Changes and Adjustments to Claims may be initiated by contacting:*

pihpclaims@dwmha.com or call (313) 344-9099 (ask for Claims Unit)

- Documentation on paper or as otherwise requested may be required for Changes and Adjustments.

Payment Advice (EOB)

- For Claims/Encounters submitted electronically, payment advice will be returned to provider electronically, according to protocols defined. Advice will be in 835 format if claims were submitted in an 837 format.
- In circumstances where claims may need to be submitted on paper, EOBs will be available electronically.
- Unique member identification number must be on the claim to avoid rejection
- Authorizations, when required, must be listed and accurate on claim form to avoid rejection
- Providers have 60 days to appeal a rejected or processed claim. Appeal must be received by the Network within 60 days of the date of the EOB on which the claim denied.

Procedure Codes

- The current state-defined procedure code set will be required by the system, and must be used in all claims. A copy of acceptable procedure code set can be obtained by contacting pihpclaims@dwmha.com or call (313) 344-9099 (ask for Claims Unit)
- The MDHHS code set is consistently under development by the state. Any additions and changes will be forwarded to the provider as soon as they are available.

Diagnostic Codes

- ICD 10 coding system and descriptors must be utilized in accordance with national standards.
- Primary diagnosis must be appropriate for services provided under this agreement listed on claim to avoid rejection. Primary diagnosis code must be listed one of the diagnosis codes accepted by the Michigan Department of Health and Human Services, if appropriate.

COORDINATION OF BENEFIT (COB)

- Provider is accountable for COB and required to follow all COB rules as funds under this agreement are those of last resort.
- Detroit Wayne Mental Health Authority is payers of last resort. Providers must collect payment from all other payers prior to submission of claims.
- Claims and encounters for services with COB shall be submitted electronically or on paper as directed by the network with EOB/payment advice from 3rd party payer stapled to claim.
- Network claims adjudicators will screen claims encounters for potential COB, and will require providers to pursue uncollected 3rd party payments.
- Providers not complying with appropriate COB rules and regulations will be subject to contract compliance standards and protocols.
- COB claim must be received within 60 days of receiving payment from primary insurance in order to process claim as Coordination of Benefits.
- Primary Payer must be billed within 90 days of date of service.

Member Numbers
• The DWMHA assigned Member Number must be included on all claims/encounters in the Insurance ID field • For services that require authorization, the authorization number must also be included on the claim form to process.
Claims Help
• Until further notice, inquiry regarding claims, claims status, and/or adjudication issues contact: *pihpclaims@dwmha.com or call (313) 344-9099 (ask for Claims Unit)*
Website Help
www.dwmha.com and www.mhwin.com

MHWIN ACCESS

Subject to the terms and conditions of this Agreement, the Authority hereby grants Service Provider non-transferable and non-exclusive access to MHWIN to permit the Service Provider and their office administrators, secretaries and clinicians (collectively "Authorized Users"), to electronically access and use MHWIN solely for storing, processing, and displaying health records and other information, images and content ("PHI") related to the provision of Covered Services to Members of Service Provider. Service Provider understands and warrants that such access and use shall be limited to that achieved through unique access codes provided to each individual Authorized User by the Authority, and that each Authorized User shall be prohibited from using another Authorized User's access code to access and/or use MHWIN. Service Provider further acknowledges and understands that the Authority may terminate individual Authorized Users' access at any time for any reason without penalty, regardless of any effect such termination may have on Service Provider's operations.

Service Provider acknowledges and agrees that any hardware, software, network access or other components necessary for Service Provider to access and use MHWIN must be obtained separately by Service Provider. The Authority shall not be responsible for the procurement, installation or maintenance of any necessary components, and the Authority makes no representations or warranties regarding the components whatsoever. Any fees for the components shall be borne by Service Provider and paid directly to the suppliers of the components.

Service Provider agrees to implement and utilize MHWIN and shall use MHWIN in accordance with all applicable laws and regulations, the terms of this Agreement, and with any network security policies issued by the Authority from time to time.

Service Provider shall designate a liaison to coordinate user access. The liaison is responsible for managing the modification and termination for accounts that the Service Provider is provided. Before access to MHWIN, each Authorized User shall select "I HAVE READ AND ACCEPT THESE TERMS." to the terms of the online confidentiality statement (the "Confidentiality Statement"). Provider agrees to ensure that each Authorized User approved for access under this Agreement adheres to the requirements of this Agreement and the Confidentiality Statement.

For purposes of this Agreement, access to MHWIN shall be permitted only for such categories of employees of Service Provider who have a reasonable need to access PHI of Authority Members for purposes of carrying out their duties to such Members. The Authorized Users of Service Provider who shall have access to MHWIN will be submitted to the Authority. Service Provider agrees to notify the Authority within 24 hours when any Authorized User is terminated or resigns from employment of Service Provider. Service Provider agrees that on a monthly basis it will validate that the Authorized Users that continue to require access to MHWIN and continue to be employees or agents of Service Provider.

Service Provider shall, within one (1) working day of becoming aware of an unauthorized use or disclosure of PHI by Service Provider, its officers, directors, employees, contractors, agents or by a third party to which Service Provider disclosed PHI, report any such disclosure to DWMHA. Such notice shall be made to the Authority's HIPAA Privacy and Security Officer(s).

Service Provider acknowledges that the Authority may implement additional safeguards and reporting requirements as it relates to Authorized User's access to MHWIN through the term of this Agreement.

Subject to the terms and conditions of this Agreement, the Authority hereby grants Service Provider non-transferable and non-exclusive access to MHWIN to permit the Service Provider and their office administrators, secretaries and clinicians (collectively "Authorized Users"), to electronically access and use MHWIN solely for storing, processing, and displaying health records and other information, images and content ("PHI") related to the provision of Covered Services to Members of Service Provider. Service Provider understands and warrants that such access and use shall be limited to that achieved through unique access codes provided to each individual Authorized User by the Authority, and that each Authorized User shall be prohibited from using another Authorized User's access code to access and/or use MHWIN. Service Provider further acknowledges and understands that the Authority may terminate individual Authorized Users' access at any time for any reason without penalty, regardless of any effect such termination may have on Service Provider's operations.

Service Provider acknowledges and agrees that any hardware, software, network access or other components necessary for Service Provider to access and use MHWIN must be obtained separately by Service Provider. The Authority shall not be responsible for the procurement, installation or maintenance of any necessary components, and the Authority makes no representations or warranties regarding the components whatsoever. Any fees for the components shall be borne by Service Provider and paid directly to the suppliers of the components.

Service Provider agrees to implement and utilize MHWIN and shall use MHWIN in accordance with all applicable laws and regulations, the terms of this Agreement, and with any network security policies issued by the Authority from time to time.

Service Provider shall designate a liaison to coordinate user access. The liaison is responsible for managing the modification and termination for accounts that the Service Provider is provided. Before access to MHWIN, each Authorized User shall select "I HAVE READ AND ACCEPT THESE TERMS." to the terms of the online confidentiality statement (the "Confidentiality Statement"). Provider agrees to ensure that each Authorized User approved for access under this Agreement adheres to the requirements of this Agreement and the Confidentiality Statement.

For purposes of this Agreement, access to MHWIN shall be permitted only for such categories of employees of Service Provider who have a reasonable need to access PHI of Authority Members for purposes of carrying out their duties to such Members. The Authorized Users of Service Provider who shall have access to MHWIN

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Service Provider acknowledges that the Authority may implement additional safeguards and reporting requirements as it relates to Authorized User's access to MHWIN through the term of this Agreement.

APPENDIX F

Ethics in Contracting Vendor Form