Contract Number.	Start Date	End Date	Contractor Name	Contract Type

MASTER AGREEMENT FOR PROVIDER SERVICES

THIS MASTER AGREEMENT FOR PROVIDER SERVICES (this "Agreement") is made and entered into on this ____ day of _____, 20___, by and between Bay-Arenac Behavioral Health Authority, whose business address is 201 Mulholland, Bay City, MI 48708 (hereinafter referred to as "BABHA" or as "CMHSP") and **[NAME OF PROVIDER]**, whose business address is [ADDRESS OF PROVIDER] (hereinafter referred to as the "Provider").

RECITALS

WHEREAS, BABHA desires to engage Provider to render certain behavioral health services to individuals for whom BABHA refers, arranges for or authorizes such services more specifically set forth in one or more Statements of Work, attached hereto and incorporated herein; and

WHEREAS, Provider desires to render certain services more specifically set forth herein pursuant to the terms and conditions of this Agreement and each applicable Statement of Work.

NOW THEREFORE, for valid consideration received, the parties, intending to be legally bound, hereby agree as follows:

1. Definitions.

1.1 All terms used in this Agreement shall be construed and interpreted as defined in this Agreement. All terms used herein and not otherwise defined shall have the meaning given in the Agreement between the Michigan Department of Health and Human Services ("MDHHS") and Mid-State Health Network (MSHN) for Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program (the "Contract"); the Mental Health Code (MHC) and the rules promulgated thereunder, the Public Health Code and the rules promulgated thereunder; or the Provider Requirements (defined below), as applicable.

1.2 For purposes of this Agreement the term "consumer" and "recipient" are the same and shall mean: an individual who is currently receiving services and/or supports through BABHA, a contracted Provider of BABHA, or a vendor through approved means of payment pursuant to a written contract with BABHA to provide services and supports.

2. Services.

2.1 Scope of Work: Provider shall render those services described more specifically in each Statement of Work according to the terms, conditions and requirements of this Agreement and each applicable Statement of Work ("SOW"), attached and incorporated hereto (the "Services"). Provider agrees to provide Services to all consumers referred by BABHA or its designee.

2.2 Medical Necessity: At the time of delivery, each Service must meet medical necessity criteria, as follows: For purposes of Medicaid, medical necessity with regard to mental health and/or substance abuse services has been defined to mean services that are: necessary for screening and assessing the presence of a mental illness or substance use disorder; and/or required to identify and evaluate a mental illness or substance use

disorder that is inferred or suspected; and/or intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness (or substance abuse) including impairment in functioning; and/or expected to arrest or delay the progression of a mental illness (or substance use) disorder and to forestall or delay relapse; and/or designed to provide rehabilitation for the recipient to attain or maintain an adequate level of functioning. Services must conform to accepted standards of care. All Services provided must be clearly specified as to scope, quantity, and duration in an approved person-centered plan of service. Services shall not be delayed or denied as a result of a dispute or potential dispute regarding payment.

2.3 Provider Requirements: All Services rendered and payment for same under this Agreement shall comply with the BABHA Provider Requirements, comprised of BABHA Policies and Procedures as applicable to Provider, the MDHHS PIHP/CMHSP Encounter Reporting Costing Per Code and Code Chart, and the MDHHS PIHP/CMHSP Provider Qualifications Chart, accessible at http://babha.org/about/for-providers/ and incorporated hereto by reference. Provider must request approval to implement specific practice areas that vary from BABHA Provider Requirements.

2.4 Description of Population to be Served. Provider agrees to provide Services under this Agreement to persons meeting the definitions of an adult with serious mental illness, a child with serious emotional disturbance, or a person with a developmental disability, or a person with a substance abuse disorder who is a resident of the catchment area of BABHA. Provider must accept referrals for all eligible and appropriate individuals as mutually determined by BABHA and Provider.

2.5 Hours of Operation: The provider is required to ensure that it offers hours of operation for consumers to be serviced under this Agreement that are no less than the hours of operation offered to commercial enrollees (if any) or comparable to Medicaid fee-for-service, if the provider services only Medicaid enrollees. When medically necessary, Provider must make Services included in this Agreement available 24 hours per day, seven days per week.

2.6 Relationship with Other Providers. Provider agrees to provide Services in cooperation with the employees and/or other contracted providers of BABHA, as directed by BABHA. The Provider shall deliver services in a manner consistent with defined service needs, objectives and arrangements. Services shall be delivered in accordance with consumer's person centered plan.

2.7 Public Health Reporting. Provider shall ensure, as applicable, that Provider's health professionals comply with all Michigan laws, rules, and regulations regarding public health reporting including, without limitation, communicable diseases, consumer abuse and neglect, and other health indicators.

2.8 Conflict of Interest: The Provider is subject to applicable federal and state conflict of interest statutes and regulations, including Section 1902(a)(4)(C) and (D) of the Social Security Act: 41 U.S.C. Chapter 21 (formerly Section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. §423): 18 U.S.C. §207)): 18 U.S.C. §208: 42 CFR §438.58: 45 CFR Part 92: 45 CFR Part 74: and 1978 PA 566: and MCL 330.1222.

2.9 Physical/Therapeutic Environment: In accordance with R 330.2807, Provider shall ensure, as applicable, that Provider's facilities and equipment comply with all applicable zoning, safety, health and building codes. Provider shall establish a program of preventative maintenance, sanitation and safety systems for its facilities and equipment. Provider shall ensure its services are physically accessible to all individuals. Provider shall establish written emergency plans which address natural disasters, fires, medical emergencies and bomb threats. Provider shall conduct and document training to familiarize its personnel with its written emergency and evacuation plans on a regular basis. Provider shall post safety and emergency rules and practices in conspicuous places.

2.10 Complaints, Appeals and Grievances: The parties hereto acknowledge and agree to comply with the provisions of the *"Complaint, Disagreement, Disputes & Grievances Policies and Procedures"* and the

"Provider Grievance and Appeal Procedure" set forth in the Provider Requirements with respect to complaints, disputes, appeals and grievances involving this Agreement, the Services or payment for same hereunder.

2.11 HCBS Transition Implementation. The Provider will work with BABHA to establish policy guidance and monitoring standards to assure full compliance with the Home and Community Based Setting requirements and the MDHHS approved transition plan.

3. Claims Administration.

3.1 Third Party Payments. Provider will comply with Provider Requirements regarding third party payments. If applicable to the provider type, the Provider agrees to pursue any other possible third party insurance benefits available to cover the charges related to the provision of consumer care. This includes participating in the Medicare program or other commercial insurance plan as an inpatient or outpatient mental health service provider as indicated. The Provider agrees to follow all applicable coverage rules in order to capture reimbursement from other health insurers prior to billing BABHA. The Provider understands that any costs incurred due to failure to follow appropriate third party insurance rules will not be reimbursed by BABHA.

3.2 Coordination of Benefits. Provider will comply with Provider Requirements regarding coordination of benefits. The Provider acknowledges that BABHA is the payor of last resort for Services. The Provider shall not bill BABHA unless and until the Provider has collected from all payors precedent, if any, to BABHA. All claims on which prior partial payment has been made by another payor other than the recipient shall be submitted using paper claim forms to BABHA accompanied by an explanation of benefits/remittance advice from the payor.

3.3 Application for Medicaid Benefits. Provider shall assist eligible consumers to apply for and maintain Medicaid coverage. Provider agrees to report Medicaid eligibility changes to BABHA or its designee. Provider will develop a process to implement the above procedures.

3.4 Ability to Pay. Provider will comply with Provider requirements regarding the assessment/determination of consumer ability to pay. Ability to pay is determined and reviewed annually as required by the Mental Health Code.

3.5 Prior Authorization Requirements. Services provided under this Agreement must conform to the requirements for medical necessity, authorization, pre-authorization, or tracking as defined in protocols located in the Provider Requirements. An authorization does not necessarily guarantee the payment for any services rendered to the consumer.

3.6 Claims Submission. Provider is encouraged to submit claims using the online billing module ("Phoenix") available to BABHA Providers. If submitting paper claims, at least 90% of all clean claims will be processed and reimbursed within 30 days of receipt. Provider is required to bill for Services rendered to the consumers as soon as practical following the service delivery, or within ninety (90) days following the date of service, or within 90 days of receipt of the explanation of benefits (EOB) from the primary insurance. BABHA will work with Provider if extenuating circumstances should arise and claim submission exceeds the required 90 days from date of service. Detailed information regarding claims submission is set forth in the Provider Requirements.

3.7 Claims Management. Provider shall not require any co-payments, recipient pay amounts, or other cost sharing arrangements unless specifically authorized by state or federal regulations and/or policies. Provider may not bill individuals for the difference between the Provider's charge and BABHA's payment for services. Provider shall not seek nor accept additional supplemental payment from the individual, his/her family, or representative, for services authorized by BABHA. Provider shall not hold a Medicaid enrollee liable for any

costs, charges, fees or other liabilities in the event that BABHA becomes insolvent, for which payment is not made by BABHA, the State, or other authorized payer, or for which Provider has not or will not be paid by BABHA, the State or other authorized payor.

3.8 Documentation Supporting Claims. All Services must be properly documented and supported by the appropriate clinical documentation written in each consumer's medical record. Documentation supporting claims must comply with Provider Requirements and at a minimum must include date, start and stop time, contact type, attendance, location of service, description of service provided and signature of the staff providing the service. Insufficient, improper or undocumented services in the medical record will not be reimbursed by BABHA and may subject the Provider to reclamation/repayment. Upon request, Provider agrees to forward all appropriate clinical documentation supporting the delivery of Services to the agency holding the active, master medical record, within seven (7) calendar days of the provision of Services.

3.9 Excluded Provider/Entity Claims. Provider will comply with Provider Requirements regarding exclusion and debarment from participation in state and federal health care programs. BABHA will not accept, under any circumstances, claims from Provider for any items or services furnished, ordered or prescribed by individuals or entities excluded, debarred or suspended from participation in Federal healthcare programs or procurement. Upon discovery by BABHA or upon notice from Provider, BABHA shall recoup, and Provider shall return, any and all prior payments made to Provider for items or services furnished, ordered or prescribed by excluded, debarred or suspended individuals or entities. In addition to the amount of any claim paid to Provider in violation of federal or state law, BABHA may also recover costs including, without limitation, administrative costs and expenses, and/or penalties or fines commensurate with amounts imposed by federal or state governments as a result of the Provider's breach. BABHA also reserves all rights to seek any other remedies available at law and/or in equity.

3.10 Overpayments: Funds paid to Provider based upon false or improper claims will be considered an overpayment by BABHA and are subject to reclamation/repayment.

4. Term and Termination.

4.1 Term. The initial term of this Agreement shall begin on October 1, 2019 and shall continue for a period of one (1) year, expiring on September 30, 2020, unless earlier terminated as set forth herein. Following expiration of the term, this Agreement will continue on a month-to-month basis unless a new agreement is executed by the parties or this Agreement is terminated as set forth herein.

4.2 Termination without Cause. Either party may terminate this Agreement at any time without cause by providing ninety (90) days prior written notice to the other party, unless a shorter time frame is mutually agreed to by both parties. This Agreement may be immediately terminated as a result of a change in the consumer's condition, including, without limitation, discharge or transfer from the program, or death.

4.3 Termination With Cause. In the event the Provider breaches any of the terms of this contract (and if BABHA deems such a breach to be a material breach), BABHA may terminate this contract immediately and without prior notice. Provider shall continue to render Services consistent with the terms and conditions of this Agreement during any notice period and shall complete all consumer documentation prior to the effective date of termination.

4.4 Extension or Renewal. Nothing in this Agreement shall be construed as requiring either of the parties hereto to extend or renew this Agreement or to enter into any subsequent agreements.

4.5 Continuity of Care Upon Termination of Agreement. Provider shall continue to render Services consistent with the terms and conditions of this Agreement during any notice period and shall complete all consumer documentation prior to the effective date of termination. Provider will assure consumer treatment and care

continues regardless of the reason for termination of this Agreement. Provider duties and responsibilities for consumer care and treatment shall survive termination or expiration of this Agreement, regardless of cause.

4.6 Return of Property. Upon termination or expiration of this Agreement, regardless of cause, Provider shall immediately surrender all property belonging to BABHA if any such property was loaned to the Provider for purposes of fulfilling its responsibilities under this Agreement within fourteen (14) days of termination or expiration.

5. Consumer Medical Records.

5.1 Creation of Medical Records. Provider agencies whose responsibilities under this agreement, as defined in the Statement of Work, are that of a primary care provider shall either utilize the BABH electronic medical record keeping system for services delivered under this agreement or establish and maintain a separate comprehensive individual service record system consistent with the provisions of the Michigan Medical Services Administration Policy Bulletins and the Michigan Medicaid Manual, and appropriate state and federal statutes. The Provider shall maintain in legible manner via hard copy or electronic storage/imaging, recipient service records necessary to full disclose and document the quantity, quality, appropriateness and timeliness of services provided.

