PROVIDER SERVICE AGREEMENT

By and Between

COMMUNITY MENTAL HEALTH OF OTTAWA COUNTY

and

This Provider Service Agreement ("Agreement") serves to confirm the mutual understandings of COMMUNITY MENTAL HEALTH OF OTTAWA COUNTY

("CMHSP"), a Community Mental Health Services Program, and , ("Provider"), (hereby collectively referred to as "Party" or "Parties.")

WHEREAS, CMHSP is a Community Mental Health Services Program ("CMHSP") created to operate, pursuant to 1974 PA 258, the Michigan Mental Health Code, as amended, ("Mental Health Code"); and

WHEREAS, under authority granted by Section 116(2)(b) and (3)(e) and Section 228 of the Mental Health Code, the Michigan Department of Health and Human Services ("MDHHS") has entered into a Managed Mental Health Supports and Services Contract for General Funds ("MDHHS/CMHSP Master Contract for General Funds") with CMHSP, to provide or arrange for the provision of mental health supports and services for certain individuals residing in CMHSP's service area; and

WHEREAS, Lakeshore Regional Entity ("LRE") was formed as a regional entity under MCL 330.1204b of the Mental Health Code and serves as the Prepaid Inpatient Health Plan ("PIHP") under 42 CFR §438 in the MDHHS-designated Region 3, where CMHSP provides services; and

WHEREAS, MDHHS has entered into the Medicaid Managed Specialty Supports and Services Concurrent 1115 Demonstration Waiver, 1915(c)(i) Waiver Program(s), the Healthy Michigan program ("HMP"), the Flint 1115 Demonstration Waiver, and Substance Use Disorder Community Grant Programs Agreement with LRE for the provision of Mental Health Services and Supports and Substance Use Disorder ("SUD") services in CMHSP's service area under authority of the MDHHS/PIHP Master Contract; and

WHEREAS, CMHSP is in need of specific Covered Services and Provider has represented to CMHSP that it is duly licensed, qualified, and willing to provide such services as required by CMHSP, and CMHSP desires to obtain such services from Provider pursuant to the terms and conditions set forth herein.

NOW, THEREFORE, in consideration of the mutual covenants and conditions contained herein, and for good and valuable consideration, the sufficiency and receipt of which are hereby acknowledged, and intending to be legally bound hereby, the Parties agree as follows:

I. DEFINITIONS.

1. Abuse. As defined in 42 CFR 455.2, Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet the professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

2. Agreement. This Provider Service Agreement between CMHSP and Provider as indicated on the signature page, and includes all Attachments, Addenda, and Exhibits attached hereto.

3. Behavioral Health Services. Those services or supplies that a health care provider is licensed, equipped, and staffed to provider and which such provider customarily provides to or arranges for Covered Persons.

4. Block Grant. Funding through either the Mental Health Block Grant or Substance Use Disorder Community Grants Program as administered by MDHHS.

5. Claim. Either the uniform bill claim form or electronic claim form in the format prescribed by CMHSP, using correct coding and billing guidelines, which is submitted by Provider to CMHSP for payment for Covered Services rendered to a Covered Person under this Agreement.

6. Clean Claim. Unless otherwise defined by any applicable Federal or State law, rule, or regulation (which definition shall then be controlling), a Claim submitted by a Provider pursuant to a Covered Service rendered under this Agreement that can be processed and determined without obtaining additional information from Provider or from a third party and which does not involve coordination of benefits, third party liability, or subrogation, or any material defect or error that prevents timely adjudication. A Claim from a Provider who is under investigation for fraud or abuse or a Claim under review for medical necessity is not a Clean Claim or Complete Claim.

7. Community Mental Health Services Program ("CMHSP"). A program operated under Chapter 2 of the Michigan Mental Health Code, as defined in MCL 330.1100a(18). CMHSP is a Member of LRE which serves as the PIHP for Allegan, Kent, Lake, Mason, Muskegon, Oceana, and Ottawa counties ("Region 3"). LRE has five (5) Member CMHSPs: Community Mental Health of Ottawa County, County of Muskegon d/b/a HealthWest, Kent County CMH Authority d/b/a Network180, OnPoint (serving Allegan County), and West Michigan Community Mental Health System (serving Lake, Mason, and Oceana counties), all of which are CMHSPs.

8. Contracting Parties. This Agreement is solely between and by the Parties named above. Neither MDHHS nor LRE are parties to this Agreement.

9. Covered Person. An individual who resides in CMHSPs' service area, receives, or is eligible to receive, Covered Services under the Behavioral Health and Intellectual and Development Disability Supports and Services section of the MDHHS Medicaid Provider Manual ("MPM"), is enrolled in the MiChild Program, or receives, or is eligible to receive, services under the SUD Community Grant Program(s), including Covered Persons eligible through Certified Community Behavioral Health Clinic ("CCBHC"), if applicable. Hereinafter may also be referred to as "Beneficiary," "Recipient," "Person Served," or "Person Receiving Services."

10. Covered Services. Medically Necessary Health Services that are within the normal scope of service and registration or licensure of Provider and for which a Covered Person is entitled to receive coverage under the Medicaid Managed Specialty Supports and Services Concurrent 1115 Demonstration Waiver, 1915(c)(i) Waiver Program(s), the

Healthy Michigan program ("HMP"), the Flint 1115 Demonstration Waiver, and Substance use Disorder Community Grant Programs Agreement.

11. Critical Incident. Critical Incidents are defined as the following events: Suicide; non-suicide death; arrest of consumer; emergency medical treatment due to injury or medication error, including injuries resulting from the use of physical management; hospitalization due to Injury or Medication Error, including hospitalization resulting from the use of physical management.

12. Dispute. Any dispute or controversy arising under, out of, in connection with, or in relation to this Agreement or the breach of this Agreement, does not include a Beneficiary Appeal as otherwise defined.

13. Behavioral Health Services. Those services or supplies that a health care provider is licensed, equipped, and staffed to provide and which such provider customarily provides to or arranges for Covered Persons.

14. Fraud. As defined in 42 CFR §455.2, the intentional deception or misinterpretation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or another person, including any act that constitutes fraud under any applicable Federal or State law, rule, or regulation.

15. Health Care Professional. Includes, but is not limited to, any of the following: physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), registered/licensed social worker, registered respiratory therapist, and certified respiratory therapy technician.

16. HIPAA. The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 1996, as amended, enacted to improve the Medicare program under Title XVIII of the Social Security Act and the Medicaid program under Title XIX of the Social Security Act.

17. HITECH. The Health Information Technology for Economic and Clinical Health Act of 2009, title XIII of the American Recover and Reinvestment Act of 2009.

18. Intellectual/Developmental Disability. As defined in MCL 330.1100a(26) of the Mental Health Code.

19. MDHHS/CMHSP Master Contract for General Funds. The agreement between MDHHS and CMHSP for the provision of mental health supports and services.

20. MDHHS/PIHP Master Contract. The agreement between MDHHS and LRE for the management of 1115 Behavioral Health Demonstration Waiver Program, the Healthy Michigan Plan, 1915(c)(i) Waiver Program(s), the Healthy Michigan Program, Flint 1115 Demonstration Waiver, and Substance Use Disorder Community Grant Programs.

21. Medical Necessity. Determination by a qualified clinician acting within the scope of their licensure that services are reasonable and necessary for the treatment of illness, injury, disease, disability, or developmental condition, including services provided in accordance with generally accepted practices, not primarily for the convenience of the covered

individual or another healthcare provider, and not more costly than an alternative treatment at least as likely to produce equivalent therapeutic value, as consistent with the Michigan Medicaid Provider Manual ("MPM"). Additional regional standards may be published and required by LRE and are incorporated herein by reference.

22. Network. A group of providers that contracts with CMHSP to provide Covered Services to Covered Persons.

23. Network Notifications. The official means of communication regarding non-material changes related to Claims and/or reimbursement such as billing code changes, documentation requirements, accepted modifiers, or other billing matters. Network Notifications are published a minimum of thirty (30) days in advance of the effective date of the change, unless such changes are necessary sooner as required by law or rule, or for CMHSP or LRE to comply with any legal or contractual obligation for which it is responsible. For the purpose of this definition, "non-material" are those changes related to Claims and/or reimbursement that will not decrease Provider's payment or compensation or will not change the administrative procedures in a way that may reasonably be expected to significantly increase Provider's administrative expense.

24. Persons with Limited English Proficiency ("LEP"). Persons who cannot speak, read, write, or understand the English language at a level that permits them to interact effectively with health care providers or social service agencies.

25. Prepaid Inpatient Health Plan ("PIHP"). In Michigan, and for the purposes of this Agreement, a PIHP is defined as an organization that manages Medicaid specialty services under the State's approved Waiver Program(s), on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR §438. LRE was created as a Regional Entity under MCL 330.1204b and under the MDHHS/PIHP Master Contract, serves as the PIHP of Region 3. LRE also manages PA2 funds in accordance with its role as PIHP.

26. Policies and Procedures. For the purposes of this Agreement, those policies, procedures, and protocols, adopted by CMHSP or LRE to be used by Provider in providing services and doing business with CMHSP under this Agreement, including but not limited to payment policies, credentialing and re-credentialing processes, utilization management, quality improvement, peer review, fair hearing, appeals and grievances, or concurrent review.

27. Practice Guideline. Developed guidelines for specific service, support, or systems models of practice that are derived from empirical research and sound theoretical construction and are applied to the implementation of public policy or service provision.

