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(i)/(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 and the MDHHS Behavioral Health Code Sets, Charts, and Provider Qualifications, 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.

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 Telemedicine. Provider will comply with all applicable State and Federal Regulations governing the delivery of behavioral health services via video and/or audio-only telemedicine.

2.11 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.

2.12 HCBS Transition Implementation. The Provider will work with BABHA to assure full and ongoing compliance with the Home and Community Based Setting requirements and the MDHHS approved transition plan.

3. Billing of and Payment for Valid Service Reimbursement / Claims Submission.

3.1 Claims. All claims should be free and clear of any problems and able to be processed for payment consideration without obtaining additional information from the Provider of the service or a third party. It does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. In cases where a Clean Claim is not submitted by the Provider within one (1) year of the consumer's date of service, BABHA shall not be required to authorize payment, unless otherwise mutually agreed upon in advance between the Provider and BABHA. Provider shall submit claims within ninety (90) calendar days of service and not to exceed forty-five (45) days from end of each fiscal year ending September 30th.

3.2 Manner/Method of Claims Submission: Provider shall be responsible for submitting claims for payment consideration in accordance with standard claims processing requirements of BABHA. BABHA shall not be responsible for processing claim(s) for payment consideration for any claim submitted by the Provider that is inconsistent with national and/or state claim submission and processing guidelines. BABHA, at its discretion, may require all claims to be submitted with all proper documentation for purposes of auditing the claim prior to reimbursement. 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.

3.3 Reimbursement Rate for Valid Claims Payments. BABHA shall make contractual payments to the Provider in accordance with the requirements of the Mental Health Code, the MDHHS Rules, the MDHHS/CMHSP Master Contract, and applicable state and federal laws, including Medicaid regulations.

3.4 Requirements for and Limitations for Billing of Claims, Documentation Requirements and Payments of Clean Claims. Provider shall submit valid claims for each period in which BABHA authorized services are rendered under this Agreement. All Provider claims shall specify billable services hereunder. In order to be considered valid claims for which payments from BABHA may be made, 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. BABHA shall authorize and process service claims payments to the Provider within thirty (30) days following receipt of a complete and accurate billing statement from the Provider.

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.

The Provider's submittal of valid claims for any service fees hereunder shall constitute Provider's verification that the required services and service documentation have been completed, in compliance with the reimbursement requirements of BABHA, the MDHHS, Medicaid, and/or third party reimbursers and is on file currently. If the Provider's services and service documentation are not in compliance with the reimbursement requirements of BABHA, the MDHHS, Medicaid, and/or third party reimbursers, the Provider shall not be paid and/or shall return payment(s) received from BABHA in such instances.

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 Denial of payment due to non-compliance with claims submission and/or financial requirements may be appealed in accordance with BABHA's Provider appeal policy and/or procedure.

3.7 BABHA may request the Provider to submit documentation to receive payments as Electronic Funds Transfer (EFT)/Direct Deposits before payment can be made. The Provider is required to update BABHA any time this information has changed. These forms will be provided to the Provider or can be obtained from BABHA's website. If BABHA does not offer payments via EFT, the Provider must supply a valid remit to address and advise BABHA in writing of any changes to their address.

3.8 Determination of Financial Status. For the consumer served under this Agreement, BABHA's staff shall complete an initial determination of financial status.

3.9 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. Provider must provide prompt notification to BABHA when it receives information about changes in a Medicaid beneficiary's circumstances that may affect the beneficiary's eligibility including, changes in the beneficiary's residence and the death of a beneficiary.

3.10 Ability to Pay. Provider will comply with the MDHHS 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.

3.11 Coordination of Benefits. The Provider shall submit itemized claims for coordination of benefits (COB) billing purposes detailing the daily revenue code to fulfill BABHA's State of Michigan reporting and COB requirements. Any dual eligible consumer with a deductible/coinsurance will be paid by BABHA in total up to the contracted rate for the billed service(s) identified in this agreement after all other payments, contractual adjustments, and any applicable co-payment, consumer pay, or Medicaid Spend Down amounts have been deducted. BABHA shall only be responsible for and limit reimbursement to the Provider for any amount less than the contracted rate or the primary payor's allowed amount, whichever is less. In cases where third party coverage reimbursement exceeds the contracted rate for the billed service(s) identified in this agreement, no additional payment will be authorized by BABHA. In all cases where BABHA is the secondary payor, the Provider shall submit an Explanation of Benefits (EOB) from the primary insurance coverage carrier along with the claim for service reimbursement to BABHA. Provider is responsible to verify

insurance regularly and report any changes in eligibility to BABHA via messaging in the electronic health record.