5.2 Submission of Medical Records. Provider agencies who responsibilities under this agreement as defined in the attached Scope of Work are that of a primary care provider and who establish and maintain their own medical record keeping system shall submit medical information and documents as required by BABH through limited direct data entry and faxing for purposes of BABH regulatory compliance and quality management of the service delivery system. Providers who are licensed independent practitioners or individual ancillary service providers shall fax completed medical record documents as required by BABH.

5.3 Retention of Medical Records. Medical records shall be retained according to the retention schedules in place by the Department of Management and Budget (DTMB) General Schedule #20 at: http://michigan.gov/dmb/0,4568,7-150-9141_21738_31548-56101--,00.html, unless a longer period applies under Michigan law, The provisions of this Section shall survive the expiration or termination of this Agreement, regardless of cause.

5.4 Access to Medical Records. Provider shall make such medical records available to BABHA for the purpose of assessing quality of care, conducting medical care evaluations and audits, determining the medical necessity and appropriateness of Services provided to consumers, and investigating grievances or complaints made by consumers. Provider shall also make consumer medical records available to the MDHHS, HHS and other state and federal regulatory bodies having jurisdiction over the delivery of Services to consumers for purposes of assessing the quality of care or investigating member grievances or complaints. Provider shall make available to consumers, at his/her request, access to consumers medical records and shall comply with all state and federal laws and regulations regarding access, privacy and confidentiality of medical records and release of such consumer's medical records to third parties. The provisions of this Section shall survive the expiration or termination of this Agreement, regardless of cause.

5.5 Transfer of Medical Records. Upon receipt of written request from BABHA, Provider shall transfer to the requesting provider copies of all consumer medical records, and other data in the possession or control of Provider pertaining to the named consumer within ten (10) working days of such notice.

6. Quality Improvement Program/Site Reviews/Performance Monitoring.

6.1 Quality (and/or Performance) Improvement. All Services rendered by Provider shall comply with the quality improvement, performance improvement, and utilization management program of BABHA. As part of the clinical management process, Provider agrees to report clinical and outcome information to BABHA or its designee. Such information is submitted on a regular basis as determined by the level of care delivered by the Provider. Provider agrees to cooperate with the CMHSP staff for purposes of assessing medical necessity and other clinical variables related to management of Services as set forth in each applicable SOW, attached an incorporated hereto.

6.2 Practice Guidelines. As applicable for certain Services, Provider shall ensure Services are delivered in accordance with the guidelines set forth this Section and more specifically described in the Provider Requirements: (i) Inclusion Practice Guideline; (ii) Housing Practice Guideline; (iii) Consumerism Practice Guideline; (iv) Personal Care in Non-Specialized Home Guideline; (v) Person-Centered Planning Practice Guideline; (vi) Attachment P3.4.10 Recovery Policy and Practice Advisory of the Master Medicaid Contract, (vii) Self Determination, (viii) CMHSP Trauma Policy, and other practice guidelines issued by BABHA.

6.3 Site Reviews, Performance Monitoring and Feedback. BABHA will conduct reviews and audits of Provider performance under this Agreement. BABHA will make a good faith effort to coordinate reviews and audits to minimize disruption to provider operations and to avoid duplication of effort. The focus of provider review is on the degree to which the provider has implemented the requirements of this Agreement and the degree of compliance with performance standards, performance indicators, and other BABHA requirements. Provider shall comply with the corrective action requirements of BABHA, including compliance with corrective action plan submission and subsequent implementation of approved corrective action plans. Corrective action plans submitted by Provider are deemed approved unless BABHA indicates, in writing within thirty (30) days of receipt of the corrective action plan, that such corrective action plan is not approved. If, during a BABHA on-site visit, the site review team member identified an issue that places a recipient in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the Provider, which must be completed in seven (7) calendar days. Provider will cooperate fully and respond promptly with requests for evidence from BABHA during preparation for CARF, MSHN and MDHHS site reviews.

6.4 Health and Safety. Provider shall immediately notify BABHA and shall arrange for the immediate transfer of recipients to a different provider, if the health and/or safety of the recipient is in jeopardy.

6.5 Smoke-Free Facilities All Services funded in whole or in part through this Agreement will be delivered in a smoke-free facility or environment. If such Services are delivered in residential facilities or in facilities or areas that are not under the control of Provider (e.g., a mall, residential facilities or private residence, restaurant, or private work site), the Services shall be delivered smoke-free.

6.6 Satisfaction Surveys.

6.6.1 The Provider's Clinical staff will obtain and document consumer feedback on satisfaction with services on at least a monthly basis. Documentation will be maintained in a progress note and/or quarterly report.

6.6.2 Provider shall conduct satisfaction surveys of persons receiving treatment at least once a year, unless notified by BABHA that satisfaction surveys will be conducted by BABHA/MSHN.

6.6.3 The results of the consumer satisfaction measurement process will be available to BABH at least annually, or per the time frame specified in provider policies or procedures pertaining to consumer satisfaction reporting. Provider shall maintain evidence that they addressed trends in the responses to the surveys.

6.7 Adverse Event Reporting System. The Adverse Event Reporting System captures information on three types of events: critical (which include sentinel), risk, and event notification. The population on which these events must be reported differs slightly by type of event. Provider agrees to comply with the BABHA Reporting and Investigation of Adverse Events Policy included in the Provider Requirements.

6.7.1 Critical Incidents. Reporting of these events minimally include

a) Suicide and non-suicide deaths

b) Emergency medical treatment due to injury or medication error

c) Hospitalization due to injury or medication error

d) Arrest of consumer

6.7.1 Risk Event Management. Reporting of these events minimally include:

a) Actions taken by individuals who receive services that cause harm to themselves

b) Actions taken by individuals who receive services that cause harm to others

c) Two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period

d) Emergency Physical Intervention

e) 911 calls to law enforcement for behavioral assistance

6.7.2 Event Notification Requirements

a) Any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing, or police investigation.

b) Relocation of a consumer's placement due to licensing suspension or revocation.

c) The conviction of a provider panel staff members for any offense related to the performance of their job duties or responsibilities which results in exclusion from participation in federal reimbursement.

7. Program Integrity.

7.1 Provider agencies shall implement and maintain written policies, procedures and standards of conduct, appropriate to the type and scale of the Provider agency, that articulate the organization's commitment to comply with the program integrity requirements of this agreement and the Provider's expectations for its personnel, including the following:

7.1.1 The designation of a compliance officer or contact person, and provisions for lines of communication between the designee and the Provider's personnel;

7.1.2 Training of personnel regarding the Federal False Claims Act, Michigan False Claims Act and Whistleblowers Protection Act, including Provider practices for the prevention, identification and

reporting errors, waste, abuse and fraud; and Provider disciplinary standards relative to fraud, waste and abuse, and their enforcement;

7.1.3 Routine internal monitoring of compliance risks, and prompt response to errors and waste identified;

7.1.4 Reporting within 24-48 hours to BABH any suspicion or knowledge of fraud or abuse, including if possible, the nature of the complaint, the name of the individuals or entity involved in the suspected fraud and abuse, including name, address, phone number, Medicaid identification number and/or any other identifying information; and

7.1.5 In the case of Provider agencies that receive annual payments under the Agreement of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act (31 USC 3729-3733, the elimination of fraud and abuse in Medicaid provisions of the Deficit Reduction Act of 2005; and the Michigan Medicaid False Claims Act (PA 72 of 1977, as amended by PA 337 of 2005) and the Michigan Whistleblowers Protection Act (PA 469 of 1980).

7.2 Providers contracting with BABHA as licensed independent practitioners or individual ancillary service providers agree to:

7.2.1 Receive compliance training through BABH and comply with all applicable federal and state standards, including but not limited to the False Claims Act (31 USC 3729-3733, the elimination of fraud and abuse in Medicaid provisions of the Deficit Reduction Act of 2005; and the Michigan Medicaid False Claims Act (PA 72 of 1977, as amended by PA 337 of 2005).

7.2.2 Utilize internal monitoring mechanisms to ensure only valid service claims, free of fraud and abuse, are submitted to BABH for payment.

7.2.3 Report within 24-48 hours to BABH any invalid claims for correction and to cooperate with BABH regarding reclamation of any payments made based upon invalid claims. Provider agrees to implement internal process changes to mitigate the risk of future claims payment issues.

7.3 Provider agrees not to investigate or resolve alleged fraud and/or abuse prior to reporting and to fully cooperate with any investigation by BABHA, its payers and/or the MDHHS or Office of the Attorney General and with any subsequent legal action that may arise from such investigation.

7.4 Provider agrees to immediately notify BABHA with respect to any inquiry, investigation, sanction or other notice received from the Michigan Office of Health Services Inspector General (MIOHSIG).

8. Licensing, Training and Staffing.

8.1 Provider shall ensure all services are provided by staff licensed, credentialed or certified under applicable state statues and regulations to do so. BABHA requires documentation to be maintained by the Provider adequate to prove compliance with this requirement.

8.1.1 The MDHHS requires BABHA to ensure that contracted providers perform criminal background checks on their employees, prior to hire and at least every two years, or have a method of auto-notification from authorities. These criminal background checks are a requirement of this Agreement. Provider must have, and follow, a policy on hiring of persons with criminal backgrounds that is consistent with applicable licensing and/or certification rules. Fingerprinting may be required for any staff providing services in licensed residential facilities. Criminal background check procedures and resources can be found in the Provider Requirements.

8.1.2 For staff transporting consumers, the Provider shall verify driver's license and proof of insurance upon hire and annually thereafter.

8.1.3 Provider shall maintain evidence that Aide level staff meet the minimum qualifications for aide level workers:

a) Must be at least 18 years of age
b) Are able to prevent transmission of any communicable disease from self to others in the environment in which they are providing supports. For provider staff serving individuals on the SED Waiver and for CLS staff in licensed settings, a TB test is required every three (3) years.
c) Are able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and report on activities performed
d) Are in good standing with the law (ie, not a fugitive from justice, and not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing)
e) Are not an illegal alien (undocumented worker)
f) Are able to perform basic first aid procedures, as evidenced by completion of a first aid training course, self-test, or other method determined by the CMHSP to demonstrate competence in basic first aid procedures, and
g) Have received training in the beneficiary's IPOS

8.1.4 The Provider shall obtain and maintain during the term of this agreement all licenses, certifications, registrations, National Provider Identifier (NPI) numbers required pursuant to Section 5005 of the 21st Century Cures Act.

8.1.5 Effective January 1, 2019, Central Registry Checks are required for all child care staff members working with minor children, per the Child Care Licensing Act 116 of 1973; MCL 722.111. Central Registry Checks are to be conducted prior to hire and at least every two (2) years.

8.2 Provider shall ensure the cultural competence of staff and the ability of its staff to assist consumers of limited English proficiency. As applicable, Provider maintains staff development plans that address cultural competency and limited English proficiency issues and ensures training in these areas. Provider is expected to document compliance in each of its employees' personnel or training files.

8.3 All persons providing professional services to consumers shall be the employees or contractors of the Provider and shall not be considered employees of the CMHSP and shall be supervised solely by the Provider.

8.4 Provider will ensure that its staff is adequately trained to provide the Services specified in the applicable SOW and in the consumer's IPOS for which Provider is responsible.

8.5 Documentation of training requirements shall be made available to the CMHSP upon reasonable request, for each employee directly participating in the care of CMHSP consumers. Documentation shall include a staff dated signature that they participated in specific training or an individual training certificate.

9. Recipient Rights.

9.1 BABHA will provide initial and annual training regarding Recipient Rights in a certified CMHSP training module that is approved by the MDHHS Office of Recipient Rights as detailed in Section 7 and 7A of the MHC. (AR 330.1806).

9.2 Provider agrees to safeguard, protect, and promote the rights of recipients. The Provider is expected to follow the Recipient Rights provisions of the Mental Health Code, corresponding Administrative Rules, and the Recipient Rights Policies and Procedures delineated in the Provider Requirements and/or Exhibit B to this Agreement, and the following provisions:

9.3 Provider hereby agrees to comply with, in their entirety, the policies and procedures providing for the safeguarding of the rights of recipients as established by BABHA.

9.4 Provider agrees to protect the rights of all persons using their services as guaranteed in 1974 Public Act 258, as amended, and 330.7001, et seq. of the Michigan Administrative Rules. Provider agrees that recipients will be protected from rights violations while receiving services under this contract.

9.5 Provider agrees to assume responsibility for the administration, quality of care, treatment services, and protective services for all consumers admitted for care. The term "Protective services" as used in this paragraph of this agreement means reporting and referral services required by the Provider under Michigan's Adult Abuse Reporting Act, being MCLA 400.1 of the Michigan Compiled Law, or the Child Protection Law, Act 238 of the Public Acts of 1975 being Section 722.621, et seq. of the Michigan Compiled Laws, as amended.