28. Protected Health Information ("PHI"). For the purposes of this Agreement, PHI shall have the meaning as defined in 45 CFR §160.103 and shall also include Patient Identifying Information ("PII") as defined in 42 CFR Part 2, Subpart B, §2.11.

29. Quality Improvement. The processes established and operated by CMHSP and/or LRE that relate to the quality of Covered Services.

30. Sentinel Event. Any unexpected event or occurrence involving death or serious physical injury or psychological injury, or the risk thereof. Serious injury includes loss of limb or function. The phrase "risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

31. Serious Emotional Disturbance ("SED"). As defined in MCL 330.1100(d)(3).

32. Serious Mental Illness. As defined in MCL 330.1100(d)(4) of the Mental Health Code.

33. Substance Use Disorder ("SUD"). As defined in MCL 330.1100(d)(12) of the Mental Health Code.

34. Utilization Management. The process(es) to review and determine whether certain health care services provided or to be provided to Covered Persons are in accordance with CMHSP and LRE Policies and Procedures.

35. Utilization Review. The monitoring and evaluation of Covered Services to determine adherence to Medical Necessity requirements.

II. ATTACHMENTS.

1. Attachment A: Covered Services
2. Attachment B: Reimbursement Terms
3. Attachment C: Insurance Requirements
4. Attachment D: Contract Monitoring
5. Attachment E-1: Recipient Rights for Mental Health Services
6. Attachment E-2: Recipient Rights for Substance Use Disorder Services
7. Attachment E-3: Recipient Rights for Inpatient Psychiatric Services
8. Attachment F: Performance Indicators
9. Attachment G: Reserved
10. Attachment H: Delegated Functions
11. Attachment I: Training Requirements
12. Attachment J: Conflict of Interest
13. Attachment K: Designated Collaborating Organization

III. GENERAL PROVISIONS.

1. Contract Authority. This Agreement is entered into for Covered Services under the authority granted Section 1116(2)(b) and (3)(e) and Section 1228 of 1974 PA 258, as amended, and, for SUD treatment services under authority granted by 2012 PA500, as amended. Applicable provisions of those Acts, all rules promulgated and adopted under those Acts, and applicable State and Federal laws, regulations, and Administrative Rules, shall govern the expenditure of funds and provision of Covered Services pursuant to this Agreement. This Agreement is entered into for Covered Services under authority of the MDHHS/PIHP Master Contract and the MDHHS/CMHSP Contract for General Funds.

2. Provision of Health Services. Provider shall make available to Covered Persons those usual and customary services that are offered within the scope of Provider's licensure and certification under applicable laws and based on the qualifications determined by CMHSP, LRE, or MDHHS. Provider shall provide authorized Covered Services in accordance with provisions contained herein and as required by the MPM during the term of this Agreement or as otherwise required by law, whichever is later. LRE acts as fiduciary for

Medicaid funding from the State of Michigan that supports payment to Provider under this Agreement.

3. Mental Health and SUD Services. When providing Covered Services pursuant to this Agreement, Provider shall abide by the applicable provisions and requirements as set forth in the Mental Health Code, as amended, including the promulgation of any Administrative Rules, and the MPM, as revised, PA500 2012, as revised, and CMHSP and LRE Policies and Procedures pursuant to the provision of Covered Services.

4. Payment. CMHSP agrees to provide payment to Provider for the purchase of authorized mental health and/or SUD services that are considered Medically Necessary as guided by Medical Necessity Criteria. Conditions for payment are described in Attachment A: Covered Services.

    A. CMHSP has the right to withhold payment of any disputed amounts until the Parties agree as to the validity of the disputed amount.

    B. Funds paid to Provider for the purchase of authorized Covered Services come from a variety of sources, including Medicaid, General Fund, and other Federal, State, and local sources, and as such, are subject to the rules, regulations, and laws of Medicaid and other Federal, State, or local funding sources, as may be the case.

5. Policies and Procedures. Provider shall comply with all LRE and CMHSP Policies and Procedures that apply to Network Providers and with LRE and CMHSP Compliance Plan(s). Information on Policies and Procedures can be found at:

    A. Allegan County Community Mental Health Services Board, d/b/a/ OnPoint: https://onpointallegan.org/providers/

    B. CMH of Ottawa County: http://www.miottawa.org/Health/CMH/

    C. HealthWest: https://healthwest.net/providers/

    D. Network180: https://www.network180.org/pnp

    E. West Michigan CMH: https://www.wmcmhs.org/for-providers/

    F. LRE: https://www.lsre.org/for-providers/policies-and-procedures

6. Agreement Contingent Upon Funding. CMHSP's payment of funds under authority of this Agreement is subject to and conditioned upon the receipt of funds for such purposes, those being Federal, State, or local funds.

7. Term of Agreement. The term of this Agreement ("Term") shall be from _____through _____, unless amended or terminated as set forth herein.

    A. CMHSP shall have the option to renew this Agreement, upon completion of the term, for an additional term of one (1) year, commencing on the day of expiration of the initial Term. Said option shall be exercised by CMHSP by written notification of its intent at least thirty (30) days prior to termination of the initial Term of this Agreement.

B. Provider shall have the opportunity to review the initial agreed upon payment rate with CMHSP on an annual basis. Such requests must be provided to CMHSP, in writing, and in accordance with established CMHSP procedures.

8. Termination of Agreement. This Agreement may be terminated as allowed herein.

A. In the event circumstances occur, which are not reasonably foreseeable, or are beyond the control of the Parties, that reduces or otherwise interferes with the ability of CMHSP to provide or maintain services or operational procedures for its service area, CMHSP shall give immediate notice to Provider if it would result in any reduction of funding upon which this Agreement is contingent. In such an event, either Party may terminate this Agreement, Covered Service(s), or programs as provided in this Section or otherwise mutually agreed to by the Parties.

B. This Agreement shall terminate immediately:

1. If the Office of Inspector General ("OIG") determines Provider is an "excluded provider" or has any employment, consulting, or any other agreement with a debarred or suspended person or entity from any Federally-funded or State health care program for the provision of items or services that are significant and material to Provider's contractual obligations hereunder.

2. Upon the revocation, restriction, suspension, discontinuation, or loss of any certification, accreditation, authorization, or license required by Federal, State, or local laws, ordinances, rules, and regulations for Provider to render Covered Services within the State of Michigan, with termination to be effective as of the date of delivery of written notice to Provider. Notwithstanding any other provision contained herein, Provider shall be required to payback any reimbursement for Covered Services rendered after the effective date of such revocation, restriction, suspension, discontinuation, or loss of any certification, accreditation, authorization, or license required pursuant to the Provider's obligations hereunder.

3. Upon the receipt of notice or discovery that Provider is:

a. Listed by a Federal agency or the State of Michigan as being suspended from participation in the Federal Medicare or Michigan Medicaid Programs, including but not limited to the Michigan Sanctioned Provider List, the OIG Exclusion Databases List of Excluded Individuals/Entities ("LEIE") and General Services Administration ("GSA"), and the System for Award Management ("SAM").

b. Listed by MDHHS or any agency of the State of Michigan in its registry for Unfair Labor Practices pursuant to 1980 PA 2789, as amended, MCL 423.321 et seq.

c. Provider is listed by the U.S. OIG in its "Excluded Provider List" as to payment made by a Federal health care program.

d. Upon receipt or notice to and/or discovery by CMHSP of any failure of 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.

C. This Agreement, Covered Service(s), or programs may be terminated or not renewed by either Party without cause and without remedy with sixty (60) calendar days written notice to the other Party, unless another date is mutually agreed to, in writing, by both Parties.

D. Any material breach of this Agreement, which has not been cured within fifteen (15) days of receipt of notice of the material breach, may result in the non-breaching party's immediate termination of this Agreement, which said termination being effective as of the date of delivery of written notification from the non-breaching party to the breaching party. 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.

E. This Agreement, Covered Service(s), or programs may be terminated at the sole discretion of CMHSP with written notification to Provider for the following reasons, including but not limited to:

1. A reduction in funding.
2. CMHSP determines or has reason to believe the health, safety, or welfare of a Covered Person is jeopardized by continuation of this Agreement. In the event of termination due to health, safety, or welfare of Covered Persons, Provider will cooperate with CMHSP to immediately transfer the Covered Person to a new provider).
3. Provider commits any fraud or misrepresentation relating to the services performed under this Agreement.

F. Should this Agreement, Covered Service(s), or programs covered by it be terminated, or not renewed by either Party, CMHSP and Provider agree to participate in the development of a written transition plan within ten (10) business days of the notice of termination or non-renewal of Agreement. The transition plan shall:

1. Specify all financial obligations owed to or from either Party at the time of termination.
2. Specify each Party's responsibilities, including dates of completion for each responsibility. In the event a date of completion cannot be met by either Party, notification shall be provided to the other Party in writing prior to the identified due date for completion.
3. Specify responsibility and dates of completion to transfer possession of relevant clinical documents, billing information for each Covered Person, and all medications, personal funds, and personal property of Covered Person(s).

4. Ensure that Provider issues written termination notice at least fifteen (15) business days prior to terminating the services of each Covered Person who has an open case and is receiving Covered Services from Provider.

5. Ensure that Provider discusses with Covered Person(s) and provides written notice of transfer of services to another provider if it is determined the Covered Person still requires medically necessary Covered Services. Evidence of compliance with this provision must be maintained in the case record.