3.12 Third Party Liability Requirements. The Provider is required to identify and seek recovery from all liable third parties, consistent with the requirements of the Mental Health Code, the MDHHS/CMHSP Master Contract for General Funds and with the MDHHS/PIHP Master Contract for Medicaid Funds. The Provider shall be responsible under this Agreement for seeking support/service reimbursements, if applicable, from third party liability claims for the consumer hereunder, pursuant to federal and State requirements. The Provider shall not seek or collect any support/service fee payments directly from the consumer, legal guardian, parents or relatives, etc. or any reimbursement fee payments from Medicare, and/or private insurers, the State of Michigan, health maintenance organizations, or other managed care entities acting on behalf of private insurers, etc., for Provider's supports/services rendered hereunder, unless authorized to do so, in writing, by BABHA.

3.13 Payment in Full. Payments from BABHA for valid claims for BABHA authorized supports and services rendered by the Provider to BABHA's consumer under this Agreement shall constitute payment in full. The Provider shall be solely responsible for its payment obligations and payments to its subcontractors, if any, for performing supports and services required of the Provider under this Agreement. Payments from the Provider to its subcontractors for performing supports and services required of the Provider hereunder shall be made on a timely basis and on a valid claim basis.

3.14 Refunding of Payments. The Provider shall not bill BABHA for supports/services rendered hereunder in any instances in which the Provider received monies directly for them from another funding source or from another party that provides for, reimburses, offsets, or otherwise covers payment retroactively, currently, or subsequently for such supports/services, the Provider shall refund to BABHA an amount equal to the sums reimbursed by third party payors and /or paid by another source. The Provider shall notify BABHA immediately of any receipt of such monies for such purposes hereunder.

3.15 Unallowable Supports/Services/Cost Claims and Financial Paybacks. Should the Provider fail to fulfill its obligations as specified in this Agreement, thereby resulting in unallowable Medicaid or non-Medicaid program supports/services or costs/claims, Provider shall not be reimbursed by BABHA. The Provider shall repay to BABHA financial paybacks of any claims payments made by BABHA to the Provider for unallowable supports/services and/or cost claims. This requirement shall survive the termination of this Agreement and such repayment shall be made by the Provider to BABHA within sixty (60) days of BABHA's final disposition notification to the Provider that financial payback of the Provider is required.

3.16 Compliance. If the Provider does not remain in compliance with the applicable requirements of this Agreement, in the sole judgement of BABHA, BABHA may take actions to void, pend or deny claims, initiate recoveries and/or sanctions, or take other actions as reasonably necessary to compel Provider compliance.

3.17 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.

4. Term and Termination.

4.1 Term. The initial term of this Agreement shall begin on October 1, 2023 and shall continue for a period of one (1) year, expiring on September 30, 2024, 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 sixty (60) days prior written notice to the other party, unless another 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. The Provider must make a good faith effort to give written notice of termination of a contracted service to each member who received his/her primary care from, or was seen regularly by, the terminating providers' program. Notice to the member must be provided by the later of thirty (30) calendar days prior to the effective date of termination, or fifteen (15) calendar days after receipt or issuance of the termination notice.

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 BABHA 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 BABHA through limited direct data entry and faxing for purposes of BABHA 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 BABHA.

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: https://www.michigan.gov/dtmb/0,5552,7-358-82548_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 BABHA or a BABHA designated 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.

5.6. Confidentiality of Records. Provider must maintain the confidentiality, security and integrity of consumer information that is used in connection with the performance of this Agreement to the extent and under the conditions specified in HIPAA, the Michigan Mental Health Code (PA 258 of 1974, as amended), the Michigan Public Health Code (PA 368 of 1978 as amended), and 42 CFR Part 2. All consumer information, medical records, data and data elements collected, maintained, or used in the administration of this Agreement must be protected by the Provider from unauthorized disclosure. Provider must have written policies and procedures for maintaining the confidentiality of data, including medical records, client information, and appointment records

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 by MDHHS at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.html.

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 as outlined in BABHA policies and procedures, including compliance with corrective action plan submission and subsequent implementation of approved corrective action plans. 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 an ongoing basis. Documentation will be maintained in a progress note and/or other clinical documentation.