9.6 Provider agrees to maintain the confidentiality of information regarding recipients in compliance with Sections 748 and 750 of the MHC.

9.7 Provider agrees to ensure that each person served under this agreement is provided with a MDHHS "Your Rights" booklet and that these booklets are made available to recipients, visitors, and employees. Each Provider site must have the name and telephone number of BABHA Recipient Rights Officer and the "Abuse and Neglect Reporting" poster posted in a conspicuous place.

9.8 Provider shall ensure a summary of section 748 of the Michigan Mental Health Code will be filed in the case record for each recipient.

9.9 Provider agrees to monitor the safety and welfare of recipients while being served under this agreement and to provide immediate comfort and protection to and assure immediate medical treatment for a recipient who has suffered physical injury. Provider shall not segregate persons receiving services under this Agreement in any way from non-CMH individuals receiving Provider's services.

9.10 Provider may designate a person to act in the capacity of a Recipient Rights Advisor for persons receiving services under this agreement. If an Advisor is designated, the Advisor shall be familiar with rights requirements and shall not provide direct treatment services. The Advisor shall work cooperatively with BABHA Recipient Rights Office. The Advisor will ensure Provider service sites maintain appropriate Recipient Rights postings and have a supply of Recipient Rights Booklets, Complaint Forms, and Incident Reporting Forms available. The Advisor will not investigate Recipient Rights complaints or interfere with the execution of the duties of the BABHA Recipient Rights Officer. The Provider agrees to ensure that the Advisor receives Recipient Rights training and receives adequate ongoing training to execute the duties of the Advisor position.

9.11 Provider agrees to ensure that persons using their services, parents, guardians, and others have access to complaint forms and information about the complaint process.

9.12 Provider shall ensure that all staff obtain Recipient Rights training from the local Community Mental Health Services Program Recipient Rights Office staff within 30 days of hire, and annually thereafter. Provider agrees to do Recipient Rights background checks for all potential employees.

9.13 Provider agrees to ensure that all verbal and/or written reports of alleged violations of Rights are forwarded immediately in writing or via phone to BABHA Rights Office.

9.14 Provider will cooperate fully during Recipient Rights investigations. The BABHA Recipient Rights officer shall have unimpeded access to all BABHA consumers, medical records, or applicable staff records at any time during alleged Recipient Rights investigations. Provider employees are required to cooperate with BABHA Recipient Rights Office during investigations. The Provider agrees to allow individuals who properly identify themselves as representatives of Michigan Protection and Advocacy Services (P&A) access to premises, recipients and service records in compliance with Sections 748 and 750 of the MHC.

9.15 Provider agrees to implement appropriate remedial or disciplinary action for substantiated allegations of rights violations and submit a written description of said remedial or disciplinary action to BABHA Recipient Rights office within five (5) business days of receipt of the Investigative Report.

9.16 Provider agrees to comply with BABHA Recipient Rights reporting requirements regarding death, unusual incidents, serious injury, suspected abuse or neglect and all other alleged rights violations concerning a recipient while they are being served under this agreement. Provider agrees to comply with those Recipient Rights reporting requirements as established by Department of Licensing and Regulatory Affairs, Protective Services (Adults & Children), state and federal law and other public agencies as applicable.

9.17 Provider agrees to furnish the BABHA's CEO with immediate notice of any sentinel event involving any Consumer being served hereunder. The Provider shall report the death, serious injuries, suspected abuse or neglect and all other sentinel events regarding a Consumer hereunder to BABHA-designated staff representatives immediately by telephone and then, in writing on BABHA-designated forms within twenty-four (24) hours of the occurrence and, as required by law, to (Adult and Children) Protective services Division of the applicable department of the State of Michigan, law enforcement, and other public agencies. In addition, incident reports for all other non-critical events will be completed and forwarded to the Recipient Rights Office within 24 hours of the occurrence.

9.18 Provider agrees to ensure that consumers, BABHA staff or anyone acting on behalf of the consumer shall be protected from harassment or retaliation resulting from Recipient Rights activities. If evidence is shown of harassment or retaliation, the Provider shall take appropriate disciplinary action.

9.19 Provider will ensure unimpeded access for BABHA to, at any time, and at least annually, to review the Providers records regarding Recipient Rights requirements such as staff training logs, to complete annual site visits for monitoring of rights protection and to ensure compliance with BABHA's policies and procedures.

10. **Representations and Warranties.**

10.1 Provider represents and warrants, on behalf of itself and its officers, directors, shareholders, employees, agents, contractors and sub-contractors, that Provider shall comply with all applicable federal and state laws and all applicable rules and regulations with respect to rendering services under this Agreement. Provider, for itself and its Personnel, further represents and warrants that Provider and its Personnel shall comply with the following: Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990, as amended (ADA); Michigan Persons With Disabilities Civil Rights Act (PWDCRA), MCL 37.1101 et seq.; Michigan's Elliot-Larsen Civil Rights Act, MCL 37.2101 et

seq.; the Pro-Children Act of 1994, 20 USC 681 et seq.; Clean Air Act, 42 USC 7401; Federal Water Pollution Control Act, 33 USC 1251; 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); the Hatch Political Activity Act, 5 USC 1501-1508, and the Intergovernmental Personnel Act of 1970, as amended by Title VI of the Civil Service Reform Act, Public Law 95-454, 42 USC 4728; the Office of Civil Rights Policy Guidance on Title VI Prohibition Against Discrimination for persons with Limited English Proficiency (guidance regarding responsibilities for providing language assistance under Title VI of the Civil Rights Act of 1964);Section 1557 of the Patient Protection and Affordable Care Act (ACA)

10.2 Debarment and Suspension. The Provider agrees that services delivered under this agreement must comply with the Federal Acquisition Regulations (45 CFR 76) and certifies that its employees and subcontractors (i) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or PIHP; (ii) have not within a three (3) year period preceding this Agreement been convicted of or had a civil judgment rendered against it for commission of fraud or 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 this Section; and (iv) have not within a three (3) year period preceding this Agreement had one or more public transactions (federal, state or local) terminated for cause or default.

10.3 Exclusion from Participation in Federal Health Care Programs. In order to comply with 42 CFR 438.610, the Provider represents and warrants that Provider does not have any of the following relationships with an individual who is excluded from participating in Federal health care programs: excluded individuals cannot be a Director, Officer or Partner of the Provider; excluded individuals cannot have a beneficial ownership of five percent or more of the Provider organization's equity; and excluded individuals cannot have an employment, consulting, or other arrangement with the Provider for the provision of items or services that are significant and material to the Provider's obligations under this agreement, and are funded in whole or in part, by the U.S. Government or state health care program.. Excluded individuals or entities are those that have been excluded from participating, but not reinstated, in the Medicare, Medicaid, or any other Federal healthcare programs. Basis for exclusion include convictions for program-related fraud and patient abuse, licensing board actions and default on Health Education Assistance loans.

10.3.1. Disclosure of Ownership and Control Interests. Provider will comply with all Federal regulations, including 42 CFR 455.104, by disclosing to the BABHA CEO information about individuals with ownership or control interests in Provider, if any, by completing and executing Exhibit C, attached and incorporated hereto, and returning same with an executed copy of this Agreement. The Federal regulations also require Provider to identify and report any additional ownership or control interests for those individuals in other entities, significant and material to Provider's obligations under this Agreement with BABHA, as well as identifying when any of the individuals with ownership or control interests have spousal, parent-child, or sibling relationships with each other. The Minimally, Provider must disclose changes in ownership and control information at the time of enrollment, re-enrollment, or within 35 days after a change in Provider ownership or control takes place. In addition, Provider shall ensure that any and all contracts, agreements, purchase orders or leases to obtain space, supplies, equipment or services provided under this Agreement require compliance with 42 CFR 455.104.

10.4 Disclosure of Business Transactions. Provider agrees to submit, within 35 days of the date of a request by BABHA or its Medicaid payers(s), ownership information regarding any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of

the request and any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request. Provider agrees that payment for services provided may be impacted in accord with 42 CFR 455.105 for failure to comply with such a request. In addition, Provider shall ensure that any and all contracts, agreements, purchase orders or leases to obtain space, supplies, equipment or services provided under this Agreement require compliance with 42 CFR 455.105.

10.5 Disclosure of Criminal Convictions. In accordance with 42 CFR 455.106, Provider agrees to promptly disclose to the BABHA CEO if Provider, including its Director(s), Officer(s), Partner(s), staff member and individuals with ownership or control interests in Provider, if any, are convicted of a criminal offense described under sections 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act. Provider agrees to include criminal offense(s) related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs. Minimally, Provider must disclose any health care related criminal convictions to BABHA at the time of enrollment, re-enrollment, or within 20 working days after Provider becomes aware of the conviction. Provider agrees BABHA may refuse to enroll or re-enroll the Provider if any person who has an ownership or control interest in the Provider, or who is a managing employee of the Provider, has been convicted of such a criminal offense. In addition, Provider shall ensure that any and all contracts, agreements, purchase orders or leases to obtain space, supplies, equipment or services provided under this Agreement require compliance with 42 CFR 455.106.

10.6 Monitoring and Disclosure of Exclusion, Debarment and Suspension. Provider agrees that failure to comply with Federal requirements that prohibit employment or contractual arrangements with providers excluded from participation under either Medicare, Medicaid or other federal or state health care programs will result in Medicaid overpayment liability and may result in civil monetary penalties. Provider agrees to perform checks at the time of initial engagement of an employee or contractor, at the time of renewal of engagement, on a monthly basis, and at the time new disclosure information is received. Checks must include the US Dep't of Health and Human Services Office of Inspector General's List of Excluded Individuals/ Entities (LEIE) at http://exclusions.oig.hhs.gov, the federal government's System for Award Management (SAM) at www.SAM.gov,and the Michigan Department of Health and Human Services website at www.michigan.gov/MDHHS (see Doing Business with MDHHS/Health Care Providers/List of Sanctioned Providers or http://www.michigan.gov/mdhhs/0, 5885,7-339-71551_2945_42542_42543_ 42546_42551-16459--,00.html). Provider agrees to maintain documentation showing proof of having completed the exclusion checks at the required frequency and to make such documentation available to BABHA personnel for verification during site visits. Provider agrees to notify the BABHA CEO within two business days if search results indicate that an employee, contractor, or individuals or entities with ownership or control interests in a provider entity appear on the exclusions databases.

10.7 Provider agrees to notify BABH if Provider receives any information, notice, actions, claims, or events regarding the representations and warranties set forth in this Section. Provider shall require the representations and warranties in this Section be included in any authorized subcontracted agreements.

10.8 Health Insurance Portability and Accountability Act and 42 CFR PART 2. The Provider agrees that all Protected Health Information and substance use disorder treatment information generated, received, maintained, used, disclosed or transmitted by Provider and BABH in the performance of this Agreement must comply with HIPAA's Privacy Rule, Security Rule, Transaction and Code Set Rule and Breach Notification Rule and 42 CFR Part 2 (as now existing and as may be later amended).

10.8.1. If the Provider is a HIPAA Covered Entity and/or Program under 42 CFR Part 2, and this Agreement is for the purpose of treatment services, Provider attests it maintains a privacy and security program which complies with the Privacy Rule, Security Rule, Transaction and Code Set Rule and Breach Notification Rule, and 42 CFR Part 2 (as now existing and as may be later

amended). The Provider agrees to report to BABHA within two business days any suspected or confirmed unauthorized use or disclosure of protected health data and information that falls under the HIPAA requirements of which the Provider becomes aware, and to provide assurances to BABHA of corrective actions to prevent further unauthorized uses or disclosures.

10.8.2. If the Provider is not a HIPAA Covered Entity and/or Program under 42 CFR Part 2, it attests it will comply with the following requirements as articulated in the MDHHS Medicaid Managed Specialty Supports and Services Contract:

a) Not sharing any protected health data and information that falls within HIPAA requirements except as permitted or required by applicable law; or to a subcontractor as appropriate under this agreement.
b) Ensuring that any subcontractor will have the same obligations as the Provider not to share any protected health data and information that falls under HIPAA requirements in the terms and conditions of the subcontract.
c) Using the protected health data and information only for the purposes of this agreement.
d) Having written policies and procedures addressing the use of protected health data and information that falls under the HIPAA requirements. The policies and procedures must meet all applicable federal and state requirements including the HIPAA regulations. These policies and procedures must include restricting access to the protected health data and information by the Provider's employees.
e) Having a policy and procedure to immediately report to BABH any suspected or confirmed unauthorized use or disclosure of protected health data and information that falls under the HIPAA requirements of which the Provider becomes aware. The Provider will work with BABH to mitigate the breach and will provide assurances to BABH of corrective actions to prevent further unauthorized uses or disclosures.
f) Failure to comply with any of these contractual requirements may result in the termination of this agreement in accordance with Section 19. In accordance with HIPAA requirements, the Provider is liable for any claim, loss or damage relating to unauthorized use or disclosure of protected health data and information by the Provider or subcontractor.
g) All recipient information, medical records, data and data elements collected, maintained, or used in the administration of this agreement shall be protected from unauthorized disclosure as required by state and federal regulations. Safeguards must be provided that restrict the use or disclosure of information concerning recipients to purposes directly connected with its administration of the agreement.
h) Written policies and procedures for maintaining the confidentiality of all protected information must be in place.