6. Require that proof of written notices required herein is given to CMHSP within seventy-two (72) hours of such notice.

G. During the transition period, Provider shall not be released from any obligation to continue to provide Medically Necessary Covered Services to a Covered Person until the responsibility for the Covered Person's Covered Services can be transferred to another provider. CMHSP shall make payments to Provider for Covered Services in accordance with the terms of this Agreement. Provider's responsibilities hereunder shall continue for a period of up to sixty (60) days, unless another date has been agreed to, in writing, by the Parties. In emergent situations potentially impacting placement, Provider shall notify and coordinate care with CMHSP.

H. Any termination of this Agreement, Covered Service(s), or programs shall not relieve either Party of the obligations prior to the effective date of such termination.

9. Independent Contractor. Provider shall perform the services under this Agreement as an independent contractor and not as an employee, agent, partner, or any other relationship with CMHSP or LRE. Provider further understands and acknowledges that it shall not be entitled to any of the benefits of a CMHSP or LRE employee, including but not limited to, vacation, sick leave, administrative leave, health insurance, disability insurance, retirement, unemployment insurance, workers' compensation, and protection of tenure. The officers, employees, servants, and agents of Provider shall in no way be deemed to be and shall not hold themselves out as officers, employees, servants, or agents of CMHSP or LRE.

10. Provider Subcontracts. Provider shall obtain CMHSP's prior written approval before subcontracting any or all of Provider's obligations hereunder. Furthermore, any subcontract shall:

A. Be in writing and include a full specification of the subcontracted supports/services.

B. Contain a provision stating this Agreement is incorporated by reference into the subcontract and made a part thereof, and as such, is subject to the terms and conditions of this Agreement.

C. Not terminate the legal responsibility of Provider to ensure that supports/services required of Provider hereunder are fulfilled.

D. Provide, prior to execution of any such subcontract, commercially reasonable efforts to furnish CMHSP with notice verifying that subcontractor and its

professional staff, if any, maintain all approvals, licenses, certifications, registrations, accreditations, and authorizations required by Federal, State, and local laws, ordinances, rules, and regulations to perform the subcontracted supports/services pursuant to the subcontract.

E. Allow for the audit and inspection of records and premises by CMHSP, LRE, the Office of Inspector General, or any State of Federal government agency, or their representatives, or any other authorized body, at any time, including but not limited to, access to inspect, review, copy, and/or audit all financial records, licenses, accreditation, certification, and program reports pertaining to the performance of obligations under this Agreement, to the full extent permitted by applicable State and Federal law.

F. Provide, prior to execution of any such subcontract, assurance that the subcontractor:

1. Is not listed by MDHHS or another agency of the Federal government or State of Michigan as being suspended from participation in Medicaid or Medicare programs.
2. Is not listed by MDHHS or any other agency of the State of Michigan in its registry for unfair labor practices.
3. Is not listed by the U.S. General Services Administration in its "Excluded Parties List" as to Federal funding.
4. Maintains workers' compensation and unemployment insurance coverage for its employees, as required by law.
5. Maintains liability insurance coverages required by CMHSP or LRE, as the case may be, for all contracted services,
6. Has procedures in place to ensure the immediate notification to CMHSP, in writing, if Provider, subsequent to the execution of any such subcontract, discovers that any of the above cited verifications are no longer true.

IV. FINANCIAL.

1. Method of Payments and Financial Reports. The payment procedures and reporting shall be followed as described in the CMHSP's Provider Manual and applicable Policies and Procedures.
2. Reimbursement. CMHSP shall reimburse Provider at the rates identified as agreed upon in Attachment B: Reimbursement Terms for Covered Services rendered by Provider. CMHSP shall be liable for payment for Covered Services authorized by CMHSP. Actual payments are subject to Ability to Pay ("ATP") in accordance with Chapter 8 of the Mental Health Code and Chapter 8 of the Michigan Administrative Rules, when applicable.
3. Claims. For claims payment, CMHSP shall adjudicate or arrange for adjudication and where appropriate make payment for Clean Claims for Covered Services submitted by Provider 90% or higher within thirty (30) business days of receipt of Clean Claims and at least 99% within ninety (90) business days receipt of Clean Claims, excepting when other timeliness standards have been specified and agreed upon by both Parties.

4. Timely Filing of Claims. Provider shall submit Clean Claims to CMHSP within sixty (60) days of the date Covered Services were rendered, and for series billing, within sixty (60) days from the end date of the service. If CMHSP is not the primary payor, and Provider is pursuing payment from the primary payor, Provider shall submit claims to CMHSP within ninety (90) days from the date of the remittance advice.

5. Denied or Corrected Claims. Any Claims to be resubmitted must be resubmitted within sixty (60) days of the date of the Denied Claims Report for CMHSP to process. If a Provider error was made in billing, the Provider will make the necessary correction(s) and resubmit the claim. If after checking for errors Provider believes the claim was rejected due to an error in CMHSP's claims processing system, Provider will submit the reason for the appeal in writing to CMHSP, along with any copies of backup evidence. In no event, regardless of the cause or circumstance, shall CMHSP or Covered Person be responsible or liable for any Claim submitted by Provider to CMHSP after the expiration of the filing deadlines set forth in this Section.

6. Financial Requirements. Provider shall be required to follow financial practices as described hereunder:

    A. To use the accrual method of accounting.

    B. For all financial recordkeeping and reporting, Provider shall use Generally Accepted Accounting Practices ("GAAP") applicable to State and local governments as promulgated by the Governmental Accounting Standards Board ("GASB").

    C. To annually obtain a financial audit when total fiscal year revenue from all sources for Provider is $750,000 or more. The American Institute of Certified Public Accountants Audit and Accounting Guidelines shall be used, as applicable, including but not limited to, specifically:

        1. The audit will cover Provider's fiscal year.

        2. The audit must be performed by a Certified Public Accountant ("CPA") to ensure the financial statements are presented in conformance GAAP accepted in the United States of America.

        3. The audit must include the required internal control and compliance reports when Government Auditing Standards (Yellow Book) or Single Audit requirements apply.

        4. The audit must comply with regulations set forth in the Single Audit Act, OMB Circular A-87, and Circular A-122, when applicable. New grants after 12/26/2014 will follow OMB Guidance 2 CFR §200.

        5. Management letter issued as a result of the audit by the CPA must be submitted to CMHSP within thirty (30) days of receipt by Provider.

        6. To submit a separate schedule of revenue and expense by CMHSP program in accordance with CMHSP Policy and Procedures when Provider's fiscal year revenue from CMHSP is $5,000,000 or more.

    D. To annually obtain a financial review when total fiscal year revenue for the Provider is between $250,000 and $750,000, unless Provider is required to obtain

an audit as part of any other obligation. Where Provider's total fiscal year revenue is less than $250,000, CMHSP may request, at Provider's sole expense, a financial review. The American Institute of Certified Public Accountants Statements on Standards for Accounting and Review Services shall be used, as applicable, including but not limited to, specifically:

1. The review will cover Provider's fiscal year.
2. The review must be performed by a CPA to provide limited assurance there are not material modifications that should be made to the financial statements to be in conformance with GAAP.
3. Management letter issued as a result of the audit by the certified public accountant must be submitted to the CMHSP within thirty (30) days of receipt by Provider.

E. Any financial audit or financial review required under this Agreement be submitted to CMHSP within one-hundred and fifty (150) days following Provider's fiscal year end. Deviation from this requirement, for any reason, must be approved in advance, in writing, by CMHSP.

7. Maintenance of Financial Records. Provider shall maintain all pertinent financial and accounting records and evidence pertaining to this Agreement based on financial and statistical records that can be verified by CMHSP or its auditors in accordance with CMHSP and LRE Policies and Procedures for Record Retention.
8. Access to Financial Records. In accordance with records access and inspection requirements contained herein, CMHSP, LRE, the Federal or State government, or their authorized representatives, shall be allowed to inspect, review, copy, and audit all financial records pertaining to this Agreement.
9. Proof of Solvency. Provider shall furnish CMHSP proof of financial solvency, prior to commencing services under this Agreement, and with immediate notice of any change in financial position material to Provider's solvency and to its continuing operation as an ongoing concern, at any time throughout the Term of this Agreement.
10. Form 990. Provider must provide a copy of Provider's Federal Form 990—Return of Organization Exempt from Income Tax to CMHSP within thirty (30) days of submission to the Internal Revenue Service ("IRS") if Provider is required to file Form 990 under IRS regulations.
11. Coordination of Benefits. CMHSP and Provider shall be responsible for the coordination of public and private benefits for each Covered Person under this Agreement. Provider acknowledges that CMHSP is the payor of last resort and, as such, Provider shall be required to identify and seek recovery from all liable first and third parties, except where Provider is furnishing services as a Designated Collaborating Organization ("DCO") as part of CMHSP's certification as a CCBHC. Third Party Liability refers to any health insurance or carrier (e.g. individual, group, employer-related, self-insured, or self-funded plan, or commercial carrier, automotive insurance, and worker's compensation) or program (e.g. Medicare) that has liability for all or part of a Covered Person's covered benefit.
12. Prohibition Against Balanced Billing. In cases where Medicaid funds are used, in whole or in part, Provider may not bill Covered Person for the difference between Provider's

charges and the Medicaid reimbursement rate described herein, nor seek nor accept additional or supplemental payment from the Covered Person, their family, or representative in addition to or in place of any amount paid by CMHSP. In cases where non-Medicaid funds are used, Provider must receive prior written approval from CMHSP before Provider may bill, seek payment, or accept payment from the Covered Person, or the Covered Person's authorized representative or family, for the difference between Provider's charges and the reimbursement rate from the non-Medicaid payor or funding source. This provision will survive the termination of this Agreement, regardless of the cause of termination and will be construed to be for the benefit of the Covered Person.

