Macomb County Community Mental Health Services
2016 - 2018 Specialty Service Contract
Index

Incorporated Attachments:

FISCAL YEAR 2016/2017 - 2017/2018
SPECIALTY SERVICES CONTRACT
BETWEEN
MACOMB COUNTY COMMUNITY MENTAL HEALTH SERVICES BOARD
and

AGENCY NAME:

ADDRESS:

TELEPHONE:

E-MAIL ADDRESS:

FEDERAL I.D. #:

FOCUS VENDOR I. D.#:

PROGRAM NAME:
(FOCUS PROVIDER I.D. #)

I. PARTIES

This contract (the "Contract") is between the Macomb County Community Mental Health Service Board (the "BOARD"), an agency of the County of Macomb, (the "COUNTY"), and

_____ (the "AGENCY"), and supersedes all previous contract(s) between these parties. MCCMH shall refer to Macomb County Community Mental Health.

This contract is entered into under the authority granted by Act 258 of the Public Acts of 1974, as amended, and in accordance with the rules and regulations adopted by the Michigan Department of Health and Human Services (MDHHS)under Act 258. Macomb County Community Mental Health Services Board ~ Managed Care Organization policies and policies established in accordance with MCL 330.1204(2) shall govern in any area not specifically specified otherwise in the contract. All of the BOARD's contracts listed on Appendix X to this Contract including, but not limited to the BOARD's Pre-paid Inpatient Health Plan (PIHP) contract, its MDHHS – MCCMH CMHSP Managed Specialty Services and Supports Contract, and other contracts with (MDHHS) (including but not limited to the contracts for the 1115 demonstration, additional waivers, and dual eligibles) are incorporated by reference as material terms of this Contract insofar as they pertain to AGENCY's qualifications, obligations, personnel and reimbursement/payment. Appendix X shall be deemed automatically amended whenever BOARD executes a new contract with a governmental or private entity. Promptly upon such execution, Board will cause to be added to the Appendix X posted on BOARD's or MCCMH's website a copy of the new BOARD contract or excerpts thereof or a summary of the provider requirements under the contract including, but not limited to, all requirements for downstream providers or downstream contracts or contractors, regardless of whether such terms are or are not capitalized in such contracts. Each such summary is referred to as a "Contract Requirements Summary" and collectively, the "Contract Requirements Summaries". Anything in this Agreement to the contrary notwithstanding, the terms of the BOARD's CMHSP general fund contract shall apply to AGENCY only if AGENCY received consumers through general fund allocation.

The following Sections are attached hereto and incorporated by reference as material terms of this Contract:

Section "A"	Provider Profile Application;
Section "B"	Specialty Services Requirements/Documentation Grid;
Section "C"	Quality Management Measures;
Section "D"	Reimbursement and Claims Processing;
Section "E"	Incorporated Administrative Procedures;
Section "F"	Recipient Rights Protection Requirements;
Section "G"	Privileging Clinical Staff by License and Payer Coverage;
Section "H"	Delegated Functions;
Section "I"	Mandatory Training Requirements
Section "J"	Recovery; and
Appendix "X"	Incorporated BOARD Contracts

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IMPORTANT: **THIS CONTRACT AND BOARD'S OBLIGATIONS UNDER IT ARE CONDITIONED UPON THE BOARD'S RECEIPT OF FUNDS SUFFICIENT TO DISCHARGE THOSE OBLIGATIONS AND THE ABSENCE OF A MATERIAL CHANGE IN THE BOARD'S FUNDING OR IN THE FUNDING METHODOLOGY FOR ANY CONTRACT OR PROGRAM.**

II. SCOPE AND PURPOSES

The purpose of this contract is to provide authorized mental health specialty services, as described in Section B (the "Contracted Services"), for persons referred to the AGENCY by the BOARD. These specialty services shall encourage individuals to be:

Empowered to exercise choice, control and self-determination over all aspects of their lives, involved in meaningful relationships with family and friends, supported to live with family while children, and independently as adults, engaged in activities that are meaningful, such as school, work, social recreation and volunteering fully in community life and activities. Individuals will be offered services, programs, and activities that will be provided in the most integrated setting appropriate to the needs of the individual. They will be offered housing and employment opportunities that meet their needs at any given time in their lives. The concepts Recovery and Resiliency will be utilized and supported for all individuals.