10.8.3. Licensed independent practitioners and individual ancillary service providers shall enter into a HIPAA Business Associate Agreement and a Qualified Service Organization Agreement with BABH that complies with applicable laws, as attached and incorporated hereto as Exhibit A.

10.9 Unfair Labor Practices. Provider shall comply with the Unfair Labor Practice Act, MCL 423.321 et seq. Provider agrees and acknowledges that BABHA may immediately terminate this Agreement if Provider or any permissible subcontractor of Provider appears in the current register maintained by Michigan Department of Licensing and Regulatory Affairs.

10.10 MDHHS Standard Release Form. It is the intent of the parties to promote the use and acceptance of the standard release form that was created by MDHHS under Public Act 129 of 2014.

11. **Business Records and Audits.**

11.1 Provider Business Records. Provider shall maintain adequate program, participant, and fiscal records and files including source documentation to support Provider's program activities and all expenditures and billings made under the terms of this Agreement, as required. Provider shall maintain records and detailed documentation for the Services rendered and identified in this Agreement for a period of not less than six (6) years from the date of termination or expiration of this Agreement, the date of submission of the final billing, or until litigation and audit findings have been resolved, whichever is longer. All of Provider's records, including consumer medical records, shall be readily available at any reasonable time for examination or audit, and Provider shall fully cooperate in the examination or auditing of its records by BABHA, its agents or any appropriate funding source or governmental agency. Upon request, Provider shall assist with interpreting its records and shall provide all background working papers or other documents, memoranda or records of any sort, which may be helpful.

11.2 Financial Review. The provider shall submit, on request of the CMHSP, financial statements and related reports and schedules that accurately reflect the financial position of the provider. Provider must submit, within 120 days of the close of its fiscal year, its financial statements and supporting reports and schedules as presented to its governance authority. The CMHSP reserves the right to require the provider to secure an independent financial audit.

11.3 Administrative Cost Requirements. Provider agrees to comply with BABHA administrative cost gathering procedures as required by the Contract with MDHHS and as may be required by BABHA from time to time.

11.4 IRS Form 990. All Providers that are nonprofit tax-exempt organizations and required to file IRS Form 990 shall submit a copy of the most recent informational return to BABHA immediately following filing of same.

11.5 Accounting and Internal Controls. Provider shall ensure its accounting procedures and internal financial controls conform to generally accepted accounting principles in order that the costs allowed by this Agreement can be readily ascertained and expenditures verified there from. The parties understand and acknowledge that their accounting and financial reporting under this Agreement must be in compliance with MDHHS accounting and reporting requirements.

11.6 Access to Books and Records. If the Secretary of the U.S. Department of Health and Human Services, the Controller General of the United States or their duly authorized representatives (hereinafter referred to as the "Requesting Parties") request access to books, documents, and records of the Provider at any time within six (6) years of the termination of this Agreement, in accordance with Section 952 of the Omnibus Reconciliation Act of 1980 [42 USC 1395x(v)(1)(I)] and the regulations adopted pursuant thereto, the Provider hereby agrees to provide such access to the extent required. Furthermore, the Provider hereby agrees that any contract between it and any other organization to which it is to a significant extent associated or affiliated with, owns or is owned by or has control of or is controlled by (hereinafter referred to as "Related Organization"), and which performs services on behalf of it or the other party hereto will contain a clause requiring the Related Organization to similarly make its books, documents, and records available to the Requesting Parties.

11.7 Right to Audit. The parties hereto agree that the right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, that occurs during such 10 year period, whichever is later, in accordance with 42 CFR 438.230(c) (3)(iii). The parties further agree that if MDHHS, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, MDHHS, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time, in accordance with 42 CFR 438.230(c)(3)(iv).

12. Non-Discrimination.

12.1 Provider shall not refuse to treat nor will they discriminate in the treatment of any consumer, recipient, patient or referral, under this Agreement, based on the individual's source of payment for services, or on the basis of age, height, weight, marital status, arrest record, race, creed, handicap, color, national origin or ancestry, religion, gender, sexual preference, political affiliation or beliefs, or involuntary patient status.

12.2 Provider shall assure equal access for people with diverse cultural background and/or limited English proficiency, as outlined by the Office of Civil Rights Policy Guidance in the Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency.

12.3 Provider agrees to assure accommodation of physical and communication limitations for consumers served under this Agreement.

12.4 Provider must assure that consumers are permitted to choose his/her health care professional to the extent appropriate and reasonable.

12.5 Provider shall not discriminate against any employee or applicant for employment or service delivery and access, with respect to their hire, tenure, terms, conditions or privileges of employment, programs, and services provided or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental disability unrelated to the individual's ability to perform the duties of the particular job or position. Additionally, Provider shall not discriminate against minority-owned, women-owned, and handicapper-owned businesses in subcontracting.

12.6 Breach of this section shall be a material breach of this Agreement.

13. **BABHA Responsibilities.**

13.1 Orientation: BABHA will orient the Provider to Provider Requirements.

13.2 Technical Assistance: BABHA will offer orientation and technical assistance to the Provider in relation to requirements concerning the authorization and claims submission process, person-centered planning, performance improvement reporting and any applicable best practice standards.

13.3 Payments: In accordance with MDHHS requirements, BABHA shall timely process payments of clean claims to Providers for approved Services rendered to consumers under this Agreement. Timely payment of clean claims means payment of 90% or higher of all clean claims from Provider within 30 days of receipt, and at least 99 percent of all clean claims within ninety (90) days of receipt from Provider.

13.4 Coordination of Benefits: BABHA shall process submitted claims according to prevailing coordination of benefits practices in order to ensure exhaustion of any potential third party liability related to primary health insurance coverage.

13.5 Communications: BABHA shall maintain a regular means of communicating and providing information regarding changes in Provider Requirements.

13.6 Anti-Interference:

(a) BABHA will not prohibit (or interfere with) a provider acting within the lawful scope of his/her practice from discussing treatment options with a recipient that may not reflect the CMHSP's position or that may not be covered by the CMHSP; and

(b) BABHA will not prohibit a provider acting within the lawful scope of his/her practice from advocating on behalf of a recipient in any grievance or utilization review process, or individual authorization process to obtain necessary health care services.

13.7 Confidentiality. Both BABHA and the Provider shall assure that services and supports to and information contained in the records of people served under this agreement, or other such recorded information required to be held confidential by federal or state law, rule or regulation, in connection with the provision of services or other activity under this agreement shall be privileged communication, shall be held confidential, and shall not be divulged without the written consent of either the recipient or a person responsible for the recipient, except as may be otherwise required by applicable law or regulation. Such information may be disclosed in summary, statistical, or other form, which does not directly or indirectly identify particular individuals.

14. **Conflict of Interest.**

14.1 Provider represents and warrants that no employee, officer, or agent of the Provider has participated in the selection, award or administration of this Agreement, which involved a conflict of financial or other interest that is either real or apparent. Provider, its officers, agents, servants, directors, and employees, represent and warrant that they have not offered or given any gratuity, favors, or anything of monetary value.

14.2 Provider represents and warrants that no principal, representative, agent, or another acting on behalf or legally capable of acting on behalf of the Provider is currently an employee of MDHHS, a Community Mental Health Board member or employee; nor is any person using or privy to insider information which would tend to give or give the appearance of tending to give an unfair advantage to said Provider. Breach of this covenant may be regarded as a material breach of this Agreement and may be cause for termination thereof.

15. **Confidential Information.** The Provider agrees that all exchanged records, including any computer based records, if any, shall be kept confidential in accordance with policies, rules or laws of the CMHSP, the MDHHS, the MHC, the HIPAA, and any other applicable federal standards and/or confidentiality requirements, and that all computer access codes and any other computer authorizations shall be kept confidential in a manner that ensures that information is safeguarded from unauthorized access.

16. **Indemnification.**

16.1 Provider shall defend, indemnify, and hold BABHA and its officers, directors, employees, agents and representatives harmless from and against all claims, damages, costs and expenses of any type or nature, including, without limitation attorney fees, that may occur as a result of (i) any acts or omissions of Provider or its officers, directors, employees, contractors, subcontractors or agents; (ii) the Services rendered by Provider under this Agreement; or (iii) a breach of this Agreement. The Provider's responsibilities as set forth in this Section shall not be mitigated by insurance coverage obtained by Provider.

16.2 To the extent permitted by law and without loss of governmental immunity, BABHA shall defend, indemnify and hold Provider and its officers, directors, employees, agents and representatives harmless from and against all claims, damages, costs and expenses of any type or nature, including, without limitation attorney fees, that may occur as a result of (i) any acts or omissions of BABHA or its officers, directors, employees, contractors, subcontractors or agents; (ii) the duties and obligations of BABHA under this Agreement; or (iii) a breach of this Agreement. BABHA's responsibilities as set forth in this Section shall not be mitigated by insurance coverage obtained by BABHA, and shall not be construed as a waiver of governmental immunity.

17. **Liability.**

17.1 Cost Liability. BABHA assumes no responsibility for liability for costs under this Agreement incurred by the Provider prior to the effective date of this Agreement. Total liability of the CMHSP is limited to the terms and conditions of this Agreement.

17.2 Contract Liability:

(a) All liability, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities to be carried our pursuant to the obligation of Provider under this Agreement shall be the responsibility of the Provider, and not the responsibility of the CMHSP, if the liability, loss, or damage is caused by, or arises out of, the actions or failure to act on the part of Provider, its employees, officers or agent. Nothing herein shall be construed as a waiver of any governmental immunity.

(b) All liability, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities to be carried out pursuant to the obligations of the CMHSP under this Agreement shall be the responsibility of the CMHSP and not the responsibility of the Provider if the liability, loss, or damage is caused by, or arises out of, the action or failure to act on the part of the CMHSP, its employee, or officers. Nothing herein shall be construed as a waiver of any governmental immunity.

(c) Each party shall notify the other in writing in the event a claim or other legal action may result in naming the other or that may result in a judgment that would limit the Provider's ability to continue rendering Services. Such notification requirement includes actions filed in court, administrative tribunals or other venues.

18. **Insurance.** Provider shall obtain and maintain the following types of insurance policies with limits set forth below:

18.1 Worker's Compensation Insurance. Workers compensation insurance including employer's liability coverage in accordance with Michigan statutes, unless Provider is a sole proprietor. In the event that Provider is a sole proprietor business, and thus not subject to the Worker's Compensation Act of the State of Michigan, then by signing this Agreement Provider acknowledges and agrees that Provider is an independent provider performing work and/or Services for BABHA and as a sole proprietor Provider does not currently, and will not employ any individuals in connection with the Services to be performed for BABHA under this Agreement. Provider shall hold BABHA and its officers, directors, employees and agents harmless from and against all injuries or illnesses that may occur by action or inaction of the Provider during the term of this Agreement. Provider shall, prior to employing one more individuals, obtain workers compensation insurance consistent with the terms of this Agreement and Michigan statute.

18.2 General Commercial Liability Insurance. Provider shall obtain and maintain an insurance policy covering general commercial liability with limits of not less than $1,000,000 per occurrence and $3,000,000 in aggregate, or $1,000,000 per occurrence and $2,000,000 in aggregate with an additional $1,000,000 per occurrence of umbrella liability insurance coverage. Such policy shall include coverage for the following: (i) Contractual Liability; (ii) Products and Completed Operations; (iii) Independent Contractors Coverage; and (iv) Broad Form General Liability Endorsement or Equivalent. If such general commercial liability insurance policy is a claims-made policy and is subsequently canceled or otherwise terminated, then Provider shall obtain and maintain an extended reporting endorsement prior to the cancellation or termination date of such insurance policy regardless of when any related incident, claim or suit might be reported.

18.3 Motor Vehicle Liability Insurance. If Provider will be transporting consumers, then all Provider-owned vehicles and all hired vehicles shall be insured by a motor vehicle insurance policy consistent with Michigan statutes and such policy(ies) shall have limits of liability of not less than $1,000,000 per occurrence combined single

limit bodily injury and property damage for all. For all non-owned vehicles, Provider's personnel must maintain adequate motor vehicle liability coverage.