13. Payment Responsibility. Provider shall not bring and/or maintain any action, lawsuit, or claim of any type against a Covered Person to collect sums owed to Provider pursuant to Covered Services under this Agreement, even in the event CMHSP fails to pay, becomes insolvent, or otherwise breaches the terms and conditions of this Agreement. This provision will survive the termination of this Agreement, regardless of the cause of termination and will be construed to be for the benefit of the Covered Person.

14. Financial Errors. If any audit or inspection of Provider's financial records reveals validated financial errors, the amount in error must be reflected as a credit or debit on subsequent invoices until the amount is paid or refunded, as the case may be. Any remaining balance at the end of this Agreement must be paid or refunded within forty-five (45) calendar days. A disputed error shall not be so reflected, but shall be resolved pursuant to the dispute resolution procedures contained in this Agreement.

15. Provider Responsibility for Training Costs. Provider will be billed annually for the cost of access to in-person and/or virtual training offered by CMHSP, regardless of actual utilization of such training. This is a fixed cost of doing business with CMHSP, and should be included in the calculation by Provider of service costs. The Training Fee is due within thirty (30) days of invoicing, and balances remaining outstanding after sixty (60) days may be automatically converted into a credit memo to offset future payments from CMHSP to Provider. This Provision shall not apply to Providers operating solely under DCO status as part of CMHSP's certification as a CCBHC Demonstration Program.

16. Taxes. Provider shall be responsible for paying any taxes required by any State, Federal, or local taxing jurisdiction. Provider agrees that CMHSP is not responsible for any of its tax obligations and further agrees that should CMHSP be compelled to pay any of the Provider's tax obligations, it shall promptly reimburse CMHSP for the full value of such paid tax obligation, plus any applicable interest and penalty.

17. Prohibition Against Provider Loans, Fund Transfers, Liens, and Encumbrances. Provider shall not lend, transfer, create or permit to be created, a lien or encumbrance, or grant a security interest in, or with respect to any funds provided in whole or in part by CMHSP, to any third party for any purpose without prior written approval from LRE.

V. PROVIDER RESPONSIBILITIES.

1. Statement of Work. Provider agrees to undertake, perform, and complete the services described the MPM, the CMHSP Provider Manual, and applicable Policies and Procedures.

2. Compliance. It is expressly understood and agreed by Provider that this Agreement is subject to the terms and conditions of the PIHP/CMHSP Subcontract, the MDHHS/CMHSP

Master Contract for General Funds, and the MDHHS/PIHP Master Contract, which together with all Attachments or Exhibits thereto, are incorporated herein by reference and made a part hereof, all of which Provider is responsible for knowledge of to the extent required to implement said requirements pursuant to compliance with this Agreement. Copies of these contracts are available by request. Provider shall comply, and shall ensure that its employees, contractors, or other authorized agents or representatives comply with all applicable provisions and requirements of said contracts, including all Attachments and Exhibits thereto, whether or not specifically referenced in this Agreement, as well as applicable provisions of the MPM, CMHSP's Provider Manual, and all MDHHS Policies, Practice Guidelines, and Technical Requirements, as amended from time to time. The provisions of this Agreement shall take precedence overs said contracts unless a conflict exists between this Agreement and any provision of said contract(s). In the event that any provision of this Agreement is in conflict with the terms and conditions of said contract(s), the provisions of said contract(s) shall prevail. However, this Agreement shall prevail in any conflict where this Agreement:

A. Contains additional provisions and additional terms and conditions not set forth in said contract(s).

B. Restates provisions of said contract(s) to afford CMHSP or LRE the same or substantially the same right and privileges as MDHHS.

C. Requires Provider to perform duties and services in less time than required of CMHSP or LRE in said contract(s) with the PIHP or MDHHS, respectively.

D. Describes payment obligations between CMHSP and Provider.

3. Policies and Procedures. Provider is responsible for the knowledge of, and to implement as practice, applicable CMHSP and LRE Policies and Procedures and provider manuals. Provider acknowledges and accepts that CMHSP or LRE may amend these items from time to time and that such amendments shall be deemed to be incorporated herein based on notification from CMHSP or LRE, as the case may be.

4. Medical Records. Provider shall prepare and maintain complete and accurate medical records, in either paper or electronic form, for all Covered Persons. For the purposes of this Agreement, references to any Covered Person's medical, clinical, or program records shall mean such records in either paper or electronic form. Medical Records shall contain such information as may be required by CMHSP, LRE, MDHHS, or any other Federal or State agency with jurisdiction over the delivery of Covered Services. CMHSP shall supply Provider with copies of its clinical protocols, which must be used by Provider in planning and providing treatment to Covered Persons. Provider shall retain all Medical Records according to the retention schedules in place by the Department of Technology, Management, and Budget #20, regardless of any change in ownership or termination of this Agreement or Covered Services for any reason. The provisions of this Section shall survive the expiration or termination of this Agreement, regardless of cause.

5. Compliance with Applicable Laws. Provider shall institute processes and practices to ensure compliance with all applicable laws, regulations, requirements, or rules, be they Federal, State, or local, including, but not limited to, demonstration of commitment to uphold high standards for ethical and legal business practices and to prevent misconduct.

6. Corporate Compliance. Provider shall participate in the implementation of CMHSP or LRE Corporate Compliance audits, reviews, investigations, and remediation. Provider will promulgate policy that specifies procedures and standards of conduct that demonstrate Provider's commitment to compliance with applicable Federal and State laws, rules, standards, and regulations.

7. Fraud, Waste, and Abuse ("FWA"). CMHSP has the responsibility and authority to report known or suspected FWA to LRE, the Office of the Michigan Attorney General, Health Care Fraud Division, the Office of Inspector General ("OIG"), and/or MDHHS. If Provider has any suspicion or knowledge of FWA with any provision of service under this Agreement, Provider must directly and immediately report it to CMHSP or the LRE Corporate Compliance Officer, or designee. Provider shall not attempt to investigate, beyond an initial inquiry of basic information for reporting purposes, or to resolve the suspected, known, or reported FWA without first reporting suspected, known, or reported FWA as required herein. Provider shall ensure that staff, board members, and any and all agents or representatives acting on behalf of Provider reasonably cooperate and assist any ongoing investigation, whether conducted by CMHSP, LRE, or any State or Federal authority charged with identifying, investigating, sanctioning, or prosecuting suspected FWA. Any unreasonable delay in reporting known or suspected FWA shall be considered a material breach of this Agreement, subject to termination as provided herein.

8. Audit and Inspection of Records and Premises. CMHSP, LRE, or any authorized State of Federal agency, or their designated representatives, authorized to do so, may, at any time, be allowed to inspect, review, copy, and audit all financial records, licenses, accreditation, certification, and program reports of Provider pertaining to the performance pursuant to this Agreement, to full extent permitted by State and Federal law. Provider shall make all medical, financial, or other records produced as part of its obligations hereunder available to CMHSP, LRE, or any authorized State or Federal agency, or their designated representatives for the purpose of assessing quality of care, coordination of care, compliance with CMHSP, LRE, or State or Federal laws, rules, or regulations, conducting medical care evaluations and audits, determining Medical Necessity and appropriateness of services provided to a Covered Person, or investigating grievances or complaints made by a Covered Persons or Covered Person's legal representative, as permitted by law. The right to audit under this provision exists for ten (10) years from the final date of this Agreement or from the date of completion of any audit, whichever is later. If an audit, litigation, or other action involving the records is initiated before the end of the Audit Period, Provider must retain the records until all issues are resolved.

9. Annual Performance Review. LRE will conduct an annual performance review of Provider's activities, if Provider operates within LRE's catchment area of Allegan, Kent, Lake, Mason, Muskegon, Oceana, or Ottawa counties, including, as applicable, conducting an on-site or virtual review of Provider's program or service sites. CMHSP is responsible for conducting an annual performance review activities if Provider operates outside the LRE's catchment area and for annual assessment of Recipient Rights reviews.

10. Remedying Noncompliance Issues. All work performed under this Agreement will be performed and reviewed according to the format and content areas, and identified timetables as set forth by CMHSP or LRE. Provider acknowledges and accepts that CMHSP

or LRE may utilize a variety of remedies ranging from requiring a corrective action plan to withholding payment or contract termination to assure compliance with this Agreement and incorporated covenants, laws, rules, policies, and procedures. Provider agrees to cooperate with CMHSP or LRE, as the case may be, in carrying out compliance auditing and monitoring activities and responsibilities, including producing the documents needed to assist with such functions. If Provider is out of compliance with any rule, law, or requirement herein or required by reference, Provider will have thirty (30) days after written notice of said noncompliance to present a plan of action acceptable to CMHSP or LRE, as the case may be, notwithstanding any other provisions of this Agreement. Where noncompliance is known or may reasonably be construed to jeopardize the health, safety, or welfare of a Covered Person, corrective action will occur immediately, as provided hereunder, and written correction will occur within three (3) days. Unsatisfactory performance, lack of response, failure to submit a plan of correction within required timeframes or subject to CMHSP or LRE approval, or discovery of significant risks may result in CMHSP application of sanction(s) or termination of this Agreement, at CMHSPs sole discretion.

11. Protection of Health and Safety. Provider shall be responsible for ensuring the health, safety, and welfare of each Covered Person pursuant to Covered Services under this Agreement, including taking immediate action, as appropriate, to protect the health, safety, and welfare of each Covered Person.