III. ETHICS AND EQUAL OPPORTUNITY

A. Ethics

No principal, representative, or agent of the AGENCY is currently an employee of the COUNTY. Nor shall any such person use insider information which secures or gives the appearance of an unfair advantage to the AGENCY in bid processes, contract procurement or related monetary gain. A breach of this condition may be regarded by the BOARD as a material breach of the contract and shall subject this contract to termination. The Macomb County Ethics Ordinance, No. 2011-10, is incorporated by reference into this contract.

B. Equal Opportunity

The AGENCY shall not discriminate against an employee or an applicant for employment with respect to hiring, tenure, terms, conditions, or privileges of employment, or with respect to a matter directly or indirectly related to employment on the basis of race, color, religion, national origin, gender, sexual orientation, height, weight, marital status, handicap, ancestry, age, political affiliation, known association or relationship with an individual with a disability, or other legally protected status . The AGENCY shall not discriminate against the BOARD's recipients or members of the public on the basis of race, color, religion, national origin, age, gender, ancestry, political affiliation, sexual orientation, height, weight, marital status, arrest record,

ability to pay, commitment status, disability, or known association or relationship with an individual with a disability, or other legally protected status. A breach of this condition may be regarded by the BOARD as a material breach of the contract and shall subject this contract to termination.

IV. AGENCY RESPONSIBILITIES

A. Provider Panel Requirements - General

The AGENCY shall:

1. Be responsible for the delivery of the Contracted Services and for the establishment of sufficient administrative capabilities to carry out the requirements and obligations of this Contract. The AGENCY shall report applicable administrative changes (including but not limited to changes in name, address, relocation of panel provider service site, etc.) within five (5) business days to the BOARD. However, if there is an emergency situation related to consumers (including but not limited to relocation of consumers due to licensing issues, home closure due to fire, etc.), the AGENCY will notify the BOARD within twenty-four (24) hours.

2. Provide the Contracted Services in the most integrated setting appropriate to their needs, as described in Section B of this Contract, to Macomb County residents assuring the application of the Person Centered Planning process to treatment and as authorized by the BOARD's Access Center.

3. Employ a sufficient workforce of persons with lived experiences across all levels who are paid fair and competitive wages commensurate with their position and with other employees of the same pay grade, and provide multiple opportunities for full and/or part-time positions, and a viable career ladder.

4. Make affirmative efforts to employ individuals with disabilities - recruit, place, with competitive pay scales, fringe benefits, and training included.

5. Implement MCCMH medical necessity criteria in determining specific services for a consumer. Medical necessity is commonly defined as a determination that a specific service is medically (clinically) appropriate, necessary to meet the consumer's behavioral health needs, consistent with the consumer's diagnosis, symptomatology and functional impairments, is the most cost effective option in the least restrictive environment, is consistent with clinical standards of care, and not primarily for the convenience of the consumer, consumer's family, or AGENCY. In addition, the AGENCY shall also consider social services, community, and natural supports that are crucial for full participation in community life, must apply person-centered planning for consumers with behavioral health, intellectual and developmental disabilities, and substance use disorder needs and must consider physical conditions, environmental factors and

other available resources that might address the treatment needs of the consumer. The criteria are intended to ensure appropriate access to care, protect the rights of consumer and facilitate an appropriate matching of supports and services to consumer needs.

7. Support consumers with disabilities to have person-centered, integrated, and competitive employment opportunities commensurate with their abilities, aptitude, and desires.

8. Protect vulnerable persons served and offer opportunities for them to:
   a. live successfully in the community;
   b. work in jobs/ways meaningful to them; and
   c. develop and maintain personal, stable, rewarding relationships.

9. Link consumers to accurate and timely information for continuation of federal/state benefits while preparing for and becoming competitively employed.

10. In person-centered planning, address current physical health conditions, health care practitioners available to address physical health conditions, and other assistance needed (referral, coordination, transportation, etc.) to access health practitioners.

11. Comply with the standards and administrative procedures as stipulated by the BOARD in Section E of this Contract.

12. Provide Contracted Services in a manner which complies with the requirements and service descriptions contained in the most current version of the MDHHS Michigan Medicaid Provider Manual and Michigan Mental Health Code.

13. Maintain clinical documentation of Contracted Services delivered by the AGENCY in accordance with each consumer's person-centered plan as authorized by the BOARD and provide timely encounter data to the BOARD on all services provided by the AGENCY at intervals required by the BOARD.