18.4 Professional Liability. Provider shall obtain professional liability insurance covering all professionals, including, without limitation, medical doctors, psychiatrists, psychologists, social workers, counselors, and nurses, rendering treatment to consumers during the term of this Agreement. Such professional liability insurance covering Provider shall include coverage for Provider's employees, volunteers, contractors and subcontractors. Provider shall maintain minimum coverage limits of $1,000,000 per occurrence and $3,000,000 in annual aggregate. If the professional liability insurance policy is a claims-made policy and is subsequently canceled or otherwise terminated, then Provider shall obtain and maintain an extended reporting endorsement (i.e., tail insurance) prior to the cancellation or termination date of such professional liability insurance policy regardless of when any related incident, claim or suit might be reported.

18.5 Additional Insured. The Commercial General Liability Insurance, Professional Liability Insurance, Motor Vehicle Liability Insurance, and umbrella coverage as described above shall include the following as "Additional Insured": Bay-Arenac Behavioral Health, including its Board of Directors and all appointed officials, employees, agents and volunteers. It is expressly understood and agreed that the insurances required above shall be primary to the Additional Insured and not contributing with any other insurance or similar protection available to the Additional Insured, regardless of whether said other available coverage be primary, contributing or excess.

18.6 Cancellation Notice. All insurances policies in this Section shall include an endorsement stating the following: "It is understood and agreed that thirty (30) days advanced written notice of cancellation, non-renewal, reduction and/or material change shall be sent to: *Bay-Arenac Behavioral Health Authority, 201 Mulholland, Bay City, MI 48708, Attn: "Chief Executive Officer".*

18.7 Proof of Insurance. Unless Provider is self-insured for the coverages identified above, all insurance coverage shall be with insurance companies licensed and admitted to do business in the State of Michigan and with insurance carriers acceptable to BABHA and have a minimum rating of A or A- by A.M. Best Company's Insurance Reports. The Provider shall provide to the CMHSP at the time this Agreement is returned for execution, a copy of certificates of insurance for each of the policies mentioned above. If so required, certified copies of all policies will be furnished.

18.8 Continuation of Coverage. If any of the above coverage expires during the term of this agreement, the Provider shall deliver renewal certificates and/or policies to the CMHSP at least ten (10) days prior to the expiration date. The duty to maintain the insurance coverage specified in this Section shall survive the expiration or termination of this Agreement and shall be enforceable, regardless of the reason for termination of this Agreement, against Provider.

19. **Contract Remedies.**

19.1 Following notice to Provider, BABHA may use a variety of means to ensure compliance with the terms and conditions of this Agreement including any of the following actions:

19.1.1 Require a plan of correction as a condition to continuing this Agreement together with status reports and/or additional oversight by BABHA;

19.1.2 Assess penalties in the form of suspended or reduced payments. Such reduction in payments may continue until compliance with the terms and conditions of this Agreement and/or the plan of correction are achieved; or

19.1.3 Terminate this Agreement.

19.2 The use of penalties will typically follow a progressive approach; however, BABHA may, in its sole discretion, impose one or more of the penalties set forth herein in any manner. In the event of the imposition of any penalties, Provider shall not withhold any services to individual consumers that would otherwise be provided according to medical necessity criteria and best practice standards, consistent with 42 CFR 422.208.

19.3 For purposes of example only, the following is a non-exhaustive list of compliance or performance issues for which BABHA may take remedial action under this Agreement, including, without limitation, sanctions to address repeated or substantial breaches, patterns of non-compliance, or substantial poor performance:

(a) Reporting timeliness, quality and accuracy;

(b) Performance Indicator Standards;

(c) Repeated Site Review non-compliance (repeated failure on same item);

(d) Failure to complete or achieve contractual performance objectives;

(e) Substantial inappropriate denial of Services required under this Agreement or substantial Services not corresponding to condition. Substantial can be a pattern, large volume or small volume, but severe impact;

(f) Repeated failure to honor appeals/grievance assurances;

(g) Substantial or repeated health and/or safety violations; and/or

(h) Failure to adhere to training requirements and timelines for completion.

(i) Failure to complete required documentation for each service provided.

(j) Failure to comply with prohibitions regarding exclusion, suspension or debarment from state and/or federal health care programs.

19.4 Dispute Resolution. In the event of the unsatisfactory resolution of a non-emergent contractual dispute or compliance/performance dispute, and if Provider desires to pursue the dispute, the Provider shall request that the dispute be resolved through the dispute resolution process. This process shall involve a meeting between agents of the Provider and BABHA. The BABHA Chief Executive Officer will identify the appropriate service directors or other department representatives to participate in the process for resolution. The Provider shall provide written notification requesting the engagement of the dispute resolution process. In this written request, the Provider shall identify the nature of the dispute, submit any documentation regarding the dispute, and state a proposed resolution to the dispute. BABHA shall convene a dispute resolution meeting within twenty (20) calendar days of receipt of the Provider's request. The CEO shall provide the Provider and BABHA representative(s) with a written decision regarding the dispute within fourteen (14) calendar days following the dispute resolution meeting. Any corrective action plan issued by BABHA to the Provider regarding the action being disputed by the Provider shall be on hold pending the final decision regarding the dispute. In the event of an emergent compliance dispute, the dispute resolution process shall be initiated and completed within five (5) working days.

20. **Regulations.**

20.1 The parties hereto acknowledge and agree that the following statutes, rules, regulations and procedures govern the provision of Services rendered hereunder and the relationship between the parties:

(a) Agreement between the Michigan Department of Health and Human Services ("MDHHS") and Mid-State Health Network (MSHN) for Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program (The "Contract");

(b) Michigan Mental Health Code and its rules and regulations, as amended;

(c) Michigan Public Health Code and its rules and regulations, as amended;

(d) MDHHS Medicaid Provider Manual, as amended;

(e) The BABHA Provider Requirements; and

(f) Any other applicable state and federal laws governing the parties hereto.

21. General Provisions.

21.1 Publication Rights**:** Where activities supported by this agreement produce books, films, or other such copyrighted materials issued by the provider, the provider may copyright but shall acknowledge that BABHA reserves a royalty-free, non-exclusive and irrevocable license to reproduce, publish and use such materials and to authorize others to reproduce and use such materials. This cannot include service recipient information or personal identification data. Any copyrighted materials or modifications bearing acknowledgment or BABHA's name must be approved by BABHA prior to reproduction and use of such materials. Provider shall give recognition to BABHA in any and all publication papers and presentations arising from the Services and this Agreement; BABHA will do likewise.

21.2 Notification Regarding Funding. Provider shall immediately notify BABHA, in writing, of any action by Provider's governing board or any other funding source, which would require or result in changes to the provision of Services, funding, compliance with the terms and conditions of this Agreement or any other actions with respective to Provider's obligations to perform under this Agreement.

21.3 Notices**:** Provider shall notify BABHA within ten (10) business days of any of the following events: (i) of any civil, criminal, or other action or finding of any licensing/regulatory body or accrediting body, the results of which suspends, revokes, or in any way limits Provider's authority to render Services; (ii) of any actual or threatened loss, suspension, restriction or revocation of Provider's license; (iii) of any malpractice action filed against provider; (iv) of any charge or finding or ethical or professional misconduct by Provider; (v) of any loss of Provider's professional liability insurance or any material change in provider's liability insurance; (vi) of any material change in information provided by BABHA in the accompanying provider network application or in the credentialing information concerning any Provider; (vii) any other event which limits Provider's ability to discharge its responsibilities under this Agreement professionally, promptly and with due care and skill; or (viii) Provider is excluded from participation with the Medicaid Program.

21.4 In addition to other reporting requirements outlined in this Agreement, Provider shall immediately notify BABHA of the following events:

(a) Any consumer death that occurs as a result of suspected staff member action or inaction.

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

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

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

or responsibilities.

21.5 Research Restrictions on Human Subjects: The Provider agrees to submit all research involving human subjects, which is conducted in programs sponsored by the Department or in programs which receive funding from or through the State of Michigan, to the Department's Research on Human Subjects Committee for approval prior to the initiation of the research.

21.6 Health and Safety**:** In the event that BABHA determines that a consumer's health or safety is in immediate jeopardy, then consumer shall be immediately transfer to another participating provider, and this Agreement may be terminated immediately by BABHA.

22. Miscellaneous.

22.1 Funding. This Agreement is contingent upon receipt by BABHA of sufficient federal, state and local funds, upon the terms and conditions of such funding as appropriated, authorized and amended, upon continuation of such funding, and collections of consumer fees and third party reimbursements, as applicable. In the event that circumstances occur that are not reasonably foreseeable, or are beyond the control of the parties, that reduces or otherwise interferes with its ability to provide or maintain specified services or operational procedures for its service area, it shall provide immediate notice to the Provider if it would result in any reduction of the funding upon which this Agreement is contingent. In the event any of the foregoing listed contingencies arise, either party may terminate or amend this Agreement.

22.2 Michigan Law. This Agreement shall be construed according to the laws of the State of Michigan as to the interpretation, construction and performance.

22.3 Compliance with Applicable Law. The parties hereto and their officers, employees, servants, and agents shall perform all their respective duties and obligations under this Agreement in compliance with all applicable federal, state, and local laws, ordinances, rules and regulations.

22.4 Non-exclusive Agreement. It is expressly understood and agreed by the parties hereto that this Agreement shall be non-exclusive and it is not intended and shall not be construed to prevent BABHA from concurrently and/or subsequently entering into and maintaining similar agreements with other public or private entities for similar or other services.

22.5 Notice. Any and all notices, designations, consents, offers, acceptances or other communications herein shall be given to either party, in writing, by receipted personal delivery or deposited in certified mail to the Executive Director (or CEO) at the address as shown in the introductory paragraph of this Agreement (unless notice of a change of address is furnished by either party to the other party hereto) and with return receipt requested, effective upon receipt.

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

22.7 Amendment. Modifications, amendments, or waivers of any provision of this Agreement may be made only by the written mutual consent of the parties hereto.

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

22.9 Completeness of the Agreement. This Agreement, the Exhibits, Attachments and Statements of Work contain all the terms and conditions agreed upon by the parties and no other agreements, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind either BABHA and Provider.

22.10 Severability. If any provision of this Agreement is held by a court of competent jurisdiction or applicable state or federal law and their implementing regulations to be invalid, void or unenforceable, the remaining provisions shall nevertheless continue in full force and effect.

22.11 Third Party Beneficiary. This Agreement is not intended by the parties hereto to be a third party beneficiary contract and confers no rights on anyone other than the parties hereto.

22.12 Gender. Wherever in this Agreement words, including pronouns, are used in one gender or number, they shall be read or construed in another gender or number whenever they would so apply.

22.13 Subcontracting. Provider shall not delegate this Agreement. Provider shall not subcontract any services to be provided under this Agreement without BABHA's express written approval. In the event BABHA allows Provider to subcontract, BABHA retains the right to review, approve and monitor any subcontracts or any subcontractor's compliance with this Agreement and all applicable laws and regulations. Any subcontracting approved by BABHA shall not terminate the Provider's legal responsibilities under this Agreement. All subcontracts that may be approved by the BABHA must be in writing, and specify the activities and/or report responsibilities delegated to the subcontractor, provide for revocation or delegation and/or imposition of sanctions if the subcontractor's performance is inadequate, provide for monitoring, including site review, of the subcontractor by the BABHA or its designee, and provide for the requirement to comply with corrective action requirements of the CMHSP or its designee.

22.14 Assignment. Provider shall not assign this Agreement without the express written consent of BABHA.

22.15 Certification of Authority to Sign the Agreement. The persons signing this Agreement on behalf of the parties hereto certify by said signatures that they are duly authorized to sign this Agreement on behalf of said parties and that this Agreement has been authorized by said parties.

22.16 Independent Contractor: The relationship between BABHA and Provider is that of an independent contractor. No agent, employee, or servant of Provider or any of its sub-contractors shall be deemed to be an employee, agent, or servant of BABHA, MSHN, or the MDHHS. Provider will be solely and entirely responsible for its acts and the acts of its agents, employees, servants, and sub-contractors.

SIGNATURES TO FOLLOW ON NEXT PAGE

Contract Number.	Start Date	End Date	Contractor Name	Contract Type

WHEREFORE, intending to be legally bound, the parties hereto have executed this Agreement as of the date set forth below.