12. Event Notifications. In addition to other reporting requirements provided for herein, Provider shall notify immediately notify CMHSP of any of the following events:

    A. Any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a Recipient Rights, licensing, or police investigation. This report shall be submitted within twenty-four (24) hours of either the death, Provider's receipt of notification of the death, or Provider's receipt of notification that a Recipient Rights, licensing, or police investigation has commenced. At minimum, Provider shall include in the report:

        1. Name of the Covered Person.
        2. Covered Person's identification number (e.g. Medicaid, MIChild, etc.)
        3. Consumer ID ("CONID"), if no beneficiary ID number.
        4. Date, time, and place of death, including license number of facility if applicable.
        5. Preliminary cause of death, if known, or known facts surrounding the event.
        6. Contact person's name, phone number, and e-mail address.

    B. Relocation of a Covered Person's placement due to licensing issues.

    C. An occurrence that requires relocation of Provider, a Provider service site, governance, or administrative operation for more than twenty-four (24) hours for any reason.

D. The conviction of Provider or a Provider staff member for any offense related to the performance of their job duties or responsibilities which results in exclusion from participation in federal reimbursement.

13. Critical Incidents and Sentinel Events. Provider shall report any Critical Incidents and Sentinel Events involving Covered Persons immediately upon receipt to CMHSP's CEO or the CEO's designated representative and, as appropriate, to MDHHS, the applicable licensing agency, or other agency of the State of Michigan (Adult or Children's Protective Services), law enforcement, or other public agency, as required by law. Provider will fully cooperate with Sentinel Event determinations, root cause analysis investigations, and implementation of any corrective action(s) required by CMHSP or LRE, as the case may be, to prevent reoccurrence of critical incidents or Sentinel Events. Any breach of this provision shall be regarded as a material breach of this Agreement, subject to termination of this Agreement as provided herein.

14. Individual Plan of Service ("IPOS"). Provider shall maintain on file during the Term of this Agreement a current copy of the IPOS of each Covered Person placed with Provider to receive Covered Services hereunder that specifies the amount, scope, and duration of each Covered Services as those terms are defined in the MPM, as well as the cost for each Covered Service.

15. Transmittance of Records. Provider will provide and facilitate ready access of a Covered Person's records for referral of a Covered Person and for transmittal of information as required between Provider and other appropriate services to ensure continuity of services to the Covered Person. Such transmittal information for Covered Persons with mental health conditions and for Covered Persons with SUD shall be consistent with the Mental Health Code and Federal laws governing the sharing or transmittance of PHI. Electronic Data Interchange ("EDI") will comply with HIPAA. To comply with the Administrative Simplification of HIPAA, all persons and organizations who meet the definition of health care provider described in 45 CFR §160.103, as amended, or as defined by MDHHS, as a required provider type, will obtain a National Provider Identifier ("NPI") to be reported in all standard transactions. If required as a condition of participation, the NPI must be submitted to CMHSP as a requirement for billing.

16. Transfer of Records. Upon receipt of a request from CMHSP, Provider shall transfer to the requesting CMHSP Provider's copies of all Medical Records for a Covered Person, and other data in possession or control of Provider pertaining to the names Covered Person within ten (10) business days of such request. In the event of an agency or program closure, Provider shall transfer to CMHSP copies of all Covered Person's Medical Records, and other data in the possession or control of Provider pertaining to the named Covered Person within ten (10) business days of such notice or as otherwise agreed to by the Parties in writing.

17. Coordinating with Health Care Providers. Provider must ensure mental health and SUD treatment services are coordinated with other health care providers, including but not limited to, primary and specialty health care providers. Treatment health records must include, at minimum, the name and address, a signed waiver of release of information for purposes of coordination, or a statement the Covered Person has refused to sign said waiver or does not have a primary health care provider, for any other health care provider.

18. SUD Records. Provider shall maintain SUD Clinical Records consistent with State and Federal law, including 1974 PA 258, 1978 PA 368, 42 CFR Part 2, and 42 USC 290dd-2, all as amended. Provider shall permit access to records by authorized representatives of CMHSP, LRE, MDHHS, the Federal Grantor Agency, Comptroller General of the United States, or any of their duly authorized representatives as allowed by State and Federal law, including 42 CFR Part 2.

    A. Medical Records of a Covered Person with SUD may not be disclosed to CMHSP on behalf of LRE without consent of the Covered Person, or their legal representative, except as may be allowed by State and Federal law, including the Mental Health Code and 42 CFR Part 2. This provision shall survive the expiration of termination of this Agreement, regardless of cause, including non-payment by CMHSP, insolvency, or breach of this Agreement by either Party.

19. Protected Health Information. HIPAA Covered Entities and their programs are subject to 42 CFR Part 2, each agrees that it will comply with HIPAA's Privacy Rule, Security Rule, Transaction and Code Set Rule, and Breach Notification Rule, and 42 CFR Part 2, as now existing or may be amended later, with respect to all PHI and SUD information that it generates, receives, maintains, uses, or discloses or transmits in the performance of its functions pursuant to this Agreement.

20. Business Associate Agreement. Provider is a HIPAA Business Associate of CMHSP. CMHSP and Provider shall enter into a HIPAA Business Associate Agreement ("BAA") that complies with applicable laws and regulations.

21. Confidentiality and Security of Information. CMHSP and Provider shall maintain the confidentiality, security, and integrity of PHI for Covered Persons that is used in connection with the performance of this Agreement to the extent and under the conditions specified by HIPAA, the Mental Health Code, The Michigan Public Health Code (1978 PA 368, as amended), and 42 CFR Part 2.

22. PHI Limited to Need to Know. The Parties hereby agree to appropriately use and safeguard a Covered Person's PHI provided or disclosed to the other Party, and to keep such information in strictest confidence to protect the privacy of all Covered Persons, including but not limited to, providing Covered Persons with a Notice of Privacy Practices. The business affairs and information of the Parties, including and without limitation to, information shared pursuant to this Agreement, are confidential and neither Party will discuss such matters with or disclose the contents of this Agreement to anyone who is not a trustee, officer, agent, or fiduciary of either Party having need to know such information in performance if their duties, all of whom shall be subject to this provision concerning confidentiality, except as otherwise obligated and permitted by law. The obligations set forth in this provision shall carry on beyond the Term of this Agreement, irrespective of whether this Agreement is terminated as provided herein or expires by its own terms.

23. Information Systems ("IS"). Provider must maintain an IS system sufficient to support, at minimum, the following requirements:

    A. History of encounter experiences for all Covered Persons receiving Covered Services pursuant to this Agreement.

B. Quality Improvement activities.

C. Tracking and reporting encounter data, including but not limited to:

1. Behavioral Health treatment Episode Data ("BHTEDS").
2. Financial data.
3. Demographic information.
4. Service use and performance indicators.
5. Coordination of care.
6. Program and service evaluation.

D. Ensure that Electronic Data Interchange ("EDI"), data handling, Network configuration, systems security, and data storage will be conducted in compliance with the security, privacy, and administrative simplification mandates required by HIPAA and HITECH.

E. Maintain policy and procedures to ensure compliance with Federal, State, and CMHSP standards regarding the integrity and security of IS, including but not limited to:

1. Deterrence of sabotage.
2. Fraud and criminal mischief.
3. Business Continuity.
4. Protection of confidentiality of health information.

F. Provider shall implement tools to prevent unauthorized access and virus protection to its internal transaction and office system using planning, management, and system monitoring techniques. To ensure adequate systems security, CMHSP reserves the right to require a review of Provider's IS by a Third Party.

24. Data Management. CMHSP is the owner of all data related to Covered Persons pursuant to this Agreement, including all data entered into Provider's IS, such as all eligibility and demographic data, utilization data, claims data, other service data, or administrative or financial information that has passed through CMHSP or Provider's operation and resides with Provider. Notwithstanding the foregoing, Provider is not precluded from maintaining and utilizing the data identified in this Section in support of Covered Services provided to a Covered Person and internal Provider operations. Provider agrees to provide information to CMHSP related to encounters, services, and administrative costs as required by MDHHS.

25. Recipient Rights. Providers shall comply with the Mental Health Code and Michigan Administrative Rules requirements pertaining to the protection of rights of Covered Person, and according to the Recipient Rights requirements as described in Attachment E-1: Recipient Rights for Mental Health Services, Attachment E-2: Recipient Rights for Substance Use Disorder Services, or E-3: Recipient Rights for Psychiatric Inpatient Services, attached hereto, as the case may be.

26. Home and Community Based Services ("HCBS"). Provider must ensure that Covered Services, including Adult Foster Care ("AFC") or specialized residential, skill-building, supported employment, community living supports, prevocational services, or out-of-home vocational service, where individuals are supported by funds from any Medicaid 1915(c) waiver program are provided in settings that maintain home and community character as required by Federal regulation and the resultant, Michigan-specific, HCBS Transition Plan. Provider agrees to cooperate with CMHSP, LRE, or MDHHS, including any authorized representatives, in any activities, including but not limited to surveys, site reviews, or other evaluation efforts pertaining to implementation of HCBS requirements.

27. Choice of Provider. Provider, to the extent possible, and as appropriate, will allow Covered Persons to choose their health care professional.

28. Disability Rights Michigan ("DRM"). Provider will allow persons who properly identify themselves as representatives of DRM access to the premises, Covered Persons, and records pertaining to those Covered Persons, in compliance with the Michigan Mental Health Code and applicable Federal law. If DRM receives a complaint or has probable cause to suspect abuse or neglect, the following conditions must be met before DRM may have access to records of a Covered Person, in accordance with 45 CFR §164.512(c), (e), and (f):

    A. DRM must demonstrate it has the authority to access a Covered Person's record under the Mental Health Code and applicable Federal law.

