Fiscal Year 20XX Contractual Agreement

BETWEEN

{{NAME OF CMHSP}}

AND

{{NAME OF PROVIDER}}

For the purpose of:
Applied Behavioral Analysis

Contents

FY20XX AGREEMENT FOR APPLIED BEHAVIORAL ANALYSIS

THIS AGREEMENT FOR PROVIDER SERVICES (this "Agreement") is made and entered into on this [___] day of [_____], 202X, by and between {{CMHSP}} whose administrative office address is {{CMHSP ADDRESS}} (hereinafter referred to as the "Payor" or "CMHSP," and {{PROVIDER NAME]], whose business address is {{PROVIDER ADDRESS}} (hereinafter referred to as the "Provider").

Whereas, the CMHSP was established by the Board(s) of Commissioners of the applicable county(ies) pursuant to Act 258 of the Public Acts of 1974, as amended (the "Mental Health Code"), MCL 330.1001 *et seq*.;

Whereas, under Section 204(b)(1) of the Mental Health Code, Arenac, Bay, Clare, Clinton, Eaton, Gladwin, Gratiot, Hillsdale, Huron, Ingham, Ionia, Isabella, Jackson, Mecosta, Midland, Montcalm, Newaygo, Osceola, Saginaw, Shiawassee, and Tuscola Counties entered into a Regional Entity arrangement for the purpose of the preparation, submission, and implementation of an Application for Participation to the MDHHS for a Medicaid Prepaid Inpatient Health Plan ("PIHP"); and

Whereas, pursuant to the Bylaws dated June 13, 2013, the Regional Entity is known as the Mid-State Health Network ("MSHN") and is designated by the CMHSPs as constituted under the Mental Health Code, to be the Medicaid PIHP; and

Whereas, the Michigan Department of Health and Human Services ("MDHHS") approved the 2013 Application for Participation and MSHN as the PIHP to contractually manage the Specialty Services Waiver Program(s) and the Supports Waiver Program(s) approved by the federal government and implemented concurrently by the State of Michigan in the designated services area of the Arenac, Bay, Clare, Clinton, Eaton, Gladwin, Gratiot, Hillsdale, Huron, Ingham, Ionia, Isabella, Jackson, Mecosta, Midland, Montcalm, Newaygo, Osceola, Saginaw, Shiawassee, and Tuscola Counties (the "Service Area") and the MDHHS entered into, effective January 1, 2014, a MDHHS/PIHP Managed Specialty Supports and Services Contract (referred to as the "MDHHS/PIHP Master Contract for Medicaid Funds") with MSHN for the provision of Medicaid mental health and substance abuse services and supports; and

Whereas, MSHN entered into, effective January 1, 20XX, a PIHP/CMHSP Medicaid Subcontracting Agreement with the CMHSP whereby the PIHP subcontracts to the CMHSP, as a Specialty Services Provider, to provide the Medicaid mental health specialty supports and services to Medicaid eligible within the CMHSP's specific County in said PIHP Medicaid services area; and

Whereas, under the authority granted by MCL 330.1116(2)(B) and MCL 330.1116(3)(e), and MCL 330.1228, the MDHHS entered into, effective October 1, 20XX, a MDHHS/CMHSP Managed Mental Health Supports and Services Contract for General Funds (the "MDHHS/CMHSP Master Contract for General Funds") with the CMHSP of the applicable county; and

Whereas, given all of the above, the CMHSP, at its discretion, has the right to direct-operate and/or contract for supports and services to persons who meet the supports/services eligibility criteria in the service area of the applicable county. Payor's service area for the purposes hereunder is {{NAME OF COUNTIES}} Counties; and

Whereas, CMHSP is, from time to time, in need of applied behavioral analysis services, under a contractual arrangement, from a qualified, licensed facility for an eligible person who meets the supports/services eligibility criteria; and

Whereas, Provider desires to render certain services more specifically set forth and pursuant to the terms and conditions of this Agreement in the **Statement of Work,** attached as **Attachment A** to this agreement and made a part hereof.

Now, therefore, in consideration of the above and in consideration of the mutual covenants contained, it is agreed by Payor and Provider as follows:

CONTRACTUAL PROVISIONS

1. Authority

a. This Agreement is entered into pursuant to the authority granted to Payor listed under the Mental Health Code. This Agreement is in accordance with the rules, regulations, and standards (the "MDHHS Administrative Rules") of the MDHHS adopted and promulgated in accordance with the Mental Health Code.

b. This Agreement is in accordance with the requirements of the Balanced Budget Act of 1997, as amended (the "BBA"), and BBA final rules, regulations, and standards, and with the requirements of the applicable State and Federal programs.

This Agreement is in accordance with the standards as contained in the aforementioned Application for Participation ("AFP") as they pertain to the provisions of specialty services to Medicaid eligible, and the plans of correction and subsequent plans of correction submitted by the PIHP and approved by the MDHHS, and any stated conditions, as reflected in the MDHHS approval of the application, unless prohibited by federal or state law.

c. The Mental Health Code, the MDHHS Administrative Rules, the MDHHS/CMHSP Master Contract for General Funds, that certain MDHHS/PIHP Master Contract for Medicaid Funds dated [_____], that certain the PIHP/CMHSP Medicaid Subcontracting Agreement dated [_____], and applicable state and federal laws shall govern the expenditure of funds and provisions of services hereunder and govern in any area not specifically covered by this Agreement.

2. Provider's Services and Responsibilities

a. Provider shall perform services hereunder at Payor-authorized service sites during this Agreement. Provider may have access to Payor's service site(s) and temporary service space therein, if approved by Payor's Chief Executive Officer ("CEO") or such CEO's designated representative(s), in order to perform services hereunder. Provider shall furnish and utilize Provider's own equipment, tools, materials, and supplies that Provider deems necessary to perform the supports/services hereunder. Provider shall not offer hours of operation that are less than the hours of operation offered to commercial members or not comparable to Medicaid fee-for-service ("FFS"), if Provider serves only Medicaid members.

b. Provider shall exercise independent control over Provider's services rendered under this Agreement, including the manner or methods of services, service duties or tasks, and the professional procedures thereof.

c. Provider shall provide the services hereunder in keeping with final results of services, deadlines for final results of services, and applicable schedules of services, as authorized by Payor's CEO or the CEO's designated representative.

d. The scheduling and amounts of service units which Provider shall render hereunder shall be flexible during the period of this Agreement and shall be subject to case-to-case assessments by Payor's CEO or the CEO's designated representative on the need of Provider's services for consumer(s) (each a "Consumer", and, collectively, the "Consumers" and their extent and the service scheduling requirements thereof. Provider is not guaranteed under this Agreement a minimum number of Consumer cases, Consumer appointments, or Consumers to be served. Payor does not guarantee to Provider hereunder either the scheduling of or the performing of a minimum amount of service units and/or hours of contractual services daily, weekly, monthly, or annually during the period of this Agreement.

e. Services performed by Provider for a Consumer under this Agreement must be in direct accordance with the written Individual Plan of Services of said Consumer as developed through a person-centered planning process in a Payor-authorized supports/services planning meeting.

f. Provider shall complete services and documentation and records thereof that meet Payor's requirements hereunder for reimbursement by Payor. Provider's services and related documentation/records shall comply with the standards of Payor, the MDHHS, an applicable licensing department or agency of the State of Michigan, Medicaid and Medicare regulations, any third party reimbursors, and any other applicable federal or state laws. Provider shall maintain complete and accurate records of all services provided under this Agreement in such form and submit them to Payor at such time as may be required by Payor's CEO or the CEO's designated representative(s).

g. Provider's designated representative(s) shall, from time to time, as may be required, meet with the designated representative(s) of Payor's CEO to discuss Consumer(s) being served and/or the services required under this Agreement. Provider shall not be responsible for supervising any employees of Payor or any work of any employees of Payor pursuant to this Agreement.

3. Term and Termination

a. **Term:** The initial term of this Agreement shall be for fiscal year 20XX (FYXX) and shall begin on _____ and shall expire on _____, unless earlier terminated by either party as set forth herein. Following expiration of the initial term, this Agreement shall automatically renew for up to two successive twelve (12) month periods under the same terms and conditions as herein contained effective October 1st of each year. Provider shall have the opportunity to review the initial agreed upon rate with Payor on an annual basis but agrees that if any change to the rate is not agreed to and fully executed before September 30 of each year, the rate then currently in effect shall remain unchanged.

b. **Termination Without Cause:** Each party to this agreement may terminate this Agreement at any time without cause by providing sixty (60) days' prior written notice to Provider or Payor, as applicable. 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 provider's program, including Payor. 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.

c. **Termination For Cause:** Any material breach of this Agreement may result in the non-breaching party's immediate termination of this Agreement, with said termination effective as of the date of delivery of written notification from the non-breaching party to the breaching party. The termination of this Agreement shall not be deemed to be a waiver by the non-breaching party of any other remedies it may have in law or in equity.

d. **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, until such time as a mutually agreeable transfer plan for any Consumers is finalized between Payor and Provider.

e. This Agreement shall terminate effective immediately upon the revocation, restriction, suspension, discontinuation, or loss of any certification, accreditation, or authorization, or license required by federal, state and local laws, ordinances, rules and regulations for Provider to operate and/or to provide Medicaid and/or non-Medicaid programs and supports/services for Payor in the State of Michigan, with said termination to be effective as of the date of delivery of written notice to Provider.

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

g. Upon any termination of this Agreement, Provider shall supply Payor with all information necessary for the reimbursement of any outstanding Medicaid claims, Medicare claims or third-party reimbursement claims within thirty (30) days.

h. Provider agrees, in the event of termination of this Agreement and non-renewal, to cooperate with Payor in the orderly transfer of Consumer, records, property, programs and services, and other items material hereunder to Payor and/or other contractors of he Payor, as applicable.

4. Funding

a. This Agreement is contingent upon receipt by Payor 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 Payor, that reduce or otherwise interfere with its ability to provide or maintain specified services or operational procedures for its service area, Payor shall provide immediate notice to Provider if it would result in any reduction of the funding upon which this Agreement is contingent. Payor shall not refer Consumers to Provider, without concurrence of Provider, for treatment hereunder if any such reduction in funding would not enable Payor to meet its financial obligations hereunder for payments to Provider for such services, as applicable.

5. Relationship of the Parties

a. In performing its responsibilities under this Agreement, it is expressly understood and agreed that Provider's relationship to Payor is that of an independent contractor. This Agreement shall not be construed to establish any principal/agent relationship between Payor and Provider.

b. It is expressly understood and agreed by Provider that the MDHHS and the State of Michigan are not parties to, nor responsible for any payments under this Agreement, and neither the MDHHS nor the State of Michigan is party to any employer/employee relationship of Provider.

c. It is expressly understood and agreed by Provider that its officers, employees, servants and agents and subcontractors providing services pursuant to this Agreement shall not in any way be deemed to be or hold themselves out as the employees, servants, or agents of Payor. Provider's officers, employees, servants, subcontractors, and agents shall not be entitled to any fringe benefits from Payor such as, but not limited to, health and accident insurance, life insurance, longevity, economic increases, and/or paid vacation and sick leave.

d. Provider shall be responsible for paying all salaries, wages, and/or other compensation due its staff psychiatrists, employees, servants, agents, and subcontractors performing services under this Agreement, and for the withholding and payment of all applicable taxes, including, but not limited to, income and social security taxes, to the proper federal, state, and local governments. Provider shall carry worker's compensation coverage and unemployment insurance coverage for its staff psychiatrists and other employees and agents as required by law and shall require the same of its subcontractors and shall provide Payor with proof of said coverage. Provider will be solely and entirely responsible for its acts and the acts of its agents, employees, servants, and sub-contractors.