"BABHA"

BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY

By:_____
Christopher Pinter
Its: Chief Executive Officer

Date: _____

By: _____
Richard Byrne
Its: Board Chairperson

Date: _____

"Provider"

[NAME OF PROVIDER]

By: _____

Print: _____

Its: _____

Date: _____

Attachments:
Statement of Work
Exhibit A: Business Associate Agreement/Qualified Service Organization Agreement
Exhibit B: BABHA Recipient Rights List of Policies and Attestation
Exhibit C: Provider Disclosures
Exhibit D: Provider Training Requirements
Exhibit E: Credentialing and Re-Credentialing Requirements AS APPLICABLE (Primary and Ancillary providers)

Contract Number.	Start Date	End Date	Contractor Name	Contract Type

STATEMENT OF WORK

Contract Number.	Start Date	End Date	Contractor Name	Contract Type

EXHIBIT A

BUSINESS ASSOCIATE AGREEMENT
QUALIFIED SERVICE ORGANIZATION AGREEMENT

(Not required for other HIPAA Covered Entities)

This Business Associate Agreement/ Qualified Service Organization Agreement ("Agreement") is made and entered into between Bay-Arenac Behavioral Health Authority ("COVERED ENTITY") having its principal place of business at 201 Mulholland, Bay City, MI 48708 and [NAME OF PROVIDER] ("Business Associate" or "BA"), having its principal place of business at [ADDRESS OF PROVIDER]. This BAA states additional terms and conditions to the Principal Agreement between Covered Entity and BA as defined in Section I below.

RECITALS:

COVERED ENTITY is a "covered entity" within the meaning of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act") of Title XIII, Division A of the American Recovery and Reinvestment Act of 2009, and related regulations found at 45 CFR Parts 160 and 164, including the standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule"), the Security Standards for the Protection of Electronic Protected Health Information (the "Security Rule"), and the rules pertaining to Compliance and Investigations, Imposition of Civil Monetary Penalties, and Procedures for Hearings (the "Enforcement Rule"), hereafter collectively referred to as the "HIPAA Rules", and as applicable, the Federal Confidentiality Law, 42 USC §§ 290dd-2 and underlying Regulations, 42 CFR Part 2 ("Part 2");.

BA, on behalf of COVERED ENTITY, creates, receives, maintains or transmits protected health information for a function or activity regulated by the HIPAA Rules and in some instances, Part 2. Accordingly, BA is a business associate of COVERED ENTITY pursuant to the HIPAA Rules and if the protected health information is covered by Part 2, a Party to a Qualified Service Organization Agreement. BA may engage Subcontractors pursuant this Agreement with COVERED ENTITY, which may involve the use or disclosure of protected health information. Accordingly, subcontractors of BA are business associates of BA pursuant to the HIPAA Rules.

COVERED ENTITY is obligated by the HIPAA Rules to obtain "satisfactory assurances" from its business associates that the business associate will appropriately safeguard PHI and EPHI. BA is obligated by the HIPAA Rules to obtain similar assurances from subcontractors who are business associates as a pre-condition of permitting access to PHI and EPHI on behalf of COVERED ENTITY.

For the foregoing reasons, COVERED ENTITY and BA desire to enter into an agreement that complies with all applicable the requirements of the HIPAA Rules regarding business associate "satisfactory assurances".

NOW THEREFORE, in consideration of the foregoing and of the mutual promises contained herein, COVERED ENTITY and BA agree as follows:

I. DEFINITION OF TERMS

As used in this Agreement:

A. Agreement means this Business Associate Agreement.

B. Confidentiality Rules means the Federal Confidentiality Regulations at 42 CFR Part 2.

C. Disclose or Disclosure has the same meaning as the terms "Disclose" or "Disclosure" in 42 CFR 2.11.

D. HIPAA Rules means the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act") of Title XIII,

Division A of the American Recovery and Reinvestment Act of 2009, and related regulations found at 45 CFR Parts 160 and 164, including the standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule"), the Security Standards for the Protection of Electronic Protected Health Information (the "Security Rule"), and the rules pertaining to Compliance and Investigations, Imposition of Civil Monetary Penalties, and Procedures for Hearings (the "Enforcement Rule").

E. Individual shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g). Furthermore, if the PHI is covered by Part 2, the meaning of Individual shall include a patient who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program and includes any individual who, after arrest on a criminal charge, is identified as an alcohol or drug abuser in order to determine that individual's eligibility to participate in a program.

F. Parties means BA and COVERED ENTITY; Party means one or the other of them as the context requires.

G. Qualified Service Organization Agreement has the same meaning as defined in 42 CFR 2.12(c)(4).

H. Services means the services described in the Statement of Work in the Principal Agreement(s) between the parties.

I. Unsuccessful Security Incidents shall include, but not be limited to, pings and other broadcast attacks on BA's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as such incidents do not result in unauthorized access, use or disclosure of COVERED ENTITY's EPHI.

Other than as defined in this Section, the following terms used in this agreement shall have the same meaning as those terms defined in the HIPAA Rules: Breach; Business Associate; Covered Entity; Data Aggregation; Designated Record Set; Disclosure; Electronic Protected Health Information; Health Care Operations; Individual; Minimum Necessary; Notice of Privacy Practices; Protected Health Information; Required by Law; Secretary; Security Incident; Subcontractor; and Unsecured Protected Health Information.

Other terms defined in the HIPAA Rules and Confidentiality Rules but not defined here are used with the same meaning given them in HIPAA Rules and Confidentiality Rules.

II. OBLIGATIONS OF BUSINESS ASSOCIATE

A. COVERED ENTITY and BA hereby agree that this Agreement constitutes a Qualified Service Organization Agreement ("QSOA") as required by 42 CFR Part 2 if the information subject to this Agreement is covered by Part 2. Accordingly, information obtained by BA relating to individuals who may have been diagnosed as needing, or who have received, chemical dependence treatment services shall be maintained and used only for the purposes intended under this Agreement and in conformity with all applicable provisions of 42 USC § 290dd-2 and the underlying federal regulations, 42 CFR Part 2. Accordingly, except as otherwise limited in this Agreement, BA may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, COVERED ENTITY provided that such use or disclosure would not violate the Confidentiality Rules as if done by COVERED ENTITY.

B. BA agrees to ensure that any subcontractor or agent to whom it provides PHI received from COVERED ENTITY, or created or received by BA on behalf of COVERED ENTITY, agrees in a written business associate agreement to the same restrictions and conditions that apply through this Agreement to BA with respect to such information. BA will ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate safeguards to protect the Electronic PHI. BA is not in compliance with this paragraph, if the BA knows of a pattern of activity or practice of a subcontractor that would constitute a material Breach or violation of the subcontractor's obligation under this Agreement, unless the BA takes reasonable steps to cure the Breach or end the violation, as applicable, and, if such steps are unsuccessful, terminates the arrangement, if feasible. Notwithstanding the preceding language of this subsection, BA acknowledges that the PHI received from COVERED ENTITY, or created by BA, that is covered by 42 CFR Part 2, shall not be disclosed to agents or subcontractors without the specific written consent of the Individual.

C. BA agrees to comply with the security rules at 164.316 Policies and Procedures and Documentation Requirements with respect to EPHI, to prevent use or disclosure of PHI and EPHI other than as provided for by this Agreement. BA further agrees to permit COVERED ENTITY to review such policies and procedures as necessary to verify compliance with this Agreement.

D. BA shall instruct each member of its work force that has contact with PHI and EPHI in the course of providing services to COVERED ENTITY about the requirements applicable to BA under the HIPAA Rules and the Confidentiality Rule. The BA will make available to the COVERED ENTITY proof of such instruction upon request.

E. BA agrees to use appropriate safeguards to prevent the use or disclosure of PHI and EPHI other than as provided for by this Agreement. BA will implement, document, and regularly maintain administrative safeguards (in accordance with 45 C.F.R § 164.308), physical safeguards (in accordance with 45 C.F.R § 164.310) and technical safeguards (in accordance with 45 C.F.R § 164.312) that reasonably and appropriately protect the confidentiality, integrity and availability of the PHI and EPHI that it creates, receives, maintains or transmits on behalf of Covered Entity in accordance with the HIPAA Rules. BA shall secure all PHI by a technology standard that renders PHI unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute ("ANSI") and is consistent with guidance issued by the Secretary specifying the technologies and methodologies that render PHI unusable, unreadable, or indecipherable to unauthorized individuals, including the use of standards developed under the HITECH Act. BA agrees to fully comply with the responsibilities of Business Associates as set forth in sections 13401 and 13404 of the HITECH Act.

F. BA acknowledges that as a Business Associate of a Covered Entity, the BA and it subcontractor or agent Business Associates, are obligated to independently comply with the Security Rule and the privacy and security breach notification provisions of the HITECH Act, and may be directly liable to the government for fines and other sanctions imposed by DHHS, and the State Attorney General for non-compliance. At the direction of, and in a time and manner directed by COVERED ENTITY or the Secretary of DHHS (or his/her designee), BA agrees to make internal practices, books, and records relating to the use and disclosure of PHI and EPHI available to COVERED ENTITY or the Secretary of DHHS (or his/her designee), for purposes of the Secretary of DHHS (or his/her designee) determining COVERED ENTITY's and the BA's compliance with the HIPAA Rules and the Confidentiality Rule.

G. Permitted Uses and Disclosures by Business Associate

1. BA may use or disclose PHI and EPHI as necessary and appropriate to perform the Services for COVERED ENTITY as set forth in Attachment A, unless otherwise limited by this Agreement.

2. BA acknowledges that the PHI received from COVERED ENTITY, or created by BA, if covered by the Confidentiality Rule, must comply with 42 CFR Part 2 and therefore BA is specifically prohibited from disclosing such information to agents or subcontractors without specific written consent of the subject individual.

3. BA may use or disclose PHI pursuant to a valid authorization by an Individual that satisfies the requirements of 45 CFR § 164.508 or a written consent by the patient that satisfies the requirement of 42 CFR Part 2, Subpart C.

4. BA agrees to limit uses and disclosures of PHI and EPHI to the minimum necessary information.

    i. BA shall limit its use of PHI, to the extent practicable, to the Limited Data Set (as that term is defined in 45 CFR § 164.512(e)(2)), or, if needed, to the minimum necessary to accomplish the Services defined in Attachment A. In the case of disclosure of PHI, the BA shall determine what constitutes the minimum necessary to accomplish the intended purpose of the disclosure.

ii. Paragraph (i) above does not apply to: (1) disclosures to or requests by a health care provider for treatment; (2) uses or disclosures made to the Individual; (3) disclosures made pursuant to an authorization as set forth in 45 CFR § 164.508; (4) disclosures made to the Secretary under 45 CFR part 160, subpart C; (5) uses or disclosures that are required by law as described in 45 CFR § 164.512(a); and (6) uses or disclosures that are required for compliance with applicable requirements of 45 CFR part 164, subpart E.

5. BA may create a Limited Data Set for the purpose of providing the Services, provided that BA:

   i. Does not use or further disclose PHI contained in the Limited Data Set except as necessary to provide the Services or as provided for in this Agreement or otherwise Required By Law;

   ii. Uses appropriate safeguards to prevent the use or disclosure of PHI contained in the Limited Data Set other than as provided for by this Agreement;

   iii. Reports to COVERED ENTITY any use or disclosure of PHI contained in the Limited Data Set of which BA becomes aware that is not provided for by this Agreement;

   iv. Ensures that any agents or subcontractors to whom it provides access to the Limited Data Set agree to the same restrictions and conditions that apply to BA under this Agreement; and

   v. Does not re-identify PHI or contact the Individuals whose information is contained within the Limited Data Set.

6. Except as otherwise limited in this Agreement, BA may use PHI for proper management and administration of the BA, to carry out the legal responsibilities of the BA and to report violations of the law to appropriate Federal and State authorities, consistent with section 45 CFR 164.502(j)(1) and 42 CFR 2.12(c).
7. Except as otherwise limited in this Agreement, BA may use and disclose PHI that does not identify the Individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual, in accordance with the standards for de-identification set forth in 45 C.F.R § 164.514 or as otherwise permitted by the HIPAA Rules.
8. BA agrees to not use or further disclose PHI and EPHI other than as permitted or required by this Agreement, the HIPAA Rules, 42 CFR Part 2 or as required by law. BA agrees to resist any efforts in judicial proceedings to obtain access to the protected information covered by Part 2 except as expressly provided for the in Confidentiality Rule.
9. BA agrees to honor any restriction on the use or disclosure of PHI or EPHI that COVERED ENTITY agrees to, provided that COVERED ENTITY notifies BA of such restriction.

H. Wrongful Use or Disclosure, Security Incidents, Breach

1. BA agrees to cooperate with COVERED ENTITY and perform such activities as COVERED ENTITY may from time to time direct, in order to mitigate, to the extent practicable, any harmful effect that is either independently known to BA or brought to BA's attention by COVERED ENTITY, as a result of a wrongful use or disclosure of PHI or EPHI by BA.
2. BA agrees to report to COVERED ENTITY any use or disclosure of PHI not provided for by the Agreement of which it becomes aware, including breaches of unsecured PHI as required at 45 CFR 164.410, and any security incident of which it becomes aware; provided, however, that the parties acknowledge and agree that this section constitutes notice by BA to COVERED ENTITY of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents of which no additional notice to COVERED ENTITY shall be required.