6.6.2 Provider shall cooperate with satisfaction surveys of persons receiving treatment conducted by BABHA/MSHN/MDHHS.

6.6.3 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 written policies, procedures and/or standards of conduct, appropriate to the type and scale of the Provider agency, that articulate the organization's commitment to program integrity and the Provider's expectations for its personnel, including the following:

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

7.1.2 Dissemination of contact information (addresses and toll-free telephone numbers) for reporting fraud, waste or abuse to the MDHHS Office of Health Services Inspector General (MDHHS-OIG), either annually or through continuous postings in areas frequented by the Provider's personnel and persons served. The Provider must indicate that reporting of fraud, waste or abuse may be made anonymously;

7.1.3 Implementation of training for employees at all levels regarding the Federal False Claims Act, Michigan False Claims Act and Whistleblowers Protection Act, including Provider practices for the prevention, identification and reporting of errors, waste, abuse and fraud; and Provider disciplinary standards relative to fraud, waste and abuse, and their enforcement;

7.1.4 Provisions for routine internal monitoring, prompt response to potential offenses ("Prompt response" is defined as action taken within 15 business days of receipt by the Provider of the information regarding a potential compliance problem), and implementation of corrective action including but not limited to voiding or correcting applicable service claims;

7.1.5 Provider must investigate program integrity complaints/issues until it has determined that potential fraud is discovered, at which point the Provider must report the issue to BABHA within five business days, including the nature of the complaint, the name of the individuals and/or entity involved, including name, address, phone number, Medicaid identification number and/or any other relevant identifying information; and

7.1.6 Provider agencies that receive annual payments under the Agreement of at least $5,000,000, shall implement 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 BABHA 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 BABHA for payment.

7.2.3 Report within two (2) business days to BABHA any invalid claims for correction and to cooperate with BABHA 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 to fully cooperate with any investigation by BABHA, MSHN and/or the MDHHS-OIG, and with any subsequent legal action that may arise from such investigation. Provider is required to comply with BABHA, MSHN, and MDHHS-OIG's requests for documentation and information related to program integrity and compliance.

7.4 Provider agrees to immediately notify BABHA with respect to any inquiry, investigation, sanction or other notice received from the MDHHS-OIG.

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, certification rules, Michigan Public Act 368 of 1978 and the Mental Health Hode Public Act 258 of 1974. 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.

Pursuant to Michigan law, all agencies subject to IRS Pub. 1075 are required to ask the Michigan State Police to perform fingerprint background checks on all employees, including Contractor and Subcontractor employees, who may have access to any database of information maintained by the federal government that contains confidential or personal information, including, but not limited to, federal tax information. Further, pursuant to Michigan law, any agency described above is prohibited

from providing Contractors or Subcontractors with the result of such background check. For more information, please see Michigan Public Act 427 of 2018. Upon request, or as may be specified by MDHHS, Contractor must perform background checks on all employees and subcontractors and its employees prior to their assignment. The scope is at the discretion of the State and documentation must be provided as requested. Contractor is responsible for all costs associated with the requested background checks. The State, in its sole discretion, may also perform background checks.

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 all rendering staff meet the minimum qualifications specified by MDHHS through the MDHHS Medicaid Provider Manual - https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5100-87572--,00.html and PIHP/CMHSP Provider Qualifications Chart - https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html.

8.1.4 Staff must be 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.

8.1.5 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.

8.1.6 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 A 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, prior to hire.

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.

This Agreement is a covered transaction for purposes of 2 C.F.R. pt. 180 and 2 C.F.R. pt. 3000. As such, the Provider is required to verify that none of the Provider's principals (defined at 2 C.F.R. § 180.995) or its affiliates (defined at 2 C.F.R. § 180.905) are excluded (defined at 2 C.F.R. § 180.940) or disqualified (defined at 2 C.F.R. § 180.935).The Provider must comply with 2 C.F.R. pt. 180, subpart C and 2 C.F.R. pt. 3000, subpart C, and must include a requirement to comply with these regulations in any lower tier covered transaction it enters into. This certification is a material representation of fact relied upon by the State. If it is later determined that the Provider did not comply with 2 C.F.R. pt. 180, subpart C and 2 C.F.R. pt. 3000, subpart C, in addition to remedies available to the State, the Federal Government may pursue available remedies, including but not limited to suspension and/or debarment.

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 B, 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. 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, as required at 42 CFR 455.436 the Social Security Administration (SSA) Death Master File (https://www.ssdmf.com) to ensure the person is not deceased if SSA permits file access and fees are not cost prohibitive, and the Centers for Medicare and Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES) (https://nppes.cms.hhs.gov/) to verify national provider numbers (NPI's), if not already verified via Medicare or Medicaid provider enrollment records; as required by 42 CFR 455.436 and 48 CFR 9.4, 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; as required by the MDHHS/PIHP Master Contract, the federal government's System for Award Management (SAM) at www.SAM.gov; and as

required by the Michigan Department of Health and Human Services Medicaid Manual, the MDHHS list of sanctioned providers 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 BABHA 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, 42 CFR PART 2, MI Mental Health Code (PA 258 or 1974 as amended) and MI Public Health Code (PA368 of 1978, as amended).