15. Utilize FOCUS as AGENCY's Electronic Medical Records Package, subject only to any variation approved in writing by the BOARD (Outpatient, Case Management, and Supports Coordination AGENCIES). In such case, AGENCY shall be solely responsible for all costs incurred by BOARD as a result of AGENCY's failure to use FOCUS including, but not limited to, all costs of accessing, obtaining, converting and translating AGENCY's data and reports to permit their use with FOCUS. In such case, AGENCY shall be solely responsible for all costs incurred by BOARD as a result of AGENCY's failure to use FOCUS including, but not limited to, all costs of accessing, obtaining, converting and translating AGENCY's data and reports to permit their use with FOCUS. BOARD may offset such costs against any sum otherwise payable to AGENCY

under this Contract.

16. Comply with all policies and procedures determined by the Office of the County Executive.

17. Comply with the BOARD's Managed Care Organization Policies and Procedures Manual (BOARD's MCO Policy Manual), and applicable MCCMH Executive Directives, including compliance with all Recipient Rights Protection Requirements and Compliance Alerts.

18. Comply with all applicable local, state and federal statutes, regulations and administrative procedures that are in effect during the term of this Contract. Federal regulations governing the BOARD with risk-based managed care plans are specified, *inter alia*, in Section 1903(m) of the Social Security Act, 42 CFR Part 434, and applicable provisions of the Balanced Budget Act of 1997, and will govern the Medicaid portions of this Contract. Subject to the preceding sentence, pertinent state statutes will govern this Contract. The State and BOARD are obligated to require implementation of any changes in federal statutes and regulations and state statues, rules, and administrative procedures effective during the term of the Contract and applicable to any BOARD contracts.

19. Cooperate with the BOARD and its Behavioral Health - Managed Care Organization responsibilities to include Service Authorization functions, Provider Network Management functions, Financial Management functions, Utilization Management functions, Credentialing functions, Coordination of care, critical risk auditing, quality improvement process, consumer relations office, corporate compliance plan and discussion of any issues relevant to the provision of services.

20. The AGENCY shall assure that services to each consumer of the BOARD are coordinated with primary health care providers, including Medicaid Health Plans, and other service agencies in the community that are serving the individual. The AGENCY will implement practices and agreements according to federal and state laws, guidelines and regulations in the implementation of this function.

21. Allow consumer and stakeholder access to clinical and financial records, as applicable to the delivery of services pursuant to the Freedom of Information Act, HIPAA, Michigan Mental Health Code, and the BOARD's Managed Care Organization (MCO) policies and procedures.

22. Utilize the Provider Appeals Process, as provided in the BOARD's MCO Policy Manual, in the event of a dispute related to the service determination (level of care) described in this Contract.

23. Indemnify, defend and hold harmless the BOARD and Macomb County, and their respective elected and appointed officials, successors, assigns, agents, representatives, directors, officers, employees, attorneys and affiliated, entities, and all persons acting by, through, under, or in concert with any of them

(collectively "BOARD Indemnified Parties" or "Board Indemnified Party" individually) from and against any and all demands, claims, actions, causes of action, assessments, losses, diminution in value, damages (including but not limited to special, punitive, consequential, and/or exemplary damages), liabilities, statutory or other penalties, costs and expenses, actual costs and expenses incurred in the defense of any litigation, including but not limited to actual attorneys' fees and any liability (collectively, "Losses"), suffered or incurred by any Board Indemnified Party by reason of, or arising out of, any of the following by way of illustration and not limitation: (a) AGENCY's provision of or failure to provide Contracted Services; (b) AGENCY's breach of any term of this Contract; (b) AGENCY's breach of any representation or warranty to the BOARD Indemnified Parties; (c) AGENCY's fraud, negligence, gross negligence or intentional wrongdoing; and/or (d) AGENCY's violation of any federal statue or regulation or any state statue, rule, or administrative procedure effective during the term of this Contract and applicable to the Board's subcontracts.

24. AGENCY shall provide assurance that pro-active efforts will be made to identify and encourage the participation of minority-owned, women-owned, and handicapper-owned businesses in contract solicitations. AGENCY is prohibited from discriminating against minority-owned, women-owned, and handicapper-owned businesses. Discrimination by AGENCY is a material breach of this contract.