3. Without limiting the generality of the foregoing, BA agrees to notify COVERED ENTITY of any Security Breach (as that term is defined in the HITECH Act) discovered by BA. A breach shall be treated as discovered by BA as of the first day on which such is known to, or by exercising reasonable diligence, would have been known to BA. BA shall be considered 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 or other agent of the BA. BA shall provide such notification to COVERED ENTITY within ten business days of the date upon which it discovered the Security Breach.
4. BA shall provide to COVERED ENTITY the names, addresses, telephone numbers, and email addresses of each individual affected by a Security Breach, along with a description of the data involved in the Security Breach, a description of how the Security Breach occurred, and a description of all internal steps that the BA has taken to prevent a future similar Security Breach.
5. BA shall cooperate with COVERED ENTITY in the investigation of such Breach to enable COVERED ENTITY to prepare and distribute notices of the Security Breach to the affected individuals, and provide notice to DHHS and media outlets as required by the HITECH Act.
6. BA shall indemnify COVERED ENTITY for any costs that COVERED ENTITY incurs due to a Breach caused by BA or any subcontractor to BA. Such indemnification shall include payment to COVERED ENTITY for the preparation and delivery of the required notices and any other expenses incurred by COVERED ENTITY as a result of such Breach.

I. Designated Record Set

1. At the request of COVERED ENTITY, and in the time and manner designated by COVERED ENTITY, BA agrees to provide access to PHI and EPHI in a Designated Record Set to COVERED ENTITY in order to meet the inspection and copying Requirements of the Privacy Rule.
2. At the direction of COVERED ENTITY and in the time and manner directed by COVERED ENTITY, BA agrees to make any amendment(s) to PHI and EPHI in a Designated Record Set in order to comply with an individual's amendment rights under the Privacy Rule.

J. Accounting of Disclosures

1. BA agrees to document all disclosures of PHI and EPHI 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 and EPHI in accordance with the HIPAA Rules.
2. At COVERED ENTITY's request, and in the time and manner designated by COVERED ENTITY, BA agrees to provide to COVERED ENTITY the information so collected to permit COVERED ENTITY to respond to a request by an Individual for an accounting of disclosures of PHI and EPHI.
3. To the extent that BA holds PHI or EPHI from an Electronic Health Record ("EHR") used by COVERED ENTITY, BA further agrees to provide to a requesting individual an accounting of disclosures of EPHI it has made, including an accounting of disclosures for treatment, payment and health care operations during the three years prior to the individual's request, if COVERED ENTITY so directs and to the extent required by, and as of the effective date of, any final regulations.

III. OBLIGATIONS OF COVERED ENTITY

A. COVERED ENTITY shall notify BA of any restriction to the use or disclosure of PHI and EPHI that COVERED ENTITY has agreed to in accordance with the Privacy Rule, to the extent that such restriction may affect BA's use or disclosure of PHI.

B. COVERED ENTITY shall not request BA to use or disclose PHI or EPHI in any manner that would not be permissible under the Privacy Rule or Security Rule if done by COVERED ENTITY, except for uses of PHI for the proper administration and management of BA or as required by law.

C. COVERED ENTITY shall not provide BA with more PHI than that which is minimally necessary for BA to provide the Services and, where possible, COVERED ENTITY shall provide any PHI needed by BA to perform the Services in the form of a Limited Data Set, in accordance with the HIPAA Rules.

D. COVERED ENTITY shall provide BA with any changes in, or revocation of, permission by an Individual to use or disclose PHI about the Individual if such changes may affect BA's permitted or required uses and disclosures.

IV. TERM AND TERMINATION

A. Term. The term of this Agreement shall be effective as of the date it is signed by both parties and shall continue conterminously with the term of all services being performed by BA for or on behalf of COVERED ENTITY, unless sooner terminated in accordance with paragraph IV(B) hereof.

B. Termination for Cause. Upon COVERED ENTITY's knowledge of a material breach by BA, COVERED ENTITY shall, at its sole option do either of the following:

1. Provide a 15 day opportunity for BA to cure the breach to COVERED ENTITY's satisfaction, or terminate this Agreement and the services relationship with BA if BA does not cure the breach to COVERED ENTITY's satisfaction, or
2. Immediately terminate this Agreement and the services relationship with BA without an opportunity to cure if COVERED ENTITY determines, in its sole discretion, that cure is not possible.

C. Upon BA's knowledge of a material breach by COVERED ENTITY, BA shall, at its sole option, do either of the following:

1. Provide a 15 day opportunity for COVERED ENTITY to cure the breach to BA's satisfaction, or terminate this Agreement and the services relationship with COVERED ENTITY if COVERED ENTITY does not cure the breach to BA's satisfaction, or
2. Immediately terminate this Agreement and the services relationship with COVERED ENTITY without an opportunity to cure if BA determines, in its sole discretion, that cure is not possible.

D. In addition to the termination for cause provisions stated in paragraph IV(B) and (C), this Agreement may also be terminated in any of the following circumstances:

1. The services relationship between BA and COVERED ENTITY is terminated for any reason;
2. The provisions of the HIPAA Rules or Confidentiality Rules are amended, modified or changed such that an Agreement such as this is no longer mandated;
3. By the mutual agreement of COVERED ENTITY and BA, provided that either a new Agreement must be substituted or the services relationship between BA and COVERED ENTITY must terminate.

E. Effect of Termination.

1. Except as provided in paragraph (B) of this section, upon termination of this Agreement for any reason, BA shall return or destroy all PHI and EPHI received from COVERED ENTITY, or created or received by BA on behalf of COVERED ENTITY, as directed by COVERED ENTITY. COVERED ENTITY has the sole authority to determine whether PHI or EPHI shall be returned or destroyed, and shall have the sole authority to establish the terms and conditions of such return or destruction. This provisions shall apply to PHI and EPHI that is in the possession of subcontractors or agents of BA. BA shall retain no copies of PHI or EPHI.
2. In the event that BA believes that returning or destroying PHI or EPHI is infeasible, BA shall provide to COVERED ENTITY an explanation of the conditions that make return or destruction infeasible. Upon COVERED ENTITY's concurrence that return or destruction of PHI or EPHI is infeasible, BA shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of PHI and EPHI to those purposes that make the return or destruction infeasible, for so long as BA maintains such PHI or EPHI. COVERED ENTITY hereby acknowledges and agrees that infeasibility includes BA's need to retain

PHI and/or EPHI to comply with its work product documentation standards and that for such retention no further notice to COVERED ENTITY is required.

3. If this Agreement is terminated and not immediately replaced with a substitute business associate agreement, and if the HIPAA Rules in effect at that time continue to mandate the execution of a business associate agreement between covered entities and their business associates, or the Confidentiality Rules in effect at that time continue to mandate the execution of a Qualified Service Organization Agreement, then the services relationship between BA and COVERED ENTITY shall immediately terminate in synchronized timing with this Agreement.

V. GENERAL PROVISIONS

A. BA agrees that the terms and conditions of this Agreement shall be construed as a general confidentiality agreement that is binding upon BA even if it is determined that BA is not a business associate as that term is used in the HIPAA Rules or if it is determined that PHI is not covered by the Confidentiality Rule.

B. COVERED ENTITY and BA shall not be deemed to be partners, joint venturers, agents or employees of each other solely by virtue of the terms and conditions of this Agreement. Agreement is an independent contractor of COVERED ENTITY for all purposes, including the federal common law.

C. This Agreement is automatically amended upon the effective date of any final regulation or amendment related to the HIPAA Rules and Confidentiality Rules that affects the terms and conditions of this Agreement, or the obligations of covered entities and/or business associates. The parties agree that the changes will be memorialized in an addendum to the agreement as soon as practical upon learning of the applicability of the regulation to the Business Associate Agreement.

D. Any communications between COVERED ENTITY and BA regarding this Agreement shall be in writing, whether or not oral communications have also occurred. Such communications shall be sent to the following Parties at the following addresses:

To Bay-Arenac Behavioral Health, at 201 Mulholland, Bay City, MI 48708, ATTN: Contracts Manager

To BA at [ADDRESS OF PROVIDER]

Written communications may be sent by certified or registered U.S. Mail, receipted courier service, receipted hand delivery, receipted fax, or by receipted email.

E. No waiver of any provision of this Agreement, including this paragraph, shall be effective unless the waiver is in writing and signed by the party making the waiver.

F. This Agreement is entered into solely for the benefit of the parties, and is not entered into for the benefit of any third party, including without limitation, any patients of COVERED ENTITY or their legal representatives.

G. This Agreement is not assignable or delegable without the express advance written consent of the party not seeking to assign or delegate.

H. This Agreement shall be governed by and construed in accordance with the laws of the United States of America and the laws of the state of Michigan.

I. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, this Agreement shall be construed as though such invalid or unenforceable provision were omitted, provided that the remainder of this Agreement continues to satisfy all of the HIPAA Rule requirements for a business associate agreement and the requirements of the Confidentiality Rule. If it does not, then the parties shall immediately renegotiate this Agreement so that it does comply with the requirements of the HIPAA Rules and Confidentiality Rules, or terminate this Agreement and the service relationship between the BA and COVERED ENTITY.

Contract Number.	Start Date	End Date	Contractor Name	Contract Type

J. This Agreement contains the entire agreement between the parties pertaining to this subject matter, and supersedes all prior understandings, whether written or oral, regarding the same subject matter.

K. The provisions of this Agreement dealing with the construction of this Agreement as a general confidentiality agreement shall survive the termination of this Agreement for any reason.

Contract Number.	Start Date	End Date	Contractor Name	Contract Type

EXHIBIT B

BABHA RECIPIENT RIGHTS LIST OF POLICIES AND ATTESTATION

Provider will comply with, in their entirety, the following policies and procedures providing for the safeguarding of the rights of recipients as established by BABHA, and amended from time to time.

POLICIES & PROCEDURES

- Abuse and Neglect
- Change in Type of Treatment
- Communication, Mail/Telephone/Visits
- Comprehensive Examination
- Confidentiality & Disclosure
- Consent for Treatment
- Dignity & Respect
- Emergency Physical Intervention
- Fingerprint, Photograph, Taping & 1-Way Glass
- Freedom of Movement
- Human Sexuality
- Medication Administration
- Personal Property & Funds
- Personal Search
- Psychotropic Medications
- Reporting and Investigation of Adverse Events
- Residential Labor
- Resident Rights
- Restraint Policy
- Right to Access Entertainment Material, Information & News
- Seclusion Policy
- Services Suited to Condition
- Sterilization/Abortion/Contraception
- Training Qualification
- Treatment by Spiritual Means

By signature below, Provider hereby acknowledges and agrees that the approved policies and procedures listed in this Exhibit B are available at http://babha.org/about/for-providers/. Provider further acknowledges, agrees and certifies that Provider will accept and comply with the policies and procedures set forth in this Exhibit B, as the same may be amended from time to time.

Provider agrees to perform Recipient Rights background checks for all potential employees utilizing the form available at http://babha.org/about/for-providers/

_____ _____

Signature of Provider Date

_____ _____

Witness Date

PLEASE RETURN THIS FORM TO THE CMHSP WITH YOUR SIGNED CONTRACT.

Contract Number.	Start Date	End Date	Contractor Name	Contract Type

EXHIBIT C

PROVIDER DISCLOSURES

Questions regarding this form may be directed to the BABHA Corporate Compliance Officer at 989-895-2760

(a) Information that must be disclosed. Provider must disclose the following information as defined in this Agreement and paragraph (b) of this Exhibit C. See BABH policy C13-S02-T11 Prohibited Affiliations, Exclusion and Debarment for more information:

Section 1: Managing Employee(s)

In accord with 42 CFR 455.104 and42 CFR 455.106 all Providers must disclose information regarding any managing employee(s).

"Managing employee" is defined in 42 CFR 455.101 as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency." Board members should be listed as managing employees, to the extent they meet the definition of a managing employee.

Table 1 Managing Employees

- Disclose the name of all managing employees, including title (e.g., Chief Financial Officer), address, date of birth (DOB) and the last four digits of their Social Security Number (SSN). If a match is found on exclusion/debarment databases the remaining digits of the SSN will be requested for verification.
- Check the box provided if none. Attach additional pages as needed to ensure disclosure of all.

Provider has no managing employees ☐

Name of Managing Employee(s)	Title	Address	DOB	Last 4 Digits of Social Security #

Table 2 Managing Employee(s)' Health Care Related Criminal Convictions

- Disclose the names of any managing employees from Table 1 who have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of these programs, even if not currently excluded by any federal or state program.
- Check the box provided if none. Attach additional pages as needed to ensure disclosure of all.