10.8.1 The Provider agrees to report to BABHA within five business days of discovery any unauthorized use or disclosure of protected health data and information that falls under the HIPAA requirements, and to provide assurances to BABHA of corrective actions to prevent further unauthorized uses or disclosures.

10.8.2. Provider attests it will comply with the following requirements:

a) Maintain the confidentiality, security and integrity of beneficiary information that is used in connection with the performance of this Contract to the extent and under the conditions specified in HIPAA, the Michigan Mental Health Code (PA 258 of 1974, as amended), the Michigan Public Health Code (PA 368 of 1978 as amended), and 42 CFR Part 2.
b) 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.
c) Safeguards shall be provided that restrict the use or disclosure of information concerning recipients to purposes directly connected with its administration of the agreement.
d) Have written policies and procedures for maintaining the confidentiality of data, including medical records, client information, and appointment records.
e) 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.
f) Ensure that any subcontractor of the Provider 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.

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 by BABHA, 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. BABHA 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 implementation and reporting 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%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. BABHA shall assure that 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 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. Indemnification.

15.1 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.

15.2 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.

16. Liability.

16.1 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.

16.2 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.

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

Required Limits	Additional Requirements
Commercial General Liability Insurance	
Minimum Limits: $1,000,000 Each Occurrence $1,000,000 Personal & Advertising Injury $2,000,000 General Aggregate $2,000,000 Products/Completed Operations	
Automobile Liability Insurance	
Minimum Limits: $1,000,000 Per Accident	PROVIDER must have their policy include Hired and Non-Owned Automobile coverage.
Workers' Compensation Insurance	
Minimum Limits: Coverage according to applicable lawsgoverning work activities	Waiver of subrogation, except where waiver is prohibited by law.
Employers Liability Insurance	
Minimum Limits: $500,000 Each Accident $500,000 Each Employee by Disease $500,000 Aggregate Disease	
Privacy and Security Liability (Cyber Liability) Insurance	

Minimum Limits: $1,000,000 Each Occurrence $1,000,000 Annual Aggregate	PROVIDER must have their policy cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability.
Professional Liability (Errors and Omissions) Insurance	
Minimum Limits: $3,000,000 Each Occurrence $3,000,000 Annual Aggregate	

17.1 Additional Insured. The Commercial General Liability Insurance, Professional Liability Insurance and Automobile Liability Insurance, 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.

17.2 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".*

17.3 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.

17.4 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.

18. Contract Remedies.

18.1 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:

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

18.1.2 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

18.1.3 Terminate this Agreement.

18.2 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.

18.3 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.

18.4 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.

19. Regulations.

19.1 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(i)/(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.

20. General Provisions.

20.1 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.

20.2 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.

20.3 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.

20.4 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.

20.5 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.

20.6 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.

21. Miscellaneous.

21.1 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.

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

21.3 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.

21.4 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.

21.5 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.

21.6 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.

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

21.8 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.

21.9 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.

21.10 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.

21.11 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.

21.12 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.

21.13 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.

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

21.15 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.

21.16 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: BABHA Recipient Rights List of Policies and Attestation
Exhibit B: Provider Disclosures
Exhibit C: Provider Training Requirements
Exhibit D: 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

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 A 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 A, 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 B

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 B. 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 B.
- 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 B.
- 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)

Contract Number.	Start Date	End Date	Contractor Name	Contract Type

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.

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

Contract Number.	Start Date	End Date	Contractor Name	Contract Type

'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.

- Disclose if any of the owners listed in the previous tables in Exhibit B 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 B 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 ☐

Contract Number.	Start Date	End Date	Contractor Name	Contract Type

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 B 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.
- 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 B 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 ☐

Contract Number.	Start Date	End Date	Contractor Name	Contract Type

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 BABHA 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 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 B 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 C

PROVIDER TRAINING REQUIREMENTS

EXHIBIT D

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 and Limited License 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
- Registered Dieticians

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 Privileging of Individual Providers. At a minimum, these standards include the following:
        i. Temporary status may be granted for not more than 120 days.
        ii. Provisional status may be granted for not more than one (1) year.
        iii. 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.
        iv. 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.
        5. Recipient Rights check
i. Provisions of the communication of all credentialing and/or privileging decisions, in writing, to applicants for credentialing or re-credentialing.
j. Provisions for appeal of privileging, 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 **https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html**
   b. Development Plans must include prompt and reasonable timeframes for completion.