25. Return to the BOARD three (3) executed signature pages, after the AGENCY reviews the materials on the Provider Portal within 90 days of issuance. The AGENCY shall upload required information to the Provider Portal at the time of execution, on an annual basis and upon request of the BOARD. Such information shall include by way of illustration and not limitation:

    a. complete and updated Provider Profile Application (Section A);
    b. supporting documentation to Section A (copies of accreditation/reports, licensures, certifications, professional/corporate liability insurance, Credential Verification Form, Quality Improvement Plan, Staff Training, Criminal Background Checks, Staff NPI numbers, Corporate Compliance Plan, W-9 Form, Provider Disclosure Information Request);
    c. Staff training and FTE information spreadsheet in the prescribed format; and
    d. Staff cost information, upon request.

26. Maintain quarterly business contact with the BOARD's assigned contract manager.

27. For BOARD-contracted provision of direct services to consumers, demonstrate that all staff meet the training requirements specified in and consistent with MDHHS Contract Requirements, the BOARD's MCO Policy Manual, relevant accrediting bodies, and all federal, state, and local laws, guidelines, rules, and regulations.

28. For BOARD-contracted provision of services to children and adolescents, comply with all provisions of Administrative Rules 330, Subpart 6, "Children's Diagnostic and Treatment Services," including the mandatory twenty-four (24) hours of training specific to the treatment and diagnosis of children/adolescents and comply with application of CAFAS for minors 7 to 17 years of age. The cost of related training shall not be billed to the BOARD, nor shall it be paid by the BOARD.

29. Give the BOARD, as holder of the consumer record (1974 PA 258, Sec. 748(1): OAG 1980, No. 5709), unimpeded access to consumer records in any form or medium, i.e., paper or electronic, at the discretion of the BOARD.

30. Be financially solvent prior to commencing performance of the Contracted Services, and give the BOARD immediate written notice of any change, at any time during the term of this Contract, in AGENCY's financial position material to such solvency and to continuing in operation as a going concern.

32. Give the BOARD immediate written notice, to the attention of AGENCY's contract manager at BOARD, of any changes in third party payers that AGENCY is able to bill.

32. Participate in all contracts specified on Appendix X to this Contract, as amended by BOARD from time to time, and comply with all provider requirements under those contracts including, but not limited to, all requirements for downstream providers or downstream contracts or contractors, regardless of whether such terms are or are not capitalized in such contracts, and the requirements specified in the contracts and the Contract Requirements Summaries incorporated into Appendix X to this Contract. AGENCY's participation in each such contract is expressly conditioned upon AGENCY's satisfaction of all criteria for participating provider status under that contract and satisfactory performance of all of its obligations thereunder.

33. In the event and to the extent of any conflict between the terms of this Contract regarding AGENCY's requirements or obligations and the terms of any BOARD contract included on Appendix X, the terms of the BOARD contract included on Appendix X shall supersede and govern.

34. All BOARD mandated reports shall be provided in the manner specified by the BOARD.

B. <u>Provider Panel Requirements - Access to Care</u>

The AGENCY shall:

1. Ensure timely access to supports and services in accordance with the required

standards as identified at a specific point in time. The AGENCY agrees to assist the BOARD in the data collection and completion of Board and state-required data, outcome, and performance indicator measures at the specified points in time. At its sole cost and expense, the AGENCY shall collect and report, in the format specified by the BOARD, performance and outcome measures as required by the BOARD and as described in Section E.

2. Assure equal access for people with diverse cultural backgrounds and/or limited English proficiency, as outlined by the Office of Civil Rights Policy Guidance of the Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency, and the BOARD's MCO Policy Manual.

3. For the supports and services provided by the AGENCY, demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all eligible consumers. Such commitment includes acceptance and respect for the cultural and religious values, beliefs and practices of the community, as well as the ability to apply an understanding of each individual and the relationships of language and culture to the delivery of supports and services.

4. Although transportation to Early Periodic Screening, Diagnosis and Treatment (EPSDT) specialty services is not a covered service under this contract, the AGENCY shall assist the BOARD and those identified consumers in obtaining necessary transportation to EPSDT services, and if applicable through either the Department of Health and Human Services or the consumer's Medicaid Health Plan.

5. The AGENCY shall follow, abide by and comply with the BOARD's MCO Policy Manual, Michigan Medicaid Provider Manual, Level of Care Criteria, and applicable Local and National Coverage Determinations, as well as all applicable federal, state and local statutes, regulations, and guidelines in the request for authorization of services on behalf of the consumers of the BOARD. Failure by the AGENCY to request PRIOR authorization of services may result in denial of payment.