Contract Number.	Start Date	End Date	Contractor Name	Contract Type

None of the managing employees have been convicted of a criminal offense related to that individual's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of these programs, even if not currently excluded by any federal or state program. ☐

Name of Managing Employee(s)	Date of Conviction	Nature of Conviction

Section 2: Ownership and Control Interests

Table 3 Applicable Exceptions to Disclosure of Ownership and Control Interests

- Non-profit organizations do not have owners and are not required to complete Section 2 of Exhibit C.
- Sole proprietorships, individual practitioners and groups of individual practitioners practicing at the same location do not have owners or control interests and are not required to complete Section 2 of Exhibit C.
- For-profit corporations and partnerships must disclose ownership and control interests.
- Check the appropriate box if an exception is applicable.

Non-profit organization ☐

Sole proprietor/ individual practitioner/ group of individual practitioners practicing at the same location. ☐

Table 4 Individuals with an Ownership or Control Interest

"Ownership or control interest" is defined in 42 CFR 455.101 as an individual or corporation that:

- Has an ownership interest totaling 5 percent or more in a Provider entity;
- Has an indirect ownership interest equal to 5 percent or more in a Provider entity;
- Has a combination of direct and indirect ownership interests equal to 5 percent or more in a Provider entity;
- Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by a Provider entity if that interest equals at least 5 percent of the value of the property or assets of the Provider;
- Is an officer or [executive] director of a provider entity that is organized as a corporation [managing employees do not need to be listed as persons with an ownership or control interest]; or
- Is a partner in a Provider entity that is organized as a partnership.

- Disclose the name of all individuals with an ownership or control interest in the Provider entity, including title (e.g., Chief Financial Officer), address, date of birth (DOB), and the last four digits of their Social Security Number (SSN) and percent of ownership. If a match is found on exclusion/debarment databases the remaining digits of the SSN will be requested for verification.
- Check the box provided if none. Attach additional pages as needed to ensure disclosure of all.

Contract Number.	Start Date	End Date	Contractor Name	Contract Type

There are no individuals with an ownership or control interest in the Provider entity ☐

Name of Individual Owners	Title	% Ownership or Control Interest	Address	DOB	Last 4 Digits of Social Security #

Table 5 Corporations with an Ownership or Control Interest

- Disclose the name of any corporations with an ownership or control interest in the Provider Entity, including Tax Identification Number (TIN), the percent of ownership, the primary business address, all other business locations, and all P.O. Box address(es).
- Check the box provided if none. Attach additional pages as needed to ensure disclosure of all.

There are no corporations with an ownership or control interest in the Provider Entity ☐

Name of Corporation	Tax Identification Number (TIN)	% Ownership or Control Interest	Primary Business Address	Other Business Locations	P.O. Box Address(es)

Table 6 Ownership or Control Interest in Other Disclosing Entities

'Other Disclosing Entity' is defined at 42 CFR 455.101 as any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

(b) Any Medicare intermediary or carrier; and

(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Contract Number.	Start Date	End Date	Contractor Name	Contract Type

- Disclose if any of the owners listed in the previous tables in Exhibit C have an ownership or control interest in another organization(s) that would qualify as an 'Other Disclosing Entity'. List the name of the owner and the Other Disclosing Entity.
- Check the box provided if none. Attach additional pages as needed to ensure disclosure of all.

None of the owners have an ownership or control interest in another organization(s) that qualifies as an 'Other Disclosing Entity ☐

Name of Owner	% Ownership or Control Interest in the Other Disclosing Entity	Name of Other Disclosing Entity	Tax ID # (TIN) of Other Entity	Primary Business Address of Other Entity	Other Business Locations of Other Entity	P.O. Box Address(es) of Other Entity

Table 7 Ownership or Control Interest in Subcontractors

- Disclose if any of the owners listed in the previous tables in Exhibit C have an ownership or control interest in a subcontractor of the Provider entity. Include the Tax Identification Number (TIN), the percent of ownership in the Provider entity, the primary business address, every business location, and P.O. Box address(es).
- Check the box provided if none. Attach additional pages as needed to ensure disclosure of all.

None of the owners have an ownership or control interest in a subcontractor of the provider entity ☐

Name of Owner	% Ownership or Control Interest in Subcontractor	Name of Subcontractor	Tax ID # (TIN) of Subcontractor	Primary Business Address of Subcontractor	Other Business Locations of Subcontractor	P.O. Box Address(es) of Subcontractor

Table 8 Owner Health Care Related Criminal Convictions

- Disclose whether any of the owners listed in the previous tables in Exhibit C have been convicted of a criminal offense related to that individual's or corporation's involvement in any program under Medicare, Medicaid, or the

Contract Number.	Start Date	End Date	Contractor Name	Contract Type

Title XX services program since the inception of these programs, even if not currently excluded by any federal or state program.

- Check the box provided if none. Attach additional pages as needed to ensure disclosure of all.

None of the owners have been convicted of a criminal offense related to that individual's or corporation's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of these programs, even if not currently excluded by any federal or state program. ☐

Name of Owner(s)	Date of Conviction	Nature of Conviction

Table 9 Relationships Between Owners

- Disclose whether any of the owners listed in the previous tables in Exhibit C are related to each other as a spouse, parent, child, or sibling. List their names and the relationship.
- Check the box provided if none. Attach additional pages as needed to ensure disclosure of all.

None of the owners are related to each other as spouse, parent, child or sibling ☐

Owner Name(s)	Relationship(s)

(b) Time and manner of disclosure.

(1) Updated information must be furnished to BABHA at the time of enrollment, re-enrollment, within 35 days after a change in Provider ownership or control takes place, within 20 working days after Provider becomes aware of a health care related criminal conviction, or within thirty-five (35) days of a written request by BABHA.

(2) In addition, ownership information must be submitted within 35 days of the date of a request by BABH or its Medicaid payers(s), regarding any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12 month period ending on the date of the request and any significant business

Contract Number.	Start Date	End Date	Contractor Name	Contract Type

transactions between the provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request. Provider agrees that payment for services provided may be impacted in accord with 42 CFR 455.105 for failure to comply with such a request.

(c) Provider agreements and fiscal agent contracts. BABHA shall not approve a Provider contract and must terminate an existing contract, if Provider fails to disclose ownership or control information as required by this Exhibit C and this Agreement.

_____ _____

Signature of Provider Date

_____ _____

Witness Date

PLEASE RETURN THIS FORM TO THE CMHSP WITH YOUR SIGNED CONTRACT.

Contract Number.	Start Date	End Date	Contractor Name	Contract Type

EXHIBIT D

PROVIDER TRAINING REQUIREMENTS

EXHIBIT E

CREDENTIALING AND RE-CREDENTIALING REQUIREMENTS

The Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration, has issued a uniform Credentialing and Re-credentialing Policy applicable to all individual and organizational providers directly or contractually employed by Pre-Paid Inpatient Health Plans (PIHP's), as it pertains to the rendering of specialty behavioral healthcare services within Michigan's Medicaid Program. PIHPs and CMHSPs are responsible for ensuring that each provider, directly or contractually employed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual Requirements.

1. Providers that employ or contract with the following health care professionals are required to have a written system (policy and procedure) in place for the credentialing and re-credentialing of these individuals.

- Physicians (M.D.s and D.O.s)
- Physician's Assistants
- Psychologists (Licensed, Limited License, and Temporary License)
- Social Workers:
    - Licensed Master's Social Workers
    - Licensed Bachelor's Social Workers
    - Limited License Social Workers
    - Registered Social Service Technicians
- Licensed Professional Counselors
- Nurse Practitioners, Registered Nurses and/or Licensed Practical Nurses
- Occupational Therapists and Occupational Therapist Assistants
- Physical Therapists and Physical Therapist Assistants
- Speech Pathologists

2. Required Components of Credentialing Policy: The Providers' policies and procedures for credentialing and re-credentialing of health care professionals must include the following elements:
    a. Scope, criteria and timeliness, and the process for credentialing and re-credentialing providers.
    b. Identification of the administrative staff person that is responsible for oversight and implementation of the process, and delineation of their role.
    c. A description of the role, if any, of participating providers in making credentialing decisions.
    d. Provisions for Temporary and/or Provisional Credentialing of Individual Providers. At a minimum, these standards include the following:
        i. Temporary or provisional status may be granted for not more than 150 days.
        ii. At a minimum, the provider must complete, date and sign an application that includes the following elements:
            1. Lack of present illegal drug use;
            2. Identification of and an explanation about any history of loss of license, registration, or certification, and/or felony convictions;
            3. Identification of and an explanation about any history of loss or limitation of privileges or disciplinary actions;
            4. A summary of the provider's work history for the past five years;
            5. Attestation by the applicant of the correctness and completeness of the application.
        iii. Primary source verification of:
            1. Licensure or certification;
            2. Board Certification, if applicable, or highest level of credential attained; and
            3. Medicare/Medicaid sanctions.
    e. The standards to be used in making a credentialing and/or re-credentialing decision. At a minimum, these standards include the following:
        i. A written application, completed, signed and dated by the health care professional,that attests to the following elements:
            1. Lack of present illegal drug use;

2. Identification of and an explanation about any history of loss of license and/or felony convictions;
3. Identification of and an explanation about any history of loss or limitation of privileges or disciplinary actions;
4. Attestation by the applicant of the correctness and completeness of the application.

ii. An evaluation of the health care provider's work history for at least the prior five years.

iii. Primary source verification of:

1. Licensure or Certification
2. Board Certification (if applicable) or highest level of credentials attained, or completion of any required internships, residency programs or other post graduate training
3. Documentation of graduation from an accredited school
4. National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all of the following must be verified:
   a. Minimum of five-year history of professional liability claims resulting in a judgment or settlement;
   b. Disciplinary status with regulatory board or agency; and
   c. Medicare/Medicaid Sanctions.
5. If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements of 1, 2, and 3 above.

f. A description of the documents and methodology to be used by the provider organization to determine that a credentialing file is complete.

g. The role of a credentialing committee and criteria for credentialing health care providers, including the role of the governing authority in making credentialing decisions.

h. Requirements for re-credentialing include, at a minimum, the following:

i. Re-credentialing at least every two years;

ii. An update to the information obtained during the initial credentialing;

iii. A process for on-going monitoring, and intervention if appropriate, of provider sanctions, complaints and quality issues which must include, at a minimum, review of:

1. Medicare/Medicaid Sanctions;
2. State sanctions or limitations on licensure, registration or certification;
3. Member (i.e., "consumer") concerns which include grievances and appeals information;
4. Quality issues.

i. Provisions of the communication of all credentialing decisions, in writing, to applicants for credentialing or re-credentialing.

j. Provisions for appeal of credentialing and/or re-credentialing decisions.

k. Approval of the policy and/or procedure by the provider's governing authority.

3. Providers are prohibited from discriminating against:
   a. a health care professional (defined above) solely on the basis of license, registration or certification; or
   b. a health care professional who serves high risk populations or who specializes in the treatment of conditions that require costly treatment.

4. Providers must ensure compliance with Federal Requirements that prohibit employment of or contracts with individuals who are excluded from participation under either the Medicare or Medicaid programs. Proof that individuals are not sanctioned or excluded from federal healthcare program participation must be maintained. A complete list of Centers for Medicare and Medicaid Services (CMS) sanctioned providers is available at http://exclusions.oig.hhs.gov. A complete list of sanctioned providers is also available on the MDHHS website at http://www.michigan.gov/mdhhs.

5. The provider must maintain an individual credentialing/re-credentialing file for each covered health care professional. Each file must include, at a minimum:

   a. The initial credentialing and all subsequent re-credentialing applications;
   b. Documented evidence of primary source verification; and
   c. Any other pertinent information the provider used in determining whether or not the provider met the credentialing and re-credentialing standards.

6. The PIHP reserves the following rights:

    a. To Approve, Suspend or Terminate from participation in the provision of Medicaid funded services any individual health care provider or health care provider organization;
    b. To provide oversight regarding all credentialing and re-credentialing decisions.
    c. To extend "deemed status" to organizations and/or individuals who are credentialed by other PIHPs provided that copies of the other PIHP's credentialing files are submitted.
    d. To credential and re-credential, at least every two years, organizational providers in its network through the validation and re-validation:
        i. That the organizational provider is licensed or certified (as necessary) to operate in Michigan, and that the organization has not been excluded from Medicaid or Medicare participation;
        ii. Ensure that contracts require organizational providers to credential and/or re-credential their direct employed and sub-contacted direct service personnel in accordance with this attachment.
    e. To verify compliance with these requirements the PIHP may:
        i. Require the provider to submit credentials files to it for review and validation;
        ii. Confirm the credentialing and re-credentialing activity of the organization during scheduled or non-scheduled site reviews by authorized PIHP representatives;
        iii. Pursue other reasonable actions to ensure compliance.

7. Providers are responsible for ensuring that direct employed and/or contractual health care professionals meet the minimum qualifications for the delivery of health care services.
    ~~a.~~ Minimum qualifications are specified for Medicaid covered services in the MDHHS Provider Qualifications document, accessible at **www.babha.org/ProviderInformation.aspx**
    b. Development Plans must include prompt and reasonable timeframes for completion.