6. Relationships with Other Contractors of Payor

a. The relationship of Provider, pursuant to this Agreement, with other contractors of Payor shall be that of independent contractor. Provider, in performing its duties and responsibilities under this Agreement, shall fully cooperate with the other contractors of Payor. Payor's requirements of such cooperation shall not interfere with Provider's performance of services required under this Agreement.

7. Subcontracting

a. Provider shall not delegate this Agreement. Provider shall not subcontract any services to be provided under this Agreement without Payor's express written consent. In the event Payor allows Provider to subcontract its performance of services and/or obligations under this Agreement, Payor retains the right to review, approve, and monitor any subcontracts or any subcontractor's compliance with this Agreement and all applicable laws and regulations.

b. Any subcontract approved by Payor shall not terminate Provider's legal responsibilities under this Agreement. All subcontracts that may be approved by Payor must be (a) in writing, (b) specify the activities and clearly delegate responsibilities of the subcontractor, (c) provide for the option to revoke such delegation and/or imposition of sanctions if the subcontractor's performance is inadequate, as assessed by Payor in its sole and reasonable discretion, (d) provide for monitoring, including, without limitation, site review of the subcontractor by Payor or its designated representative(s),

and (e) provide for the requirement to comply with the corrective action requirements of Payor or designated representative(s).

c. Provider may subcontract for the provision of any of the services specified in this Agreement, including, without limitation, contracts for administrative and financial management and data processing. Provider shall be held solely and fully responsible to execute all provisions of this Agreement, whether or not said provisions are directly pursued by Provider or pursued by Provider through a subcontract vendor. Provider shall ensure that all subcontract arrangements clearly specify the type of services being purchased. Subcontracts shall ensure that Payor and the MDHHS are not parties to the contract and therefore not a party to any employer/employee relationship with the subcontractor of Provider. Subcontracts entered into by Provider shall address such provisions as Provider deems necessary for the development of the service delivery system and shall include standard terms and conditions as MDHHS may develop.

8. Assignment

a. Provider shall not assign this Agreement without the express written consent of Payor. Notwithstanding the foregoing, and provided notice is given to the other party, either party may assign its rights and obligations under this Agreement without the other party's prior written consent to a successor entity (in whole or part) in connection with an internal reorganization, whether through conversion, merger, or a related transaction.

9. Business Records, Maintenance of Records & Audits

a. **Financial Review:** Provider shall submit, upon request of Payor, financial statements and related reports and schedules that accurately reflect the financial position of Provider. Provider must submit, upon request of Payor, its financial statements and supporting reports and schedules as presented to its governance authority. Payor reserves the right to require Provider to secure an independent financial audit.

b. **Accounting and Internal Controls:** Provider shall ensure its accounting procedures and internal financial controls conform to generally accepted accounting principles ("GAAP") to ensure that the costs allowed by this Agreement can be readily ascertained and expenditures verified therefrom.

c. **Access to Books and Records:** Payor, the MDHHS and the State of Michigan or their designated representative(s) shall be allowed to review, copy, and/or audit all financial records, licensure, accreditation, and certification reports and to review and/or audit all clinical service records of Provider pertaining to performance of this Agreement, to the full extent permitted by applicable federal and state laws. Refusal to allow Payor, the MDHHS or the State of Michigan or their designated representative(s) access to said records for the above-stated purposes shall constitute a material breach of this Agreement for which Payor may exercise any of its remedies available both under this Agreement and at law or in equity, including, without limitation, the immediate termination of this Agreement. Clinical and financial records and supporting documentation must be retained by Provider and be available for audit purposes as required by applicable law.

d. **Access to Books and Records by Federal Authorities:** If the Secretary of the U.S. Department of Health and Human Services, the Comptroller General of the United States or their designated representative(s) (the "Requesting Parties") request access to books, documents, and records of Provider as outlined in Provider's manuals and/or policies and in accordance with Section 952 of the Omnibus Reconciliation Act of 1980 and the regulations adopted pursuant thereto, Provider agrees to provide such access to the extent required. Furthermore, Provider 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 (the "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.

10. Conflict of Interest

a. Provider affirms that no principal, representative, or another agent acting on behalf of or legally capable of acting on behalf of Provider is currently an employee of the MDHHS or any of its constituent institutions, an employee of Payor or of a party to a contract with Payor or administering or benefiting financially from a contract with Payor, or serving in a policy-making position with an agency under contract with Payor; nor is any such person related to Provider currently using or privy to such information regarding Payor which may constitute a conflict of interest. Breach of this covenant may be regarded as a material breach of the Agreement and a cause for termination.

11. Non-Discrimination

a. In performing its duties and responsibilities under this Agreement, Provider shall comply with all applicable federal and state laws, rules and regulations prohibiting discrimination.

b. Provider shall not discriminate against any employee or applicant for employment with respect to hire, tenure, terms, conditions, or privileges of employment or a matter directly or indirectly related to employment because of race, color, religion, national origin, age, gender identity, sexual orientation, height, weight, or marital status pursuant to Act 453 of the Public Acts of 1976, as amended (the "Elliott-Larsen Civil Rights Act"), MCL 37.2101 *et seq.*) and 42 CFR 438.206(c)(2).

c. Provider shall comply with the provisions of Act 220 of the Public Acts of 1976, as amended (the "Persons With Disabilities Civil Rights Act"), MCL 37.1101 *et seq.*).

d. Provider shall comply with the Americans with Disabilities Act of 1990, as amended (the "ADA"), 42 USC 12101 *et seq.*), and regulations promulgated thereunder.

e. Provider shall comply with the Title VI of the Civil Rights Act of 1964, 42 USC 2000d *et seq.*) and Office of Civil Rights Policy Guidance on the Title IV Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency,

Section 504 of the Federal Rehabilitation Act of 1973, as amended, PL 93-112, Title IX of the Education Amendment of 1972, as amended (20 USC 1681-1683 and 1685-1686) and the regulations of the U.S. Department of Health and Human Services issued thereunder (45 CFR Parts 80, 84, 86 and 91).

f. Provider shall comply with the Age Discrimination Act of 1975, as amended, 42 USC 6101 *et seq*.

g. Provider shall not refuse to treat nor discriminate in the treatment of Consumer under this Agreement, based on the individual's age, height, weight, marital status, arrest record, race, creed, disability, color, national origin or ancestry, religion, gender, and/or political affiliation or beliefs.

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

i. Provider must assure that Consumers are permitted to choose their health care professional.

12. Disclosure of Ownership and Control

a. Provider will comply with all federal regulations by disclosing to Payor's CEO information about individuals with ownership or controlling interests in Provider, if any, by completing and executing **Attachment I** and returning same with an executed copy of this Agreement. The federal regulations also require Provider to identify and report any additional ownership or controlling interests for those individuals in other entities, significant and material to Provider's obligations under this Agreement with Payor and to identify when any of the individuals with ownership or controlling interests have spousal, parent-child, or sibling relationships with each other. Provider must disclose changes in ownership and control information at the time of enrollment, re-enrollment, or whenever a change in entity ownership or control takes place.

13. Indemnification and Hold Harmless

a. Provider shall, at its own expense, protect, defend, indemnify, and hold harmless Payor and its elected and appointed officers, employees, servants and agents from all claims, damages, costs, and expenses, arising from personal and/or bodily injuries or property damage that any of them may incur as a result of any acts, omissions, or negligence by Provider, and/or its officers, employees, servants, or agents that may arise out of this Agreement.

b. Provider's indemnification and hold harmless responsibilities under this Section shall include the sum of claims, damages, costs, lawsuits and expenses which are in excess of the sum reimbursed to Payor and its elected and appointed officers, employees, servants and agents by the insurance coverage obtained and/or maintained by Provider pursuant to the requirements of this Agreement.

c. To the extent permitted by law, Payor shall defend, indemnify and hold harmless Provider, its Board of Dire

ctors,
directors, officers, employees, agents and representatives harmless from and against all claims, damages, co sts 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 Payor or its officers, directors, employees, contractors, subcontractors or agents; (ii) the duties and obligations of Payor under this Agreement; or (iii) a breach of this Agreement.

d. The Payor's indemnification and hold harmless responsibilities under this Section shall include the sum of claims, damages, costs, lawsuits and expenses which are in excess of the sum reimbursed to Payor and its elected and appointed officers, employees, servants and insurance coverage obtained and/or maintained by Provider pursuant to the requirements of this Agreement.

14. Liability Insurance

a. The PROVIDER, or any of their subcontractors shall not commence work under this Agreement until they have obtained the insurance required under this paragraph, and shall keep such insurance in force during the entire life of the contract.

i. All coverage shall be with insurance companies licensed and admitted to do business in the State of Michigan with a minimum “A-“rating by Best’s Insurance Rating Service. The requirements below should not be interpreted to limit the liability of the PROVIDER.

ii. All deductibles and self-insured retention (SIRs) are the responsibility of the PROVIDER.

iii. The PROVIDER shall maintain certificates of insurance from all PAYOR-approved subcontractors and ensure adequate coverage is provided throughout the term of the subcontractor’s agreement. All coverage for subcontractors shall be subject to the minimum requirements identified below.

iv. PROVIDER, at its sole expense, must maintain the insurance coverage identified below. All required insurance must protect the PAYOR from claims that arise out of, are alleged to arise out of, or otherwise result from PROVIDER's or subcontractor's performance. 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	
If a motor vehicle is used in relation to the Contractor's performance, the Contractor must have vehicle liability insurance on the motor vehicle for bodily injury and property damage as required by law.	
Workers' Compensation Insurance	
Minimum Limits: Coverage according to applicable laws governing 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: $1,000,000 Each Occurrence $3,000,000 Annual Aggregate	

Additional Insured: Commercial General Liability, as described above, shall include an endorsement stating the following shall be additional insured: PAYOR, together with all elected and appointed officials, all employees and volunteers, all boards,

commissions, and/or authorities and board members, including employees and volunteers thereof. It is understood and agreed by naming the PAYOR as additional insured, coverage afforded is considered to be primary and any other insurance PAYOR may have in effect shall be considered secondary and/or excess, unless specifically waived in writing by the PAYOR.

Cancellation Notice: All insurances policies as described above shall include an endorsement stating the following: "It is understood and agreed that thirty (30) days' (ten (10) days for non-payment of premium) advance written Notice of Cancellation, Non-Renewal, Reduction and/or Material Change shall be sent to the PAYOR."

v. **Proof of Insurance**: The PROVIDER shall provide PAYOR, at the time that the contracts are returned for execution, a Certificate of Insurance as well as the required endorsements. In lieu of required endorsements, if applicable, a copy of the policy sections where coverage is provided for additional insured and cancellation notice is acceptable. Copies or certified copies of all policies mentioned above shall be furnished, if so requested.

vi. **Continuation of Coverage**: If any of the above coverages expires during the term of this agreement, the PROVIDER shall deliver renewal certificates and/or endorsements to the PAYOR at least ten (10) days prior to the expiration date, or if after expiration date renewal certificate shall indicate coverage from the expiration date forward.

vii. 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.