    B. DRM must request the Covered Person's records in writing.

    C. Provider may question DRM's authority if it is unclear, must limit the disclosure to the relevant information expressly authorized by statute or regulations, and must maintain documentation of all disclosures.

29. Quality Improvement ("QI"). Provider will maintain a systemic QI process to measure, evaluate, and improve clinical and administrative performance, including cooperation with CMHSP and LRE QI Plans and Policy and Procedure.

    A. Provider will participate in CMHSP and LRE activities pertaining to performance improvement, including but not limited to, credentialing and re-credentialing processes; assessing the satisfaction of Covered Persons and other stakeholders; evidence of active participation of Covered Persons served; utilization of standardized performance measures; gathering and utilizing performance data; reporting and reviewing adverse events; and documentation of complaints and action(s) taken in response to complaints.

    B. Provider agrees to engage in activities as required by CMHSP or LRE pertaining to performance improvement and quality assurance and quality improvement, including but not limited to, participation or completion of Corrective Action Plans ("CAP") or specific activities to address performance deficiencies.

    C. Provider agrees to establish and monitor performance indicators for the purposes of identifying process improvement projects that achieve a beneficial effect on health outcomes, clinical or administrative performance, and the satisfaction of Covered Persons.

30. Cultural Competence. Covered Services pursuant to this Agreement shall be provided in a manner demonstrating an ongoing commitment to linguistic and cultural competence that promotes access and meaningful participation for all Covered Persons, including but not limited to, acceptance and respect for diverse cultural values, beliefs, and practices, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of Covered Services.

    A. To effectively demonstrate commitment to culturally competent Covered Services, Provider must have five (5) components in place:

        1. A method for assessing the cultural needs of Covered Persons being served.
        2. Sufficient policy and procedure to reflect Provider's value and practice expectations.
        3. A method of service assessment and monitoring.
        4. Ongoing training to ensure staff are aware of, and able to effectively implement, policy.
        5. The provision of Covered Services within the cultural context of Covered Persons served by Provider.

    B. Provider shall participate in CMHSP's efforts to promote the delivery of Covered Services in a culturally competent manner to all Covered Persons, including those with LEP and diverse cultural and ethnic backgrounds.

31. Notifications. Provider will notify CMHSP, in writing, when there is a change of status resulting in any of the following:

    A. Loss of insurance.
    B. Qualified opinion on financial audit or financial review.
    C. Pending or successful litigation claim against Provider.
    D. Loss of SUD treatment, prevention, or DEA license or MDHHS certification.
    E. Any change in state licensure or certification, including but not limited to, termination, revocation, suspension, or investigation.
    F. Loss of or change in accreditation status.

32. Standard Consent Form. For all electronic and non-electronic Health Information Exchange ("HIE") environments, Provider will follow CMHSP and LRE Policy and Procedure requiring Parties to use and accept the standard release form MDHHS-5515 created under 2014 PA 129.

33. Transporting Covered Persons. Provider shall promulgate policy and implement proactive practices to ensure only responsible staff with an appropriate and valid driver's license, as required by State law, operate motor vehicles while transporting Covered Persons, including measures to ensure safe transportation of Covered Persons and verification of automobile insurance coverage. Provider will ensure vehicles that are used to transport Covered Persons, whether directly owned or leased by Provider, or owned or leased by staff, or owned or leased by any other party, are maintained in safe working order.

34. Media Releases. Any news releases, including promotional literature and commercial advertisements, which contain specific reference to CMHSP, LRE, or MDHHS, or pertain to this Agreement, must not be made without prior written approval from CMHSP or LRE, as the case may be, and then only in accordance with the explicit written instructions of CMHSP or LRE, and/or CMHSP or LRE's Media Policies, as the case may be.

35. Notices to Covered Persons. Provider, if delegated by CMHSP, shall:

    A. Annually provide Covered Persons with information on recipient rights and protections as required by the Mental Health Code.

    B. Ensure that Covered Persons are informed of their right to be free from any forms of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

    C. Record in the health record compliance with this Section.

36. Covered Persons. Provider or any health care professional employed or contracted by Provider operating within the lawful scope of practice and with consent of Covered Person or their legal representative may not be restricted from advising or advocating on behalf of a Covered Person for the following:

    A. Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

    B. Any information the Covered Person needs to decide among relevant treatment options.

    C. The risks, benefits, and consequences of treatment or non-treatment.

    D. The Covered Person's right to participate in decisions regarding their health care, including the right to refuse treatment and the right to express preferences about future treatment decisions.

37. Service(s) to Covered Persons Out of County. When Provider assumes responsibility for serving a Covered Person from any other county of financial record ("COFR"), other than the CMHSP named in this Agreement, Provider retains responsibility for meeting the service needs of that Covered Person until (1) the financial responsibility is expressly and knowingly assumed by CMHSP or (2) the Covered Person relocates to another state or service area by choice. In any event, CMHSP bears no financial responsibility, nor will Provider seek nor expect reimbursement in whole or in part from CMHSP, for Covered Services provided to Covered Persons for which CMHSP is not the COFR.

38. Collaboration and Joint Planning. Provider is expected to and shall assist CMHSP or LRE, as the case may be, with the planning and management of the system of care, with the goal of this partnership to ensure quality services to Covered Persons, timely and proactive decision making, enhancement of community involvement, design and implementation of services that are responsive to the needs of Covered Persons.

39. Selected Block Grant Requirements. The following provisions are only applicable to Providers operating under specific Mental Health or SUD Block Grant Funding. As applicable, Block Grant funding:

A. Shall not be used to pay for inpatient hospital services except under conditions specified in Federal law.

B. Shall not be used to make cash payments to intended recipients of services.

C. Shall not be used to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or any facility, or purchase major medical equipment.

D. Shall not be used to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funding.

E. Shall not be used to provide Covered Persons with hypodermic needles for the use of illegal drugs.

F. Shall not be used to enforce State laws regarding the sale of tobacco products to individuals under the age of twenty-one (21).

G. Shall not be used to pay the salary of an individual at a rate in excess of Level I of the Federal Executive Schedule, or approximately $199,700 annually.

VI. PROVIDER ELIGIBILITY REQUIREMENTS.

1. Exclusion Monitoring and Attestation. Federal regulations and State law preclude reimbursement for any services ordered, prescribed, or rendered by any provider who is currently suspended or terminated from direct or indirect participation in the Michigan Medicaid program of Federal Medicare program. Provider must ensure the Exclusion of Certain Persons and Entities from Participation in Medicare and State Health Care Programs, including Social Security Act Sections 1128, 1128A, 1156; 42 CFR §438.214, §455.100. Provider attests that:

   A. Provider and its subcontractors, as applicable, Board of Directors, and employees are not debarred, suspended, proposed for debarment, declared ineligible, or excluded from a Federal or State health care program.

   B. Provider and its subcontractors, Board of Directors, and employees have not been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract; violation of Federal or State antitrust statute; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property.

   C. Provider and its subcontractors, Board of Directors, and employees are not indicted or otherwise criminally or civilly charged by a government entity (Federal, State, or local).

   D. Provider and its subcontractors, Board of Directors, and employees 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.

   E. Provider shall ensure an initial examination of Federal and State databases of excluded Parties and litigation checks are conducted on Provider's employees and board members. Such examination shall take place at the time of hire, and

monthly thereafter, for all Provider employees, members of the Provider's Board of Directors, and, if applicable owners or those with controlling interests.

F. Provider will notify CMHSP immediately when there is litigation initiated against Provider.

G. Provider shall immediately disclose to CMHSP any information regarding the ownership or control by a person convicted of a criminal offense described under Sections 1128(a)(b) and 1128(b)(1)-(3) of the Social Security Act and if any employee, whether directly hired or under contract, any member of the Board of Directors, or any person with any arrangement with Provider has been convicted of a criminal offense described under Section 1128A of the Social Security Act.

H. Provider agrees to notify CMHSP of any threatened, proposed, or actual exclusions of Provider or its staff from any Federally-funded health care program.

2. Disclosure of Ownership. In accordance with 42 CFR §455.104-106, and pursuant to Sections 1128 and 1128a of the Social Security Act, disclosure of ownership, controlling interests, and management from Provider is a condition of participation under the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program. Provider hereby agrees to provide ownership, controlling interests, and management information as required pursuant to its obligations under State and Federal disclosure regulations, law, or rules. Failure to provide this information shall constitute a material breach of this Agreement, subject to termination as provided herein.

3. Proof of Authority to do Business. Provider shall furnish CMHSP notice of proof of Provider's authority to conduct business in the State of Michigan and in what business capacity (Corporation, etc.), prior to commencing the provision of Covered Services under this Agreement, and with notice of any related organization of Provider per alliance, affiliation, joint venture, parent/subsidiary, or other business relationships that Provider is a party to during the term hereunder.

4. Conflict of Interest. Provider affirms that no principal, representative, agent, or employee of Provider or anyone acting on behalf of or legally capable of acting on behalf of Provider shall engage in activities which are incompatible or in conflict with the discharge of their duties and responsibilities under this Agreement. Provider represents that no employee, officer, or agent of Provider has participated in the selection, aware, or administration of this Agreement, which involved a conflict of financial or other interest that is either real or apparent. Provider agrees that no principal, representative, agent, employee, or anyone acting on behalf of or legally capable of acting on behalf of Provider is currently an employee of CMHSP nor is any person using or privy to insider information which would give the appearance of providing an unfair advantage to Provider. Provider must immediately complete and return to CMHSP Attachment J: Conflict of Interest with this executed Agreement.