If any required policies provide claims-made coverage, the PROVIDER must: (i) provide coverage with a retroactive date before the effective date of this contract or the beginning of contracted activities; (ii) maintain coverage and provide evidence of coverage for at least three (3) years after completion of the contracted activities; and (iii) if coverage is cancelled or not renewed, and not replaced with another claims-made policy form with a retroactive date prior to the effective date of this contract, PROVIDER must purchase extended reporting coverage for a minimum of three (3) years after completion of work.

PROVIDER must: (i) provide insurance certificates to the PAYOR, containing the agreement or delivery order number, at the time of contract execution and within twenty (20) calendar days of the expiration date of the applicable policies; (ii) require that subcontractor's maintain the required insurances contained in this Section; (iii) notify the PAYOR within five (5) business days if any policy is cancelled; and (iv) waive all rights against the PAYOR for damages covered by insurance. Failure to maintain the required insurance does not limit this waiver.

This Section is not intended to and is not to be construed in any manner as waiving, restricting or limiting the liability of either party for any obligations under this Contract (including any provisions hereof requiring PROVIDER to indemnify, defend and hold harmless the PAYOR).

15. Compliance with the Law; Applicable Law and Venue

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

b. Payor and Provider agree that the venue for the bringing of any legal or equitable action under this Agreement shall be established in accordance with the statutes of the State of Michigan and/or Michigan court rules. In the event that any action is brought under this Agreement in federal court, the venue for such action shall be the Federal Judicial District of Michigan.

c. Provider, its 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.

d. The Provider acknowledges and agrees that the following statutes, rules, regulations, and procedures govern the provision of services rendered hereunder and the relationship between the parties:

i. The MDHHS/PIHP Master Contract for Medicaid Funds, and the MDHHS/CMHSP Master Contract for General Funds

ii. The Michigan Mental Health Code and its rules and regulations;

iii. Act 368 of the Public Acts of 1978, as amended (the "Michigan Public Health Code"), MCL 333.1101 *et seq*., and its rules and regulations, as amended;

iv. MDHHS Medicaid Provider Manual, as amended;

v. Policies and procedures of Payor with respect to Provider networks, and the provision and payment of services contemplated by this Agreement;

vi. 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, PL 104-209. Further, Provider shall require that the language of this assurance be included in the award documents of all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

vii. Pursuant to Act 278 of the Public Acts of 1980, as amended, MCL 423.321 *et seq.*, the State shall not award a contract or subcontract to an employer or any subcontractor, manufacturer or supplier of the employer, whose name appears in the current register compiled by the Michigan Department of Licensing and Regulatory Affairs. The State of Michigan or Payor may void any contract if, subsequent to award of the contract, the name of Provider as an employer, or the name of the subcontractor, manufacturer or supplier of Provider appears in the register.

viii. Any other applicable state and federal laws governing the parties hereto.

16. Compliance with the MDHHS/CMHSP Master Contract for General Funds and the MDHHS/PIHP Master Contract for Medicaid Funds

a. It is expressly understood and agreed by Provider that this Agreement is subject to the terms and conditions of the MDHHS/CMHSP Master Contract for General Funds and the MDHHS/PIHP Master Contract for Medicaid Funds (collectively, the "Master Contracts"). The provisions of this Agreement shall take precedence over the Master Contracts unless a conflict exists between this Agreement and any provision of the Master Contracts. In the event that any provision of this Agreement is in conflict with any provision of the Master Contracts, the provision of the Master Contracts shall prevail. However, a conflict shall not be deemed to exist where this Agreement:

i. contains additional provisions and additional terms and conditions not set forth in the Master Contracts;

ii. restates provisions of the Master Contracts to afford Payor or the PIHP the same or substantially the same rights and privileges as MDHHS; or

iii. requires Provider to perform duties and services in less time than required of Payor or the PIHP in the Master Contracts.

17. Debarment, Suspension, and Exclusion

a. Provider represents and warrants that Provider and its personnel will comply with the Federal Acquisition Regulations (45 CFR 76)l and that Provider and its personnel:

i. are not presently debarred, suspended, proposed for debarment, declared ineligible, or excluded from covered transactions by any federal department, government programs or PIHP or Payor;

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, briber, 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; and

v. have not been notified by any means or methods that Personnel are the subject of any investigation or review regarding participation in any government programs.

b. Provider agrees to immediately notify Payor if Provider or its Personnel are under investigation or 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 Payor-approved subcontractor agreements.

18. Licenses, Certifications, Credentialing and Privileging Requirements

a. Provider shall obtain and maintain during the term of this Agreement all licenses, certifications, registrations, and national Provider identifiers pursuant to Section 5005 and Section 12006 of the 21st Century Cures Act of 2016, PL 114-255, accreditations, authorizations, and approvals required by federal, state, and local laws, ordinances, rules and regulations for Provider to operate and provide Medicaid and/or non-Medicaid programs and services within the State of Michigan.

b. Provider shall insure that there are systems in place to assure that its personnel meet appropriate licensure, competency, and criminal history standards including systems for the primary verification of professional credentials.

c. Providers must perform l background checks on their personnel, including:

i. Criminal Background Checks using Internet Criminal History Access Tool (ICHAT) or a source that reveals information substantially similar to information found on an ICHAT: https://apps.michigan.gov

ii. Michigan Public Sex Offender Registry: https://mspsor.com

iii. National Sex Offender Registry: http:/www.nsopw.gov

iv. MDHHS Central Registry check required for staff working directly with children: https://www.michigan.gov/mdhhs/0,5885,7-339-73971_7119_50648_48330-180331--,00.html

d. These background checks are a requirement of this Agreement. Provider must have, and follow, a policy on hiring of persons with backgrounds that is consistent with MCL 333.18263, the Mental Health Code for Behavior Technicians, the Social Security Act of 1935, as amended, 42 USC 1320a-7(a), the Michigan Medicaid Manual, and applicable licensing and/or certification rules. Background checks shall be conducted prior to any Consumer contact. An offer of employment may be made contingent on a background check and should expressly note that there is to be no contracted service provided until all background checks are complete (*See* Section IV).Background checks shall be repeated at a frequency defined in CMHSP participant policy and as required by MDHHS for all persons who have direct contact with

Consumers or direct access to Consumer information.

e. Provider must require each new employee, subcontractor, subcontractor employee, or volunteer (including students and interns) who works under this Agreement, works directly with Consumers, or who has access to Consumer information to notify the Provider in writing of criminal convictions (felony or misdemeanor), pending felony charges, or placement on the Central Registry as a perpetrator either at hire or within ten (10) days of the event after hiring.

f. Providers that employ or contract with licensed health care professionals are required to have a written policy or procedure in place for credentialing and re-credentialing individuals in accordance with the BHDDA credentialing and recredentialing processes. Provider shall refer to Payor's manuals, policies, and/or procedures for more specific information about required credentialing and re-credentialing expectations.

g. Prior to commencing services under this Agreement, Provider, as applicable, shall furnish Payor with notice of primary verification that its healthcare providers, if any, have obtained and maintain all approvals, certifications, and licenses required by federal, state and local laws, ordinances, rules and regulations to practice their professions and to perform Medicaid and/or non-Medicaid services hereunder. If any such license, certification, or authorization is ever suspended, restricted, revoked, or expires and is not renewed, Provider shall immediately notify Payor, in writing. Such information shall also be reported on **Attachments C and F**.

h. Provider, as a member of Payor's service provider network, shall cooperate with Payor on an ongoing basis and, as applicable, shall ensure that Provider's healthcare providers meet Payor's credentialing and privileging requirements, including, without limitation, recredentialing and competency standards necessary to perform the supports/services required under this Agreement.

i. Provider shall re-apply to Payor every three (3) years to continue in Payor's provider network.

j. In accordance with the Medicaid Provider Manual and specifically, sections related to non-emergency medical transportation, individuals transporting Consumers must hold a valid driver's license appropriate to the class of vehicle being operated as defined by the Act 300 of the Public Acts of 1949, as amended (the "Michigan Vehicle Code"), MCL 257.1 *et seq*.

19. 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 subcontractor, at the time of renewal of engagement, on a monthly basis, and at the time new disclosure information is received. Checks must include the US Department of Health and Human Services Office of Inspector General's List of Excluded Individuals/ Entities ("LEIE") at http://exclusions.oig.hhs.gov, the federal government's System for Award Management ("SAM") at www.SAM.gov,and the MDHHS website at www.michigan.gov/MDHHS (see Doing Business with MDHHS/ Health Care

Providers/ List of Sanctioned Providers or http://www.michigan.gov/mdhhs/0, 5885,7-339-71551_2945_42542_42543_42546_42551-16459--,00.html). Provider agrees to maintain documentation showing proof of having completed the exclusion checks at the required frequency and to make such documentation available to Payor for verification during site visits. Provider agrees to notify Payor's CEO or designated representative(s) within two (2) business days if search results indicate that an employee, contractor, or individuals or entities with ownership or controlling interests in a Provider entity appear on the exclusions databases.

20. Staffing and Training Requirements

a. Provider, pursuant to this Agreement, shall ensure that:

i. Active treatment is provided by Provider's personnel to each Medicaid covered and non-Medicaid Consumer hereunder at the medically necessary level of care; and,

ii. All services hereunder are to be provided by Provider's personnel in a manner that demonstrates cultural competency and is consistent with applicable medical standards of professionalism.

iii. Provider shall maintain staffing consistency and programming continuity in the provision of services to Consumer(s) hereunder.

b. Provider's personnel, when performing services under this Agreement, shall comply with:

i. All applicable provisions and requirements for services in the Mental Health Code, the MDHHS rules, Medicaid regulations, and the MDHHS/PIHP Master Contract for Medicaid Funds and the MDHHS/CMHSP Master Contract for General Funds; and,

ii. All applicable policies, guidelines, and standards established by Provider.

c. Orientation of and ongoing training and education of Provider's personnel shall follow minimum training requirements as listed in **Attachment E**.

d. Provider shall mandate continuing education to Provider's personnel as needed or when necessitated by changes in Provider's programs or as stated in recipient rights requirements, including but not limited to, the requirements identified by MDHHS in its "Continuing Education Requirements for Recipient Rights Staff."

21. Recipient Rights

a. Provider shall ensure that all of its personnel, volunteers, students, and any other agent of Provider obtain recipient rights training from the CMHSP ORR approved resource within thirty (30) days of hire, and annually thereafter in a

training module that is approved by the MDHHS Office of Recipient Rights as detailed in Chapters 7 and 7A of the Mental Health Code, and Rule 1806 of the Michigan Administrative Code, R 330.1806.

b. Provider agrees to safeguard, protect, and promote the rights of Recipients, also referred to as Consumer. 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 **Attachment G**.

c. Provider agrees to comply with, in their entirety, the policies and procedures, delineated in Attachment G, providing for the safeguarding of the rights of Recipient's as established by Payor.

d. Provider agrees to protect the rights of all persons using their services as guaranteed in the Mental Health Code and 330.7001, *et seq.*. of the Michigan Administrative Rules.

e. Provider agrees that Recipients will be protected from rights violations while receiving services under this Agreement.

f. Provider agrees to assume responsibility for the administration, quality of care, treatment services, and protective services for all Recipient's admitted for care. The term "protective services" as used in this paragraph means reporting and referral services required by Provider under the Michigan adult abuse reporting requirements pursuant to Act 280 of the Public Acts of 1939, as amended (the "Social Welfare Act"), Michigan Compiled Law 400.11 *et seq.*, or Act 238 of the Public Acts of 1975, as amended (the "Child Protection Law"), Michigan Compiled Law 722.621 *et seq.*.

g. Provider agrees to maintain the confidentiality of information regarding Recipients in compliance with Michigan Compiled Law330.1748 and Michigan Compiled Law 330.1750.

h. Provider agrees to ensure that MDHHS "Your Rights" booklets are made available to Recipients, visitors, and employees.

i. Each Provider site must have the name and telephone number of Payor Recipient Rights Officer and the "Abuse and Neglect Reporting" poster posted in a conspicuous place. Contact Payor Recipient Rights Office to obtain copies of the MDHHS "Your Rights" booklet and Abuse and Neglect Reporting poster.

j. Each Provider shall ensure that Chapters 7 and 7A of the Mental Health Code be readily available, either paper or an electronic version.

k. Provider shall ensure a summary of Michigan Compiled Law 330.1748 will be filed in the case record for each Recipient.

l. Provider agrees to monitor the safety and welfare of Recipient and to provide immediate comfort and protection to, and assure immediate medical treatment for, a Recipient who has suffered physical injury or illness.

m. Provider agrees to ensure that Recipients using their services, parents, guardians, and others designated representative(s) have access to complaint forms and information about the complaint process.

n. Provider agrees to ensure that all verbal and/or written reports of alleged rights violations are forwarded immediately in writing and via phone to Payor's Rights Office.

o. Provider will cooperate fully during recipient rights investigations. Any CMHSP Recipient Rights Officer shall have unimpeded access to all Payor and Recipient evidence necessary to conduct a thorough investigation or to fulfill its monitoring function, including personnel and all programs and services. Provider's personnel are required to cooperate with Payor's Recipient Rights Office during investigations. Provider agrees to allow individuals who properly identify themselves as representatives of Disability Rights Michigan access to premises, Recipients, and service records in compliance with Sections Michigan Compiled Law 330.1748 and Michigan Compiled Law 330.1750.

p. Provider agrees to implement appropriate remedial or disciplinary action for substantiated allegations of rights violations and submit a written description of the remedial or disciplinary action to Payor's Recipient Rights Office within five (5) business days of receipt of the investigative report.

q. Provider agrees to comply with Payor's recipient rights reporting requirements regarding death, unusual incidents, serious injury, suspected abuse or neglect and all other alleged rights violations concerning a Recipient being provided services under this Agreement. Provider agrees to comply with those reporting requirements as established by Department of Licensing and Regulatory Affairs, Protective Services (Adults & Children), state and federal law, and all other public agencies, as applicable.

r. Provider agrees to furnish Payor's CEO with immediate notice of any sentinel event involving any Recipient being served hereunder. Provider shall report any deaths, serious injuries, suspected abuse or neglect and all other sentinel events regarding a Recipient hereunder to Payor's designated staff representatives immediately by telephone and then, in writing on Payor's designated forms within twenty-four (24) hours of the occurrence and, as required by law, to Adult or 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 Payor within twenty-four (24) hours of the occurrence.

s. Provider agrees to ensure that Recipients, Payor personnel or anyone acting on behalf of Recipient shall be protected from harassment or retaliation resulting from recipient rights activities. If evidence is shown of harassment or retaliation, Provider shall take appropriate disciplinary action.

t. Provider will ensure unimpeded access for Payor, at any time, and at least annually for the purpose of annual assessments, to review Provider's 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 Payor's policies and procedures.

22. Consumer Grievance Procedures

a. Provider agrees to fully comply with Payor's Consumer Grievance and Appeals Policy and Procedure, Recipient Rights Policies and Procedures, and Incident/Sentinel Event Reporting, Policies and Procedures.

b. These policies and procedures shall be located on Payor's website. Payor agrees to distribute regular updates, as needed, and Provider agrees to maintain updates provided by Payor.

23. Consumer Medical Records

a. Provider, pursuant to this Agreement, shall establish and maintain a comprehensive individual service record system consistent with the provisions of MDHHS Medical Services Administration ("MSA") Policy Bulletin Chapter 1, the Michigan Department of Technology, Management, and Budget Retention General Schedule #20 Community Mental Health Programs Dated March 2, 2007, and appropriate state and federal statutes.

b. Payor has the right to full access to all records pertaining to any Consumer and services rendered pursuant to this Agreement. Provider agrees to furnish Payor with copies of all records pertaining to any Consumer and services rendered pursuant to this Agreement upon reasonable request.

c. To the extent that the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), PL 104-191 is pertinent to the services that Payor purchases and Provider provides under this Agreement, Provider ensures that it is in compliance with the HIPAA requirements (as further defined below).

d. All Consumer information, medical records, data, and data elements collected, maintained, or used in the execution of this Agreement shall be protected by Provider from unauthorized disclosure as required by state and federal regulations. Provider must provide safeguards that restrict the use or disclosure of information concerning Consumers to purposes directly connected with the execution of this Agreement.

e. Because of the nature of the relationship between the parties hereto, there shall be an ongoing exchange of confidential information for Consumers served under this Agreement.

f. Provider shall comply with all applicable federal and state laws, rules, and regulations, including the Mental Health Code and the MDHHS rules, on confidentiality with regards to disclosure of any materials and/or information provided pursuant to this Agreement. Any release of information must be in compliance with MCL 330.1748, MCL 330.1748a, and MCL 330.1750.

g. Provider shall assure that services to and information contained in the records of Consumers served under this Agreement, or other such recorded information required to be held confidential by federal or state laws, rules or regulations, in connection with the provision of services or other activity hereunder shall be privileged communication.

Privileged communication shall be held confidential and shall not be divulged without the written consent of either Consumer or a person responsible for Consumer, except as may be otherwise required by applicable laws. Such information may be disclosed in summary, statistical, or other form, which does not directly or indirectly identify particular individuals.

24. Health Insurance Portability and Accountability Act ("HIPAA")

a. To the extent that HIPAA applies to the services that Provider provides under this Agreement, Provider assures that it is in compliance with HIPAA requirements, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act") of Title XIII, Division A of the American Recovery and Reinvestment Act of 2009,PL 111-5, as amended (the "ARRA"), and related regulations found at 45 CFR Parts 160 and 164, including the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule), the Security Standards for the Protection of Electronic PHI (Security Rule), and the rules pertaining to Compliance and Investigations, Imposition of Civil Money Penalties, and Procedures for Hearings (Enforcement Rule), as amended from time to time, (hereafter collectively referred to as "HIPAA Regulations"); the Federal Confidentiality Law, 42 USC 290dd-2 and underlying regulations, and 42 CFR Part 2. This includes the distribution of Consumer handbooks and Provider directories to Consumers, and/or the HIPAA Privacy Notice.

25. Compliance Program

a. Provider shall implement and maintain a compliance plan in accordance with federal and state laws (the "Compliance Plan"). The Compliance Plan must include, at a minimum, all of the following elements:

i. An employee/contractor code of conduct and standards of conduct for compliance with federal and/or state standards;

ii. Employee education program(s);

iii. Communication processes between senior management and employees regarding the compliance program;

iv. Guidance and reporting system(s);

v. Prompt investigation and complaint resolution processes;

vi. Corrective action planning and implementation;

vii. Data monitoring and evaluation.

b. Upon request, Provider shall furnish a copy of the Compliance Plan to Payor. Provider agrees to immediately notify

Payor with respect to any inquiry, investigation, sanction or otherwise from the Office of Inspector General ("OIG") with respect to any compliance issues.

26. Quality Improvement Program/Site Reviews/Performance Monitoring

a. Provider shall maintain a fully operational internal Quality Assessment and Performance Improvement Program ("QAPIP") or comply with Payor QAPIP.

b. Provider agrees, pursuant to this Agreement, to cooperate fully in Payor's implementation of:

i. performance improvement projects;

ii. quantitative and qualitative member assessments periodically, including Consumer satisfaction surveys and other Consumer feedback methodologies;

iii. regular measurement, monitoring, and evaluation mechanisms as to services, utilization, quality, and performance;

iv. systems for periodic and/or random compliance review or audit; and,

v. studies to regularly review outcomes for service recipients as a result of programs, treatment, and community services rendered to individuals in community settings.

c. **Site Reviews, Performance Monitoring and Feedback:** Payor will conduct reviews and audits of Provider performance under this Agreement. Payor will make a good faith effort to coordinate reviews and audits to minimize disruption to Provider operations and to avoid duplication of efforts.

i. The focus of Provider's review shall be the degree to which Provider has implemented the requirements of this Agreement and the degree of compliance with performance standards, performance indicators, and other Payor requirements.

ii. Provider shall comply with the corrective action requirements of Payor, including compliance with corrective action plan submission and subsequent implementation of approved corrective action plans. Corrective action plans submitted by Provider are deemed approved unless Payor indicates, in writing within thirty (30) days of receipt of the corrective action plan, that such corrective action plan is not approved.

d. **Quality Assurance:** Provider shall cooperate with Payor and participate in and comply with all peer review programs, utilization review, quality assurance and/or total quality management programs, audit systems, site visits, grievance procedures, satisfaction surveys and other procedures as established from time to time by Payor, or as required by

regulatory or accreditation agencies. Provider shall be bound by and comply with all final determinations rendered by each such peer review or grievance process.

27. Dispute Resolution

a. Any disagreements with respect to this Agreement, including, without limitation, actions taken in this Section against Provider, shall be addressed through the dispute resolution procedures detailed in Provider manual and/or policies. In the event that a dispute remains unresolved following use of such procedure, then the dispute shall be reduced to writing and submitted to each party's CEO or other designated representative(s). If such disputes cannot be resolved between Payor and Provider, either party may seek resolution through exercise of any available legal and/or equitable remedies.

b. All decisions to authorize, deny, continue, or discontinue Payor's payments for Provider's services to Consumers hereunder shall be those of Payor's CEO. Decisions to continue services without reimbursement from Payor shall be those of Provider.

28. Notices

a. Provider shall notify Payor 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 Covered 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 Payor 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.

b. 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 addressed to the addressee shown below (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:

c. Notice to Payor should be addressed to Payor's Chief Executive Officer, or as outlined in **Attachment C** which delineates additional points of contact for Payor.

29. Miscellaneous Provisions

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

b. **Binding Effect of the Agreement:** This Agreement shall be binding upon Payor and Provider and their respective successors and assigns.

c. **Further Assurances:** The parties hereto shall execute all further instruments and perform all acts which are or may become necessary from time to time to effectuate this Agreement.