5. Licensure and Certification. Provider agrees to maintain in full force and effect any licensing required as a condition of performing Covered Services and to ensure Covered Services will be provided by staff who are duly licensed or certified under applicable State statutes and regulations.

A. Provider will maintain policies and procedures to ensure that contracted physicians and other health care professionals are licensed by the State of Michigan and provide Covered Services within their scope of licensure or certification. Policies and procedures shall include practices to ensure licenses and certifications are current and valid throughout the Term of this Agreement. Provider must immediately notify CMHSP if any license is lapsed, terminated, revoked, or suspended or if any State licensure or certification is under investigation at any point during the Term of this Agreement.

B. Provider will maintain policies and procedures to ensure that support staff who are not licensed or certified are qualified to perform their jobs, including but not limited to, any requirements in the MPM, any MDHHS certifications, and as required in the MDHHS Behavioral Health Code Charts and Provider Qualifications document.

C. SUD organizations/programs must be licensed or certified, as appropriate, for SUD service provision.

6. Accreditation. Provider may be required to obtain and provide proof of certification from a national accrediting organization recognized by MDHHS and CMHSP, as determined by CMHSP, for some or all services provided under this Agreement. If Provider has accreditation, Provider must immediately notify CMHSP of any change or cancellation in accreditation status. Accreditation by the following accrediting organizations is accepted under this Agreement:

   A. CARF International.

   B. The Joint Commission (TJC).

   C. Council on Accreditation for Families and Children (COA).

   D. The American Osteopathic Association (AOA)

   E. National Committee on Quality Assurance (NCQA).

   F. Accreditation Association for Ambulatory Health Care (AAAHC) may be used for SUD Providers only.

   G. Utilization Review Accreditation Commission (URAC), which is not applicable to SUD Providers.

   H. Other accrediting organizations may be considered for approval in writing by CMHSP.

7. Credentialing. Provider must maintain policies and procedures consistent with CMHSP and LRE Policy and Procedure pertaining to personnel selection, credentialing, re-credentialing, and privileging, including but not limited to, job descriptions or similar documentation that describes specific credentialing, privileging, or other requirements for all staff that deliver Covered Services to Covered Persons and including mechanisms to ensure requirements are met by all staff consistent with MDHHS Policy and Procedure.

   A. Provider, if requested, will submit to CMHSP or LRE verification of staff credentials or qualifications pursuant to Covered Services provided.

B. Provider will ensure staff credentials are consistent with Medicare and Medicaid regulations, and other applicable laws, regulations, and rules, including the Michigan Behavioral Health Code Charts and Provider Qualifications, as revised, and the MPM, as revised.

8. Criminal History Checks. Provider will require and conduct criminal background checks prior to hire, and at least every two years thereafter, for all persons (staff, management, and non-management) providing services to or interacting with Covered Persons or persons (staff, management, and non-management) who have authority or ability to access or create any financial or Covered Person records pursuant to this Agreement.

   A. Criminal history checks must be completed through the State of Michigan Licensing Regulatory Affairs ("LARA") Workforce Background Check System (also known as "Rapback"); Internet Criminal History Access Tool ("ICHAT"); or other service as approved by LRE.

   B. Provider shall have written procedures in place to respond to criminal history reports.

   C. Provider shall notify CMHSP immediately if any board member has been convicted of a felony or misdemeanor related to patient abuse, health care, or any type of fraud, a controlled substance, or any obstruction of any investigation.

9. Insurance Requirements. Provider shall maintain liability insurance during the Term of this Agreement. The liability insurance policy shall provide limits which are consistent with industry standards based upon Covered Services provided by Provider under this Agreement in compliance with Attachment C: Insurance Requirements. CMHSP shall be identified as an additional insured on the liability insurance policy required above to the extent the additional insured is held responsible for the acts, omissions, or negligence of Provider pertaining to Provider's work pursuant to this Agreement. Evidence of required insurance must be provided to CMHSP.

   A. The insurance company providing liability insurance shall be an authorized or eligible unauthorized State of Michigan insurer.

   B. Provider shall give CMHSP written notice of any changes in or cancellation of the insurance policies required to be maintained by Provider at least fifteen (15) days before the effective date of such changes or cancellations. If Provider's insurance coverage is at any time throughout the Term of this Agreement reduced or terminated, CMHSP may terminate this Agreement effective immediately upon delivery of notice of termination to Provider.

   C. Failure to comply with any provision of this Subsection shall constitute a material breach of this Agreement, subject to termination as provided herein.

VII. STANDARD CONTRACT PROVISIONS.

1. Non-Exclusivity. This Agreement is not exclusive, and nothing contained within shall be construed to restrict the right of either Party to enter into other similar contracts or arrangements.

2. Amendment. Amendments to this Agreement must be made in writing and signed by the Parties. However, CMHSP may amend this Agreement or Attachments without written

agreement from Provider if such amendment is necessary to comply with Federal or State statutes, regulations, or as otherwise required by CMHSP's funders, and/or in such cases where modification is non-material and may reasonably be construed to be to the benefit of Provider. Such amendment may be made by prompt written notice from CMHSP to Provider and be incorporated therein by reference.

3. Delegation. The Provisions of the Balanced Budget Act of 1997 ("BBA"), allow states to establish protections for Covered Persons in areas such as quality assurance, grievance and appeal rights, and customer service. Notwithstanding any other provision in this Agreement, CMHSP is required to oversee and be accountable for any administrative function or responsibility it has delegated or assigned to Provider, pursuant to 42 CFR §438.230(b)(2), including provisions allowing for the revocation of delegation or assignment, or the imposition of other sanctions, if Provider's performance is inadequate.

4. Notice Provision. Any and all notices, designations, consents, offers, acceptances, or other communications herein shall be given to either Party, in writing, by facsimile, electronic transmission, personal delivery, or certified mail to the other Party as follows, or at such other address as the Parties shall provide each other in writing after execution of this Agreement:

CMHSP		**Provider**	
Person/Title:	Lynne Doyle, MPA, MA, LLP, Executive Director	Person/Title:	
CMHSP:	Community Mental Health of Ottawa County	Provider:	
Address:	12265 James Street	Address:	
City/State/Zip:	Holland, MI 49424	City/State/Zip:	
Fax #:	616-393-5687	Fax #:	
E-mail:	ldoyle@miottawa.org	E-mail:	
CC:	cmhcontractservices@miottawa.org	CC:	

5. Assignment. This Agreement shall be binding upon and inure to the benefit of the respective legal successors and assignees of the Parties. However, neither this Agreement, nor any rights or obligations hereunder may be assigned by operation of law or otherwise, delegated, transferred in whole or in part, without the prior written consent of the other Party. "Assign" here shall include assignment to any successor in interest from a merger, acquisition, reorganization, or sale of all or substantially all of a Party's assets. Any attempted assignment in violation of this provision shall be void.

6. Liability of Provider. All liability, loss, or damage as a result of claims, demands, costs, or judgment arising out of activities to be carried out pursuant to the obligations Provider under this Agreement shall be the responsibility of Provider, and not the responsibility of CMHSP and/or LRE if the liability, loss, or damages are caused by, or arises out of, the actions or failure to act on part of Provide or its employees or agents. Provider agrees to hold harmless CMHSP and/or LRE, as the case may be, from and against all loss, liability, or expense that may be incurred, including reasonable attorney fees and costs by reason of any claim arising out of or in connection with Provider's work under this Agreement.

7. Liability of CMHSP. All liability, loss, or damage as a result of claims, demands, costs, or judgment arising out of activities to be carried out pursuant to the obligations of CMHSP

or LRE, as the case may be, under this Agreement shall be the responsibility of CMHSP or LRE, as the case may be, and not the responsibility of Provider, if the liability, loss, or damages are caused by, or arises out of, the actions or failure to act on the part of any CMHSP or LRE, or its employees or agents, provided that nothing herein shall be construed as a waiver of any governmental immunity CMHSP or LRE, or its employees or agents, have as provided by statute or modified by Court decisions.

8. Governing Law. This Agreement shall be governed by and enforced in accordance with the laws of the State of Michigan as to the interpretation, construction, and performance.

9. Dispute Resolution. Issues arising between CMHSP and Provider involving contractual terms or performance of either Party pursuant to this Agreement will be addressed utilizing CMHSP dispute resolution processes. Disputes that cannot be resolved through CMHSP's contract dispute process shall be reviewed by LRE upon Provider request and consistent with LRE's Policy for dispute resolution. Notwithstanding any of the above, either Party may seek any available legal and/or exhaustion of remedies to resolve disputes.

    A. All decisions to authorize, continue, or discontinue CMHSP payments for Covered Services to Covered Persons will be those of the CMHSP's Executive Director or designee.

10. Severability. If any provision of this Agreement, or any portion thereof, is held to be invalid and unenforceable, then the remainder of this Agreement shall nevertheless remain in full force and effect.

11. Website Incorporation. CMHSP is not bound by any content on Provider's website unless expressly incorporated by reference into this Agreement.

12. Entire Agreement. This Agreement, its referenced Attachments, and any Policy or Procedure, laws, rules, regulations, or statutes incorporated herein by reference, are intended by the Parties to constitute the entire and integrated understanding between them and supersedes all previous agreements related to the subject matter, such previous agreements being void and having no force and effect.