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

e. **Completeness of the Agreement:** This Agreement, the attached Exhibits, and the additional and supplementary documents incorporated herein by specific reference contain all the terms and conditions agreed upon by Payor and Provider and no other prior agreements, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind either Payor or Provider.

f. **Severability and Intent**

i. If any provision of this Agreement is declared by any court having jurisdiction to be invalid, such provision shall be deemed deleted and shall not affect the validity of the remainder of this Agreement, which shall continue in full force and effect. If the removal of such provision would result in the illegality and/or unenforceability of this Agreement, this Agreement shall terminate as of the date in which the provision was declared invalid.

ii. This Agreement is not intended by Payor or Provider to be a third-party beneficiary contract and confers no rights on anyone other than the parties hereto.

g. **Notification Regarding Funding:** Provider shall immediately notify Payor, 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.

h. **Research Restrictions on Human Subjects:** Provider agrees to submit all research involving human subjects, which is conducted in programs sponsored by the MDHHS 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.

i. **Information Requirements:** Payor and Provider shall comply with MDHHS information requirements and standards, including those for Advance Directives. Any marketing or informative materials intended for distribution through written or other media to eligible non-Medicaid Consumers, Medicaid eligible, or the broader community that describe the availability of covered services and supports and how to access those services and supports pursuant to this Agreement, must be submitted by Provider or Provider's subcontractors for Payor's approval or disapproval prior to any distribution.

j. **Publications:** Any drawings, records, documents, papers, reports, charts, maps, graphics or manuscripts prepared for or pertaining to the supports/services performed hereunder which are published or in any other way are provided to third parties shall acknowledge that they were prepared and/or created pursuant to this Agreement. Such acknowledgement shall include a clear statement that Payor and its elected and appointed officers, employees, and agents are not responsible for the contents of the item(s) published or provided by Provider to third parties.

k. **Time of the Essence:** Time is of the essence in the performance of each and every obligation herein imposed.

l. **Waivers**

i. 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.

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

m. **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.

n. **Non-Third Party Beneficiary Contract:** This Agreement is not intended to be a third party beneficiary contract and confers no rights, nor obligations on anyone other than the parties hereto.

o. **Cultural Competence/Limited English Proficiency:** Provider shall assure equal access for people with diverse cultural backgrounds and/or limited English proficiency. Provider shall demonstrate a commitment to linguistic and cultural competence that includes the ability to apply an understanding of the relationships of language and culture to the delivery of services. Provider shall ensure the cultural competence of staff including documentation of training in each employee's personnel file.

p. **Ethics:** The parties agree and acknowledge that each is subject to and shall comply with the Ethics Policy set forth in Provider Manual.

q. **Health and Safety:** Provider shall immediately notify Payor and shall arrange for the immediate transfer of Consumers to a different Provider if the health and/or safety of Consumer is in jeopardy.

30. Certification of Authority to Sign the Agreement

a. The persons signing this Agreement on behalf of the parties hereto certify by their signatures that they are duly authorized to sign this Agreement on behalf of the parties, and that this Agreement has been authorized by the parties.

SIGNATURES TO FOLLOW ON NEXT PAGE

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

PAYOR: [CMHSP Name]

_____ _____

NAME, TITLE Date

WITNESSED BY:

_____ _____

Date

PROVIDER: [PROVIDER Name]

_____ _____

Date

WITNESSED BY:

_____ _____

Date

I. TARGET SERVICE GROUP AND ELIGIBILITY CRITERIA FOR SERVICES:

The target group for the Applied Behavior Analysis ("ABA") benefit includes Consumers from birth through twenty (20) years of age, ending on the 21st birthday with a diagnosis of Autism Spectrum Disorder ("ASD") based upon a medical diagnosis in the Diagnostic and Statistical Manual of Mental Disorders ("DSM-5") of ASD, who have the developmental capacity to clinically participate in the available interventions covered by the benefit, and who have Medicaid insurance. A well-established DSM-5 diagnosis of Autistic Disorder, Asperger's Disorder or Pervasive Developmental Disorder Not Otherwise Specified ("PDD-NOS") should be given the diagnosis of ASD. In addition, only Consumers who have received an independent needs-based evaluation, is eligible to receive ABA.

II. DESCRIPTION OF SERVICES:

a. ABA is a structured program that relies upon the variety of Behavior Health Treatment ("BHT") services that include behavioral interventions which have been identified as evidence-based by nationally recognized reviews and/or other nationally recognized scientific and clinical evidence. BHT services are designed to be delivered primarily in the home and in other community settings. Behavioral intervention services include, but are not limited to, the following categories of evidence-based interventions:

Collecting information systematically regarding behaviors, environments, and task demands (e.g., shaping, demand fading, task analysis); Adapting environments to promote positive behaviors and promote learning while discouraging negative behaviors (e.g. naturalistic intervention, antecedent based intervention, visual supports, stimulus fading); Applying reinforcement to change behaviors and promote learning (e.g. reinforcement, differential reinforcement of alternative behaviors, extinction); Teaching techniques to promote positive behaviors, build motivation, and develop social, communication, and adaptive skills (e.g., discrete trial teaching, modeling, social skills instruction, picture exchange communication systems, pivotal response training, social narratives, self-management, prompting, chaining, imitation); Teaching parents/guardians to provide individualized interventions for their child for benefit of the child (e.g., parent/guardian implemented/mediated intervention); Using typically developing peers (e.g., individuals that do not have ASD) to teach and interact with children with ASD (e.g., peer mediated instruction, structured play groups, peer social interaction training); and Applying technological tools to change behaviors and teach skills (e.g., video modeling, tablet based learning software). Comprehensive Behavioral Intervention is reserved for Consumers with weekly ABA authorizations exceeding 16 - 25 hours, on average per week, likely resulting in more comprehensive care. Focused Behavioral Intervention is reserved for Consumers with weekly ABA authorizations of 5 - 15 hours, on average or less per week, likely resulting in more focused care (actual hours for both interventions are determined by the behavioral plan of care and interventions required). ABA must be provided by staff with appropriate training and/or certification.

Behavior Technician ("BT") staff providing direct services must be supervised by a qualified staff for a minimum of one (1) hour out of every ten (10) hours of therapy.

b. **Treatment Methodology:** Treatment methodologies will use an ethical, positive approach to any serious behaviors (e.g., self-injury, aggression) based on a comprehensive assessment of skills deficits and maladaptive behavior repertories, including direct methods, indirect methods, and/or the systematic manipulation of variables (functional analysis) performed by a qualified professional. The use of restraints, seclusion, and aversive techniques are prohibited by the MDHHS in all home and community settings.

c. Telemedicine must only be utilized when there is a clinical benefit to the beneficiary. Examples of clinical benefit include: Ability to diagnose a medical condition in a beneficiary population without access to clinically appropriate in-person diagnostic services. Treatment option for a beneficiary population without access to clinically appropriate in-person treatment options. Decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process). Decreased number of future hospitalizations or physician visits. More rapid beneficial resolution of the disease process treatment. Decreased pain, bleeding, or another quantifiable symptom.

Furthermore, telemedicine must only be utilized when the beneficiary's goals for the visit can be adequately accomplished, there exists reasonable certainty of the beneficiary's ability to effectively utilize the technology, and the beneficiary's comfort with the nature of the visit is ensured. Telemedicine must be used as appropriate regarding the best interests/preferences of the beneficiary and not merely for provider ease. Appropriate guidance must be provided to the beneficiary to ensure they are prepared and understand all steps to effectively utilize the technology prior to the first visit. Beneficiary consent must be obtained prior to service provision (see policy for "Consent for Telemedicine Services" for further information).

d. **Transportation:** Non-emergency transportation as a covered medically necessary service may be used to transport a Consumer. If transportation while providing ABA treatment is medically necessary , there needs to be one person driving the vehicle and one person providing the direct ABA. If there is not a driver, separate from the behavior technician providing services, the behavior technician must not bill for direct ABA services during that transportation time. The case of medical necessity will be confirmed by a code for non-emergency transportation (a covered service separate from the BHT benefit) in Consumer's person-centered plan of service along with clearly established conditions, including policies/procedures to address the use of the service, staff credentialing and requirements, and if ABA will be provided during the transport then health and safety of the service setting should be addressed. Payor strives to reduce transportation barriers to accessing services, using the best quality, Consumer-friendly, cost-efficient means possible. Transportation services are not a guaranteed benefit and are limited by the availability of Payor funding during each fiscal year. Medicaid Health Plans will be required to cover non-emergency medical transportation (NEMT) to any Medicaid-covered service for health plan enrollees.

III. **DOCUMENTATION/REPORTING REQUIREMENTS:**

a. **Transportation Logs:** Provider must maintain documentation for transportation provided to a Consumer including name of transporter and whether or not ABA services were provided during transport. If ABA services are provided by a BT, the name of the BT must also be included.

b. **Direction/Supervision Logs:** Supervision Logs that indicate the date, duration, and content of supervision will be maintained for each Consumer and submitted for verification, as outlined in **Attachment C**. Logs must include supervisor name and signature, staff name, client name. Provider is responsible for maintaining a tracking system to ensure the minimum ten percent (10%) supervision compliance ratio is met.

c. **Family Training Progress Notes:** Family training notes should include date, content, duration, and family member receiving training and staff providing the training as outlined in **Attachment C**. If provided to more than one family member, a progress note is required for each Consumer's family member.

d. **Social Skills Group Progress Notes:** Adaptive Behavior Social Skills Group notes should indicate date, content, and duration of treatment session, and signature of BHT supervisor facilitating the group and submitted as outlined in **Attachment C**.

e. **Group Adaptive Behavior Treatment:** Administered by technician or BHT supervisor. Progress note of group should include date, content, duration of treatment session, and signature of technician providing the service and submitted as outlined in **Attachment C**.

f. **ABA Exposure Adaptive Behavior Treatment:** Double staffing treatment notes should include date, content, duration of session, and signature of both staff performing the service. If this service is medically necessary, the ABA provider must work with the CMHSP to ensure that Behavior Treatment requirements have been adequately

g. **Behavioral Assessment**: A developmentally appropriate applied behavior analysis (ABA) assessment process must identify strengths and weaknesses across domains and potential barriers to progress. The information from this process is the basis for developing the individualized behavioral plan of care with the individual, family, and treatment planning team. Behavioral assessments can include direct observational assessment, record review, rating scales, data collection, functional or adaptive assessments, structured interviews, and analysis by a board certified and licensed behavior analyst (BCBA/LBA). Behavioral assessment tools must describe specific levels of behavior at baseline to inform the individual's response to treatment through ongoing collection, quantification, and analysis of the individual's data on all goals as monitored by a BCBA/LBA.

h.

Documentation of the signed assessment, along with evidence of measurable progress will be forwarded to Payor within time frame specified. Evidence of improvement is required in order to continue the level of service. To the extent possible, a risk-benefit analysis should be conducted on the procedures to be implemented to reach the objective. The description of program objectives and the means by which they will be accomplished is an ongoing process throughout

the duration of Consumer-practitioner relationship. Provider is responsible for maintaining a tracking system to ensure assessments are completed every six months from the initial assessment date. In the event of non-compliance by Provider Payor may withhold payment in the event the above noted items have not been received.

i. **ABA Behavioral Follow Up/Functional Behavior Assessment / FBA:** If necessary, a functional assessment may be conducted in addition to the semi-annual assessments in an attempt to understand more significant behavioral challenges. If there are significant reasons where an FBA is needed to occur more than two times per year, then an authorization must be received prior to service delivery. Results of the functional assessment should be used to develop other plans such as IPOS, ABA Plan, Positive Support Plan, etc. If a behavior plan following a FBA involves any restrictive or intrusive interventions aimed at reducing defined target behavior(s), the author of the plan must follow the MDHHS contract for Behavior Treatment Plan Review (BTPR) and receive PIHP/CMHSP Committee approval prior to implementation of the intervention(s) and plan. See BTPR section of the Medicaid Provider Manual.

j. **Annual ABA Plan/Behavior Support Plan:** The comprehensive individualized ABA behavioral intervention plan shall be part of the child's IPOS (Person Centered Plan, ABA plan, Person Centered Pre-Plan, and **Attachment D**) and will identify specific targeted behaviors for improvement and shall include measurable, achievable, and realistic goals for improvement. The actual hours to be provided must be based on established individualized needs and reflected in the IPOS and cannot exceed those approved in the Person-Centered Plan that is included as part of the child's IPOS. Any change in ABA scheduled that may impact hourly utilization needs to be communicated to the case manager and Payor before the change occurs. As deemed appropriate, a Positive Support Plan will be developed in conjunction with the ABA behavioral interventions to address disruptive, intrusive, or stereotypical behaviors associated with autism. Any plan with restrictive and intrusive techniques (some examples may include buckle buddies, safety mats or helmets, response cost, 2:1 staffing, etc.) will need to be approved by the Behavior Treatment Committee prior to implementation and according to each CMH's local policies.

k. **Compensation:** Provider shall be reimbursed for services rendered under this Agreement in accordance with **Attachment B**. Rate changes shall require written amendment to this Agreement. Rates are all-inclusive. The costs associated with supervision, time, documentation, supplies, testing materials and as well as other functions and materials, are included in the rate.

l. **Dual Insurance:** Provider is required to determine if Consumer is dually insured, prior to submitting claims to Payor and at a minimum of monthly. In instances when Consumer has dual insurance (i.e., Blue Cross and Medicaid), Provider must bill the commercial insurance first. Medicaid shall always be Payor of last resort. It is Provider's responsibility to follow all insurance rules and collect directly from the primary insurance. In order to qualify for any Medicaid benefit, Consumer must be receiving services through the CMH where services are being authorized and Provider must first obtain the Authorization Form from Payor. Provider must notify Payors in writing that Consumer is dually insured. This should occur prior to ABA treatment beginning under the BHT benefit. If requirements are met as described, Provider must submit the actual Explanation of Benefits ("EOBs") from the primary insurance to Payor in order to receive consideration of payment through Medicaid. The Medicaid benefit will only reimburse Provider for the difference between

any primary insurance payment and Provider's contracted rate with Payor. Provider may not seek nor accept additional or supplemental payment from Consumer, their family, or other representative when Consumer is enrolled in the BHT benefit. Provider must notify Payor of any changes to Consumer's primary insurance at any time during treatment.

m. **ABA During School Hours:** The benefit states, "supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant responsibilities of educational or other authorities."

Consumer's IPOS specify how identified supports and services will be provided as part of an overall, comprehensive set of supports and services that does not duplicate services that are the responsibility of another entity, such as a private insurance or other funding authority, and do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004, as amended (the "IDEA"), PL 108-446, that are available to the child through a local education agency. Consumer's school schedule must be identified in the Individual Education Plan ("IEP") and provided to Payor.

n. **Transition and Discharge:** The desired BHT goals and outcomes for discharge should be specified at the initiation of services, monitored throughout the duration of service implementation, and refined through the behavioral service level evaluation process. Transition and discharge from all BHT services should generally involve a gradual step-down model and require careful planning. Transition and discharge planning from BHT services should include transition goal(s) within the behavioral plan of care or plan, or written plan, that specifies details of monitoring and follow-up as is appropriate for the individual and the family or authorized representative(s) utilizing the PCP process. Discharge from BHT services should be reviewed and evaluated by a qualified BHT professional for children meeting the criteria outlined in the State of Michigan Provider Manual (18.8 Transition and Discharge Criteria).

IV. Staff Qualifications and Staff Training

a. Prior to providing any billable services, Provider must assure all of its personnel meets the qualifications, including background checks, in accordance with the CMHSP participant policy and MDHHS provider qualifications requirements. Provider will maintain documentation of all staff credentials and will submit all required documents related to licensing, certifications, and transcripts for current BHT staff as requested by Payor. All new BHT staff must be credentialed prior to providing services. Failure to provide verification could result in loss of payment for services provided by that staff.

b. **Provider Training:** Provider agrees to obtain, at its own expense, ongoing training, and supervision according to applicable mental health practices and the licensing, credentialing or other qualifications policies, procedures or regulations of the State of Michigan and/or Payor as outlined in **Attachment E**. Provider shall furnish a written summary of such training and supervision efforts to Payor upon request. **Provider may utilize internal trainings that meet the requirements outlined in Attachment E, upon approval by Payor.**

V. SERVICE ACCESS, PREAUTHORIZATIONS, DELIVERY, AND UTILIZATION MANAGEMENT PROCEDURES

a. Providers conducting diagnostic or behavioral assessments who also provide additional services outside of the ABA service array (i.e., CLS, Respite, Personal Care) for the same Consumer must notify Payor. Payor may request an additional review and/or authorization of the recommended number of treatment hours.

b. ABA services shall be provided based on medical necessity in the quantity, scope, and duration authorized, and at times specified in Consumer's Individual Plan of Service. Addendums to the Plan shall authorize changes to the quantity of services, as well. Services provided in excess of authorizations or prior to authorization shall not be reimbursed by Payor.

c. Provider must maintain a copy of the most recent IPOS and any changes via authorization forms for each Consumer receiving services under this Agreement.

d. Providers may request changes to authorized hours via the ABA Authorization Form included as **Attachment D** or other form approved in advance by Payor.

e. Payor shall provide Provider access to necessary clinical, social, and demographic information and documentation to foster continuity of care.

f. Payor is responsible for monitoring Consumer services under this Agreement and its corresponding exhibits/attachments.

g. Provider is responsible for providing the individual services and supports as noted under this Agreement and its corresponding exhibits. Payor may request an additional review and/or authorization of the recommended number of treatment hours.

h. Payor and Provider are equally responsible for communicating all pertinent information with each other in order to promote continuity of care.

i. Payor shall provide 24-hour community crisis intervention services which Provider may access as needed for support, intervention, and general communication of information at times of Consumer crises.

j. Provider shall complete and furnish all service documentation as well as Provider credentials as requested by Payor and in a timely manner.

VI. BILLING OF AND PAYMENT FOR VALID SERVICE REIMBURSEMENT /CLAIMS SUBMISSION

a. **Claims:** All claims should be received by Payor within the timeframe indicated in **Attachment C** and should be free and clear of any problems. Such claims should be able to be processed for payment consideration without obtaining additional information from 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 (as defined below) is not submitted by Provider within one (1) year of Consumer's date of service, Payor shall not be required to authorize payment, unless otherwise mutually agreed upon in advance between Provider and Payor. 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; or within thirty (30) calendar days of receipt of remittance advice from Payor's precedent to the AUTHORITY, not to exceed a year from date of service.

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

c. **Reimbursement Rate for Valid Claims Payments**. Payor shall make contractual payments to 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.

d. **Requirements for and Limitations for Billing of Claims and Payments of Clean Claims**. Provider shall submit a periodic billing statement with valid claims for each period in which Payor-authorized services are rendered under this Agreement. All periodic billing statements of Provider shall specify billable services hereunder. In order to be considered valid claims for which payments from Payor may be made, Provider's billing of service claims must be received by Payor as outlined in **Attachment C** following the completion of the period in which the services were rendered hereunder. Payor shall authorize and process service claims payments to Provider within thirty (30) days following receipt of a complete and accurate billing statement from Provider.

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 Payor, the MDHHS, Medicaid, and/or third party reimbursors and is on file currently. If Provider's services and service documentation are not in compliance with the reimbursement requirements of the MDHHS, Payor, Medicaid, and/or third party reimbursors, Provider shall not be paid and/or shall return payments received from Payor in such instances.

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

f. Payor may request Provider to submit documentation to receive payments as Electronic Funds Transfers ("EFT")/direct deposits before payment can be made. Provider is required to update Payor any time this information has changed. These forms will be provided to Provider or can be obtained from Payor's website. Any contract reconciliation shall be completed in full compliance with the Mental Health Code, the MDHHS rules, the MDHHS/CMHSP Master Contract for General Funds, the MDHHS/PIHP Master Contract for Medicaid Funds and applicable state and federal laws, including

Medicaid regulations. If Payor does not offer payments via EFT, Provider must supply a valid remit to address and advise Payor in writing of any changes to their address.

g. **Revenue/Cost Projections; Subsequent Rate Determinations.** Provider, upon request by Payor, shall provide Payor with projected revenue and cost analyses (using formats acceptable to the parties) and all source documents for review in the subsequent determination by Payor of the claims reimbursement methodology/rate(s) for authorized supports/services hereunder.

h. **Determination of Financial Status and Benefits Status of Consumer.** For Consumer served under this Agreement, Payor's personnel shall complete an initial determination and periodic predeterminations of financial status and public and/or private benefits status. Payor shall be responsible for establishing Consumer's eligibility for third party reimbursement status, Supplemental Security Income ("SSI") benefit status, and other benefits status, if any. Provider's personnel will assist Payor's staff, when possible, in securing and maintaining such benefits status of Consumer hereunder. Provider's personnel shall make pertinent sections of recipient program records available to appropriate staff of Payor as required to meet the obligations hereunder.

i. **Coordination of Benefits.** Provider shall submit itemized claims for coordination of benefits ("COB") billing purposes detailing the daily revenue code to fulfill Payor's State of Michigan reporting and COB requirements. Any dual eligible Consumer with a deductible/coinsurance will be paid by Payor in total up to the agreed upon payment amount 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. Payor shall only be responsible for and limit reimbursement to Provider for any amount less than the agreed upon amount for the billed service(s) identified in this agreement. In cases where third party coverage reimbursement exceeds the agreed upon amount for the billed service(s) identified in this agreement, no additional payment will be authorized by the Payor. In all cases where Payor is the secondary Payor, Provider shall submit an EOB from the primary insurance coverage carrier along with the claim for service reimbursement to Payor.

j. **Third Party Liability Requirements.** 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. Provider shall be responsible under this Agreement for seeking support/service reimbursements, if applicable, from third party liability claims for Consumer hereunder, pursuant to federal and state requirements. Provider shall not seek or collect any support/service fee payments directly from 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 Payor.

k. **Payment in Full.** Payments from Payor for valid claims for Payor authorized supports and services rendered by Provider to Payor's Consumer under this Agreement shall constitute payment in full. Provider shall be solely responsible for its

payment obligations and payments to its subcontractors, if any, for performing supports and services required of Provider under this Agreement. Payments from Provider to its subcontractors for performing supports and services required of Provider hereunder shall be made on a timely basis and on a valid claim basis.

Provider and/or its subcontractors, if any, shall not seek or collect any support/service fee payments directly from Consumer, legal guardian, parents or relatives, etc., unless specifically authorized by Payor, in writing, to do so. It is expressly understood and agreed by Provider that:

1. Provider and/or its subcontractors shall not require any co-payments, recipient pay amounts, or other cost sharing arrangements for Provider's supports/services required hereunder and/or for supports/services of a subcontractor, unless specifically authorized by Payor, the state or federal regulations and/or policies thereof.