13. Waivers. No failure or delay on the part of either of the Parties to this Agreement in exercising any right, power, or privilege hereunder shall operate as a wavier, 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. In no event shall the making by CMHSP of any payment to Provider constitute or be construed as a waiver by CMHSP 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 CMHSP while any such breach or default shall exist, shall in no way impair or prejudice any right or remedy available to CMHSP in respect to such breach or default.

14. Binding Effect. This Agreement shall be binding upon CMHSP and Provider and their respective successors and permitted assigns.

15. Disregarding Titles. The titles and 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.

16. Completeness of Agreement. This Agreement, Attachments, and additional and supplementary documents incorporated herein by specific reference contain all terms and conditions agreed upon by CMHSP and Provider and no other agreements, oral or written, regarding the subject matter of this Agreement or any part thereof shall have any validity to bind either CMHSP or Provider unless this Agreement is amended as provided for herein.

17. Certification of Authority to Sign This Agreement. The person(s) signing this Agreement on behalf of the Parties hereto certify by said signatures that they are duly authorized to sign this Agreement on behalf of said Parties and that this Agreement has been authorized by said Parties. This Agreement shall be deemed executed, valid, enforceable, and binding upon the Parties once signed in handwriting or by any electronic means and may be delivered by facsimile or electronic transmission.

[SIGNATURE PAGE TO FOLLOW]

IN WITNESS WHEREOF, the authorized representatives of the Parties hereto have fully executed this Agreement on the day and year first written above.

FOR PROVIDER:	**FOR CMHSP:**
Provider Name	Community Mental Health of Ottawa County
Street Address	12265 James Street
City, State, Zip	Holland, Michigan 49424
By: [[SertifiSStamp_1]]	**By:** [[SertifiSStamp_2]]
Its: [[SertifiTitle_1]]	**Its:** Executive Director
By: [[SertifiSStamp_4]]	**By:** [[SertifiSStamp_5]]
Its: Chairperson, County Board of Commissioners	**Its:** Clerk/Register, County of Ottawa

CMHOC Contract Manager: [[SertifiSStamp_3]]

ATTACHMENT A
COVERED SERVICES

CMHSP: Community Mental Health of Ottawa County
Provider:

Reimbursement for the Covered Services indicated below can be found as described in Attachment B: Reimbursement Terms. The provision of Covered Services by Provider are subject to the provider requirements as defined in the Michigan Medicaid Provider Manual.	
☐ Assertive Community Treatment	☐ Assessments
☐ Behavior Treatment Review	☐ Behavioral Health Treatment/ABA
☐ Children's Waiver	☐ Clinical Services (OT, PT, SLP)
☐ Clubhouse	☐ Community Living Supports (CLS)
☐ Crisis Intervention	☐ Crisis Residential
☐ Direct Prevention	☐ Enhanced Pharmacy
☐ Family Support and Training	☐ Fiscal Intermediary
☐ Health Services	☐ Home-Based Services
☐ Housing Assistance	☐ Individual/Group Therapy
☐ Intensive Crisis Stabilization	☐ Nursing Facility Mental Health Monitoring
☐ OBRA PAS/ARR	☐ Peer-Delivered and Peer Operated Supports
☐ Personal Care- Residential Setting	☐ Private Duty Nursing
☐ Psychiatric Services	☐ Respite Services
☐ SED Waiver	☐ Skill Building Non-Vocational
☐ SUD Community-Based Treatment	☐ SUD Medication Assisted Treatment (MAT)
☐ SUD Outpatient Treatment	☐ SUD Residential and Recovery Residences
☐ SUD Residential Withdrawal Management	☐ Supported Employment
☐ Supports Coordination	☐ Targeted Case Management
☐ Transportation	☐ Treatment Planning
☐ Wraparound Services	☐ Other:

Attachments to Services Agreement. Attachments can be located at: Resources - Ottawa County, Michigan (miottawa.org). All posted attachments should be considered the most current and up-to-date.	
☒ C: Insurance Requirements	☒ D: Contract Monitoring/PQR
☒ E-1: RR for Mental Health	☐ E-2: RR for SUD
☐ E-3: RR for Inpatient Psychiatric Services	☒ F: Performance Indicators
☒ H: Delegated Functions	☒ I: Training Requirements
☒ J: Conflict of Interest	☐ K: DCOs

ATTACHMENT B
REIMBURSEMENT TERMS

CMHSP: Community Mental Health of Ottawa County
Provider:

For medically necessary covered services rendered to Covered Persons by Provider, in accordance with the terms of this Agreement, Provider shall accept as payment in full the lesser of (1) Provider's billed charges or (2) the rates as described in the compensation schedule below or inserted into CMHSP's current electronic system, including the following required elements: billing code; modifier (if applicable); service description; reporting unit; reimbursement rate.

☐ Billing codes and rates for authorized services can be found electronically at: _____.
☒ Billing codes and rates for authorized services are defined in the Compensation schedule below.

Code	Modifier (if applicable)	Service Description	Reporting Unit	Rate

Codes must be consistent with the definitions outlined in the MDHHS PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes document.

1) **Provider Responsibilities:**

   a) Provider shall submit clean and timely claims for reimbursement for services authorized and rendered under this Agreement. By submitting claims for reimbursement, Provider attests that the billed services and corresponding documentation have been completed in compliance with the reimbursement requirements of CMHSP, the PIHP, the MDHHS, Medicaid, Medicare, and/or third-party payors.

   b) **Eligibility Monitoring:** It is the Provider's responsibility to monitor and verify funding eligibility for clients receiving services from Provider on behalf of CMHSP. This includes identifying any and all primary payors. Any changes to a client's funding eligibility or changes in a client's Coordination of Benefits must be reported to CMHOCFINANCE@miottawa.org in a timely manner.

c) **Ability to Pay Monitoring:** It is the Provider's responsibility to verify and calculate the Ability to Pay (ATP) for Covered Person receiving services from Provider on behalf of CMHSP. The Covered Person's ATP should be verified/calculated at the onset of services and at least annually thereafter. Additionally, if the Covered Person experiences a significant change in financial status, the Provider shall update the ATP and report the change(s) to CMHOCFINANCE@miottawa.org.

d) **Coordination of Benefits:** It is the Provider's responsibility to identify and seek reimbursement from any and all primary payors for services being provided on behalf of CMHSP. This may include, but is not limited to, Medicare, commercial insurance, Ability to Pay, etc. It is the Provider's responsibility to ensure that the requirements of all primary payors are followed. Medicaid is the payor of last resort.

e) **Clean Claims:** According to MDHHS requirements, in order to be considered clean claims, the Provider shall submit claims that are timely, complete, accurate, and ready for processing without obtaining additional information from the Provider or third party. If Coordination of Benefits is required, evidence that the Provider billed the primary payor shall be included with the claims.

f) **Timely Billing:** The Provider shall submit claims to CMHSP in a timely manner.

   i) The Provider shall bill CMHSP either monthly or semimonthly. Any alternate billing schedule must be approved, in advance, by CMHSP.

   ii) If Coordination of Benefits is not required, claims submitted more than 60 days after the date of service will be denied, except as detailed in section f.iv. of this document.

   iii) If Coordination of Benefits is required for a claim, the Provider shall submit the claim to CMHSP within 90 days of receipt of the EOB from the third-party payor. The claim shall include the third-party EOB as evidence that the primary payor was billed. Regardless of the EOB date, claims submitted more than 365 days after the date of service will be denied, except as detailed in section f.iv. of this document.

   iv) The CMHSP's fiscal year is October 1 through September 30. At the end of the CMHSP's fiscal year, all claims for the fiscal year are due to CMHSP by 2nd Friday of October of the following fiscal year. Any disputed claims, resubmissions, or claims awaiting Coordination of Benefits must be reported to CMHOCFINANCE@miottawa.org by 2nd Friday of November. Claims not submitted by these deadlines may be denied.

   v) A rejected 837 claim is not a valid claim submission and will not be considered in timely filling decisions for payment.

   vi) Previously denied claims should be corrected and re-billed to the CMHSP within 60 days from the date of denial for re-processing and reimbursement. Re-billed claims submitted more than 60 days from the date of denial will be ineligible for payment.

g) **Claim Submission Method:** The Provider shall submit claims via CMHSP's electronic billing system, ProviderConnectNX, or by 837 electronic file which has been validated through testing by CMHSP (refer to the 837 Companion Guide located in the CMHSP website under Community Provider Resources). Any alternate methods of billing must be approved, in advance, by CMHSP. When Coordination of Benefits is required, the third-party EOB(s) should be submitted by secure email or fax when the billing batch is submitted to CMHSP.

h) **Total Payment:** The Provider may not bill Covered Person for the difference between the Provider's charge and the CMHSP's payment for services. The Provider shall not seek nor accept additional supplemental payment from the Covered Person, his/her family, or representative, for services authorized by the CMHSP.

i) **Post-Payment Review:** The Provider shall provide any relevant information requested by CMHSP to conduct post-payment review of claims. If services or documentation are identified that are not in compliance with the requirements of CMHSP, the PIHP, the MDHHS, Medicaid, Medicare, and/or third-party payors, payback of funds may be required.

Services must be reported consistent with requirements outlined in the MDHHS Reporting Requirements as periodically updated. The reporting requirements are available at:

Reporting Requirements (michigan.gov)

j) CMHSP is not independently responsible for payment under this contract except through the PIHP or its federally compliant risk reserve funded by the State of Michigan.

2) **CMHSP Responsibilities:**

a) The CMHSP shall adjudicate claims in a timely manner. Except in unusual circumstances, payment shall be issued for approved claims within thirty (30) days following the receipt of a clean claim from the Provider.