2. Provider and/or its subcontractors shall not bill the individual for any difference between a supports/services charge of Provider nor of a subcontractor and Payor's payment for Provider's supports/services required hereunder.

3. Provider and/or its subcontractors shall not seek nor accept additional supplemental payments from the individual, his/her family, or representative, for Provider's supports/services required hereunder and/or for the supports/services of a subcontractor. Provider shall not bill Consumer for missed appointments or fee associated with no-show, per Medicaid Provider Manual.

l. Refunding of Payments. Provider shall not bill Payor for supports/services rendered hereunder in any instances in which 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. At any time it is determined, after supports/services claims reimbursement to Provider has been made by Payor, that Provider received monies directly for the supports/services 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, Provider shall refund to Payor an amount equal to the sums reimbursed by third party Payors and/or paid by any other source. Provider shall notify Payor immediately of any receipt of such monies for such purposes hereunder.

m. Unallowable Supports/Services/Cost Claims and Financial Paybacks. Should 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, it shall not be reimbursed by Payor hereunder for any such supports/services and/or cost claims; thereto, Provider shall repay to Payor as financial paybacks of any claims payments made by Payor to 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 Payor within sixty (60) days of Payor's final disposition notification to Provider that financial payback by Provider is required.

n. **Compliance.** If Provider does not remain in compliance with the applicable requirements of this Agreement, in the sole discretion of Payor, Payor 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.

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

Attachment B – Service Codes and Rates

Code	Service Description	Modifiers	Reporting Units	Provider Type	BCBA	BCBA/LBA	BCaBA	LP/LLP	BT	Notes
97151	ABA Behavior Identification Assessment	HN, HO	Per 15 minutes	BCBA, BCaBA, or LP/LLP						
0362T	Behavior Follow-Up Assessment	HN, HO	Per 15 minutes	BCBA, BCaBA, , or LP/LLP						
97153	ABA Adaptive Behavior Treatment, individual	HM, HN, HO,	Per 15 minutes	BCBA, BCaBA, LP/LLP, or BT						
97154	ABA Adaptive Behavior treatment, group	HM, HN, HO	Per 15 minutes	BCBA, BCaBA, LP/LLP, or BT						
97155	Clinical Observation and Supervision	HN, HO	Per 15 minutes	BCBA, BCaBA, or LP/LLP						
97156	Family training	HN, HO	Per 15 minutes	BCBA, BCaBA, , or LP/LLP						
97157	Family training, multiple families	HN, HO	Per 15 minutes	BCBA, BCaBA, or LP/LLP						
97158	Adaptive Behavior Treatment Social skills group	HN, HO	Per 15 minutes	BCBA, BCaBA, or LP/LLP						

0373T	Direct treatment, requiring two or more technicians	HM, HN, HO	Per 15 minutes	BCBA, BCaBA, LP/LLP, or BT						

MODIFIERS:

Modifier	Description
HM	Less than Bachelor's Level provided service
HN	Bachelor's Level provided service
HO	Master's Level provided service
U5	Autism (State defined modifier)

PLACE OF SERVICE CODES:

Code	Name	Description
02 & 10	Telemedicine	*As allowable as identified and in effect, in the Bureau_of_Specialty_Behavioral_Health_Services-Telemedicine_Database.pdf (michigan.gov) Chart*
03	School	A facility whose primary purpose is education (effective January 1, 2003).
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.

SAME TIME SERVICE REPORTING:

- A child may be receiving one service at the same time other services are being provided to their parent/guardian (on the child's behalf) by another provider.
- ABA Behavior Identification Re-Assessments (97151) can be reported at the same time as ABA Adaptive Behavior Treatment (97153 and 97154), ABA Exposure Adaptive Behavior Treatment (0373T), as well as potentially 97157 and 97158. IF there are two separate providers.
- 97156 (family adaptive behavior treatment guidance) can be provided by the BCBA/LBA to the guardian/caregiver while 97153 (adaptive behavior treatment by protocol) is being provided face to face to the child by a behavior technician (BT).

- 97153 (adaptive behavior treatment by protocol) and 97155 (adaptive behavior treatment protocol modification) can occur at the same time, just not by the same person. 97153 is typically provided by the BT 97155 is provided by the BCBA/LBA while supervising the BT.
- For ABA, Targeted Case Management can be provided at the same time as a beneficiary is receiving a direct ABA covered service.

Attachment C – Local Practices and Reporting Requirements

PAYOR CONTACTS

Department/Function	Name	Phone	Email
Authorizations			
Billing/Reimbursement			
Reporting Requirements			
Recipient Rights			
Other:			

REPORTING REQUIREMENTS

Report	Due Date	Method of Submission
Supervision Logs		☐ Email: ☐ EHR ☐Other:
Family Training Progress Notes		☐ Email: ☐ EHR ☐Other:
Social Skills Group Progress Notes		☐ Email: ☐ EHR ☐Other:
Group Adaptive Behavior Treatment Progress Notes		☐ Email: ☐ EHR ☐Other:
ABA Exposure Adaptive Behavior Treatment Progress Notes		☐ Email: ☐ EHR ☐Other:

Semi-Annual Reviews of Progress		☐ Email: ☐ EHR ☐Other:
Staff Credentials Verification (Attachment F)		☐ Email: ☐ EHR ☐Other:
Clean Claims Submission	[X] days of Consumer's date of service	☐ Email: ☐ EHR ☐Other:
Criminal Background Checks, , – (ICHAT (or a search that reveals information substantially similar to information found on ICHAT)) Upon hire and:	☐Annually ☐Biennially	☐ Email: ☐ EHR ☐Other:
Sanction Checks (OIG, SAM.gov, MDHHS), Upon hire and:	☒Monthly	
MDHHS Central Registry Checks, National Sex Offender Registry, Michigan Sex Offender Registry (Central Registry check for new employees, subcontractors, subcontractor employee, or volunteers who are under this contract working with children.) Upon hire		
Incident Reports	Within 24 hours of incident	☐ Email: ☐ EHR ☐Other:

Attachment D – Autism Benefit ABA Authorization Form

FORM ON FOLLOWING PAGE

MSHN
Mid-State Health Network

FORM: AUT-A

Autism Benefit ABA Authorization Form

This form is to be completed in its entirety and submitted to MSHN's autism staff via fax at 517.253.7552 or email at autismbenefit@midstatehealthnetwork.org. If the form has missing information, the appropriate CMHSP contact person will be notified and responsible for immediate submission of the missing information. In the event immediate response is not received, the form will be returned to the CMHSP contact via email for completion.

☐INITIAL (Start Date of ABA): _____ **☐UPDATE (Effective Date of Change): _____**

☐ Annual ☐ Mid-Year Change ☐ Change in Provider

Consumer Name:	CMHSP:
Medicaid ID:	DOB:
Type of Insurance: ☐Medicaid Only ☐ Dual Insurance	
ABA Provider:	BHT Supervisor Name:
BHT Supervisor Credential: ☐ BCBA ☐ BCaBA ☐ QBHP	Treatment Plan Date:

SERVICES AUTHORIZED			
Code	**Service Description**	**Units Authorized**	**Frequency (Choose one: weekly, monthly, quarterly, every 6 months, annually, or duration of plan)**
☐ 97151	ABA Behavior Identification Assessment		
☐ 0362T	Behavior Follow-Up Assessment		
☐ 97153	ABA Adaptive Behavior Treatment, Individual		
☐ 97154	ABA Adaptive Behavior Treatment, Group		

☐ 97155	Clinical Observation and Direction		
☐ 97156	Family Training		
☐ 97157	Family Training, multiple families		
☐ 97158	Adaptive Behavior Treatment, Social Skills Group		
☐ 0373T	Direct Treatment, requiring two or more technicians		

Attachment E –Training Requirements

[INSERT REGIONAL TRAINING GRID and Local Requirements if applicable]

Attachment F – Autism Provider Staff Credentials Verification

[INSERT Regional Credentials Verification Docs; method and manner of submission added to Local Practices document]

Attachment G – Recipient Rights Policies & Attestation

In accordance with Michigan Compiled Law 330.1752, each community mental health services program, each licensed hospital, and each service Provider under contract with the department, a community mental health services program, or a licensed hospital shall establish written policies and procedures concerning recipient rights and the operation of an office of recipient rights.

Provider attests to the following policies and procedures providing for the safeguarding of the rights of Recipients.

POLICIES & PROCEDURES

1. Complaint and Appeal Process
2. Consent to Treatment and Services
3. Sterilization, Contraception, and Abortion
4. Fingerprinting, Photographing, Audiotaping, and use of 1-way glass
5. Abuse and Neglect, including detailed categories of type of severity
6. Confidentiality and Disclosure
7. Treatment by Spiritual Means
8. Qualifications and Training for Recipient Rights Staff
9. Change in Type of Treatment
10. Medication Procedures
11. Use of Psychotropic Drugs
12. Use of Restraint
13. Right to be Treated with Dignity and Respect
14. Least Restrictive Setting
15. Services Suited to Condition
16. Comprehensive examinations
17. Freedom of movement
18. Use of seclusion

By signature below, Provider acknowledges, agrees, and certifies that Provider will accept and comply with the policies and procedures set forth in this attachment, as the same may be amended from time to time.

_____

Signature, Provider Authorized Representative

_____

Print, Provider Authorized Representative

_____

Date

*Return this form with signed contract. *

Attachment H – Glossary and Definitions

Capitalized terms used in this Agreement shall be construed and interpreted based on the definitions provided in the Agreement or as otherwise defined below:

ABA - Applied Behavior Analysis: A process of systematically applying a variety of evidence-based practices to improve socially significant behavior (e.g., those important for successful functioning in a variety of environments).
ABA is founded in the scientific principles of behavior and learning and includes, but is not limited to, functional communication training, discrete trial training, reinforcement, prompting, incidental teaching, schedules, naturalistic teaching, shaping, and pivotal response training.

ABI Applied Behavioral Intervention: Per the Michigan 1915(i) State Plan Amendment, a less intensive and focal model of ABA where treatment is provided an average of 5 to 15 hours per week.

ABLLS-R Assessment of Basic Language and Learning Skills Revised: An assessment tool and treatment guide used for the evaluation and instruction of language and critical learner skills for Consumers with autism or other developmental disabilities.

ADI-R Autism Diagnostic Interview Revised: A structured interview tool that may be used to diagnose Autism Spectrum Disorder (ASD), plan treatment, and distinguish autism from other developmental disorders.

ADOS-2 Autism Diagnostic Observation Schedule: An instrument that may be used in the diagnostic and assessment process for Autism Spectrum Disorder (ASD).

AFLS Assessment of Functional Living Skills: An assessment tool and treatment guide used for the evaluation and instruction of essential life skills so that individuals with Autism Spectrum Disorder (ASD) or developmental delays may live independently.

ASD - Autism Spectrum Disorder: A developmental disability affecting social skills, communication, and behavior. Abilities in these areas range depending on the individual.

Agreement: Means this Agreement whereby Payor purchases services on a subcontracted basis from the party designated as the "Provider" in the introductory paragraph of this Agreement.

BACB - Behavior Analyst Certification Board: A national nonprofit corporation established to coordinate BCBA-D, BCBA, BCaBA, and RBT credentials.

BCaBA - Board Certified Assistant Behavior Analyst: A bachelor level certification for a person who may provide behavioral assessment, behavioral intervention, and behavioral observation and direction under the supervision of a BCBA-D or BCBA.

BCBA-D - Board Certified Behavior Analyst- Doctoral: A doctoral level certification for a person who may provide behavioral

assessment, behavioral intervention, and behavioral observation and direction.

BCBA - Board Certified Behavior Analyst: A master's level certification for a person who may provide behavioral assessment, behavioral intervention, and behavioral observation and direction.

BHT - Behavioral Health Treatment: The "umbrella" of behavioral interventions, including Applied Behavior Analysis (ABA), which have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized substantial scientific and clinical evidence.

BPOC - Behavior Plan of Care: A behavior plan that defines how behavior goals in the child's IPOS will be attained.

BT - Behavior Technician: The individual responsible for the direct implantation of the BHT/ABA services under the supervision of a BCBA-D, BCBA, or BCaBA. A BT is not credentialed by the BACB.

BTPRC/BTRC - Behavior Treatment Plan Review Committee/Behavior Treatment Review Committee: The BTPRC/BTRC reviews and approves or disapproves treatment plans that propose to use restrictive or intrusive interventions with individuals served by the public mental health system who exhibit aggressive, self- injurious, or other challenging behaviors.

CBI - Comprehensive Behavioral Intervention: An intensive BHT service level where services are provided an average of 16 to 25 hours per week (actual hours needed are determined by behavioral plan of care and interventions required).

CMHSP - Community Mental Health Services Program: A government contracted entity that manages mental health services for people enrolled in Medicaid.

Clean Claim: A clean claim is one that can be processed without obtaining additional information from Provider of the service or a third party and as further described in the Social Welfare Act, State of Michigan Statutes and Federal Statutes. 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.

CMHSP: Means the Community Mental Health Services Program operated under Chapter 2 of Act 258 of the Public Acts of 1974, as amended (the "Mental Health Code"), MCL 330.1200 *et seq*.

Compliance Plan: Refers to the implementation of a systematic process designed to ensure that the organization is performing business functions in a manner in compliance with the prevailing federal and state laws concerning health care billing practices and fraud detection and/or prevention. These regulations include the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), PL 104-191, the Stark Act, 42 USC 1395nn, the Medicare and Medicaid Fraud and Abuse Statute, 42 USC 1320a-7b(b) and the False Claims Act, 31 USC 3729.

Consumer: Means an individual who is an eligible person who is:

1. A resident of the service area, and

2. Is covered as a priority population under the Mental Health Code, and
3. Who meets the service eligibility criteria, and
4. Is receiving specialty supports and services under this Agreement.

Consumer, individual, recipient and patient are used interchangeably and refer to persons receiving services under the terms of this agreement.

Consumer Incident: Means events which include, but are not limited to, the following for persons living in 24-hour specialized residential settings: death of the recipient, any injury or medication error that requires emergency medical treatment or hospitalization, suspected abuse and neglect of a recipient, incidents that involve the arrest of a resident. Michigan law and rules promulgated thereto require the mandatory reporting of such matters within 48 hours for persons in licensed residential settings. Incidents shall be reported to Payor through the incident reporting procedures.

Co-Payment: Means a payment made to Provider by Consumer in accordance with the recipient's personal health care insurance plan.

Covered Services: All authorized mental health care services offered within Provider's current level of credentialing, rendered to a Payor-referred or authorized Consumer for which Payor is obligated to reimburse at an established fee and transaction type included in the contractual agreement between Provider and Payor.

Cultural Competency: Is an acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work towards better meeting the needs of minority populations.

DD - Developmental Disability/Disorder: A group of disabilities characterized by deficits in motor skills, learning, language, and behavior. These conditions arise during a child's development and impact their everyday functioning.

DSM-V (5) - Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition: The fifth edition of the standard classification of mental disorders containing a listing of diagnostic criteria for every psychiatric disorder recognized by the U.S. healthcare system.

EIBI - Early Intensive Behavioral Intervention: Per the Michigan 1915(i) State Plan Amendment, an intensive model of ABA where treatment is provided an average of ten (10) to twenty (20) hours per week.

EPSDT - Early and Periodic Screening, Diagnostic, and Treatment Benefit: A benefit that provides comprehensive and preventive health care services for Consumers under the age of 21 who also are enrolled in Medicaid.

FBA - Functional Behavior Assessment: An assessment used to identify the function of certain behaviors of an individual with a developmental disability.

FBI - Focused Behavioral Intervention: A BHT service level where services are provided an average of 5 to 15 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).

Health Insurance, Portability and Accountability Act, of 1996 (HIPAA), PL 104-191: A law to improve the Medicare program under title XVIII of the Social Security Act of 1935, as amended, (the "Social Security Act"), PL 74-271, the Medicaid program under title XIX of the Social Security Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information. HIPAA provides for improved portability of health benefits and enables better defense against abuse and fraud, reduces administrative costs by standardizing format of specific healthcare information to facilitate electronic claims, directly addresses confidentiality and security of patient information – electronic and paper-based, and mandates "best effort" compliance.

Incident Report: Refers to documentation of an event that varies from established policies and procedures for care or service.

IDD - Intellectual Developmental Disability/Disorder: A developmental disability specifically characterized by deficits in intellectual functioning and adaptive behavior.

IEP - Individualized Education Program: A plan developed by a team, for eligible students with disabilities under state and federal special education law, that describes the offer of free appropriate public education in the least restrictive environment, including special education, and/or related services and/or supplementary aids and services.

IFSP - Individualized Family Service Plan: A plan for infants and toddlers (birth-3) that includes early intervention services. The IFSP may also include special education if the child qualifies for special education.

IPOS - Individual Plan of Service: Developed through the Person-Centered Planning (PCP) process, the IPOS includes information about the individual, goals and outcomes, and the services needed to achieve those goals and outcomes.

LP - Licensed Psychologist: A doctoral certification for a person who may provide behavioral assessment, behavioral intervention, and behavioral observation and direction.

LLP - Limited Licensed Psychologist: A master's level certification for a person who may provide behavioral assessment, behavioral intervention, and behavioral observation and direction under the supervision of a BCBA.

Limited English Proficiency (LEP): Means individuals who cannot speak, write, read, or understand the English language at a level that permits them to interact effectively with health care Providers and social services agencies.

M-CHAT - Modified Checklist for Autism in Toddlers: A screening tool used to help identify Autism Spectrum Disorder (ASD) in children ages sixteen (16) months to thirty (30) months.

MDHHS: Means the Michigan Department of Health and Human Services.

MDHHS/CMHSP Master Contract for General Funds: Means the current MDHHS/CMHSP Managed Mental Health Supports and Services Contract for General Funds between the MDHHS and CMHSP.

MDHHS/PIHP Master Contract for Medicaid Funds: Means the current MDHHS/Prepaid Inpatient Health Plan Managed Specialty Supports and Services Contract between the MDHHS and Mid State Health Network (MSHN).

Medicaid eligible: Means an individual who has been determined to be entitled to Medicaid for service dates rendered This includes persons entitled to Medicaid who are on a spend-down who have met their deductible for a given month and persons who are retro-eligible for Medicaid.

Medically Necessary or Medical Necessity: Medical necessity and recommendation for BHT services is determined by a physician or other licensed practitioner working within their scope of practice under state law. The child must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criteria A and B (listed below); and require BHT services to address the elements identified in the Medicaid Provider Manual 18.4 Medical Necessity Criteria.

Mental Health Code: Means Act 258 of the Public Acts of 1974, as amended, MCL 330.1001 *et seq*.

Minor Children: Means any of the following: (i) a person less than 18 years of age, (ii) a person who is a resident in a child caring institution, foster family home, or foster family group home, who is at least 18 but less than 21 years of age, and who meets requirements of the young adult voluntary foster care act, (iii) a person who is a resident in a child caring institution, children's camp, foster family home, or foster family group home; who becomes 18 years of age while residing in a child caring institution, children's camp, foster family home, or foster family group home; and who continues residing in a child caring institution, children's camp, foster family home, or foster family group home to receive care, maintenance, training, and supervision. A minor child under this subparagraph does not include a person 18 years of age or older who is placed in a child caring institution, foster family home, or foster family group home under an adjudication under Section 2a of Act 288 of the Public Acts of 1939, as amended (the "Probate Code of 1939"), MCL 712A.2a, or under Section 1 of Act 175 of the Public Acts of 1927, as amended (the "Code of Criminal Procedure"), MCL 769.1 or (iv) a person 18 years of age or older who is placed in an unlicensed residence under section 5(4) or a foster family home under section 5(7).

Performance Improvement (PI): Means the continuous study and adaptation of functions and processes of a health care organization to increase the probability of achieving desired outcomes and to better meet the needs of the members and other users of services.

Potential Consumer: Means an individual who is a customer residing in Payor's service area. A potential Consumer is not a person receiving specialty supports and services under this Agreement.

Prepaid Inpatient Health Plan (PIHP): An organization that manages Medicaid specialty services under the state's approved Waiver program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR Part 401, regarding Medicaid managed care. In this Agreement, the PIHP is Mid-State Health Network (MSHN).

Provider: Means the party designated as the "Provider" in the introductory paragraph of this Agreement.

RBT - Registered Behavior Technician: The individual responsible for the direct implantation of the BHT/ABA services under the supervision of a BCBA-D, BCBA, or BCaBA. An RBT is credentialed by the BACB.

Recipient: means an individual who receives mental health services, either in person or through telemedicine, from the department, a community mental health services program, or a facility or from a provider that is under contract with the department or a community mental health services program. For the purposes of this act, recipient does not include an individual receiving substance use disorder services under chapter 2A unless that individual is also receiving mental health services under this act in conjunction with substance use disorder services.

Rules: Means rules, regulations, and standards promulgated and adopted by the MDHHS in compliance with the Mental Health Code.

SCQ - Social Communication Questionnaire: A screening tool used to help identify Autism Spectrum Disorder (ASD) in children ages 4-6.

Sentinel Events: Means an "Event" or "unexpected occurrence" involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a "serious adverse outcome." Any injury or death as a result of emergency physical intervention is considered a sentinel event and must be reported.

Event: Means any and all of the following:

1. relocation of a Consumer due to licensing issues;
2. relocation of the service site or administrative operations of Provider for more than 24 hours;
3. conviction of a Provider staff for any offense related to the performance of their job duties/responsibilities;
4. Unusual incidents such as emergency medical treatment, hospitalization, medication error, arrest of a Consumer, behavioral incidents that are unexpected/not addressed, harm to self, and harm to others.

An Event must be in writing within 24 hours and is generally reported to Payor on an "Incident Report."

Service area: Means the county(ies) served by Payor.

Telemedicine: Telemedicine is the use of telecommunication technology to connect a beneficiary with a Medicaid-enrolled health care professional in a different location.

Attachment I – Disclosure of Ownership, Controlling Interest, and Criminal Convictions

CMH Contract Manager to insert

Attachment J - BAA

CMH Contract Manager to insert