C. Provider Panel Requirements-

Financial The AGENCY shall:

1. Submit Clean Claims to the BOARD for only those services authorized by the BOARD and described in Section D of this contract. A Clean Claim is one completed in the correct format as specified by the BOARD and that can be processed without obtaining additional information from the provider of service or a third party. For example, Minimum Data Set Requirements must be completed before submission of a claim in order for it to be deemed a Clean Claim.

2. Comply with BOARD policy regarding consumer fee determinations as specified in the BOARD's MCO Policy Manual. The AGENCY shall collect fees that are assessed, in accordance with BOARD policy, from the consumer. The AGENCY shall not require any co-payments, additional consumer pay amounts, or other cost sharing arrangements unless specifically authorized by state or federal regulations and the Board. The AGENCY shall not bill the consumer for the difference between the AGENCY's charge and the BOARD's payment for covered services. The AGENCY shall not seek nor accept additional supplemental payment from the consumer, his/her family, or representative in addition to the amount paid by the BOARD, even when the recipient has signed an agreement to do so.

3. The BOARD is the payer of last resort. The AGENCY shall be required to identify and seek recovery from all other liable third parties. Third Party Liability (TPL) refers to any other health insurance plan or carrier, (e.g., individual group, employer-related, self-insured, or self-funded plan or commercial carrier, automobile insurance and worker's compensation or other) or program (e.g., Medicare) that has liability for all or part of a consumer's covered benefit. The AGENCY shall provide services in compliance with the consumer's third party-payer and collect all payments available from other health insurers including Medicare and private health insurance for services provided to the BOARD's recipients of services in accordance with Section 1902(a) (25) of the Social Security Act and 42 CFR 433 Subpart D, the Michigan Mental Health Code, and the Michigan Public Health Code as applicable. The AGENCY shall be responsible for identifying and collecting third-party liability information. The AGENCY is responsible to report third-party collections as required by the BOARD. The AGENCY may retain third-party collections, as provided for in Section 226a of the Michigan Mental Health Code as part of its payment in full. The AGENCY shall bill the Board only for the net cost of services after payment from all other sources not to exceed the lesser of the third party's reasonable/allowable/customary charge or the AGENCY's contract rate with the BOARD.

4. Assure that BOARD consumers are served by clinicians credentialed and enrolled to the minimal level required by the BOARD or the consumer's third-party carrier, whichever is more stringent.

5. Ensure that all consumers apply for all entitlements (i.e. Medicaid, Medicare, Social Security, Unemployment) for which they may be eligible and complete the Ability To Pay documenting entitlements received or reasons for denial in the notes section of the Self-Pay Insurance Policy layer in Focus.

6. Assist in initiation and submission of, and follow-upon, on-line Medicaid applications for all consumers served pursuant to this Agreement who are not initially determined to be covered by Medicaid within 30 days of an initial visit. The AGENCY shall maintain documentation of application by scanning the confirmation page from MI Bridges showing the tracking number of the

application into the DHS/SSA Documents section of Focus. If a paper application is necessary, AGENCY will contact its DHS liaison housed at MCCMH Administration. AGENCY agrees to monitor on-going Medicaid eligibility and assist in the submission and follow-up of the DHS Re-Determination (DHS Form 1010) online. AGENCY will assist in the preparation and submission of Medicaid Deductible Report Form for all Medicaid Deductible (Spend-down) consumers. The AGENCY will report third-party collections as required by the BOARD. When a Medicaid beneficiary is also enrolled with a liable third party (Medicare, etc.), the liable third party will be the primary payer ahead of any BOARD payment.

7. Maintain all pertinent financial and accounting records and evidence pertaining to this Contract based on financial and statistical records that can be verified by the BOARD and/or its auditors. Financial reporting shall be in accordance with Generally Accepted Accounting Principles (GAAP) and as otherwise required by the BOARD.

8. The AGENCY agrees that the BOARD may recover payments based on audit exceptions, overpayment, inadequate documentation of services provided, non-compliance with contractual staffing expectations or failure to comply with all applicable service and billing requirements. BOARD's recovery may include full extrapolation of dollars based on audit sample findings. The methodology used for sample selection (random sample with 95% confidence and 1% materiality) allows the audit exceptions to be extrapolated to the entire claims population. For example, a five percent exception (error) rate found in the audited sample would be applied to the entire population of claims dollars. In addition to any other remedy available to it by law or in equity, the BOARD may recover any overpayment or improper payment by offsetting such payment against any sum otherwise payable to AGENCY under this Contract. In circumstances of suspected fraud, audit findings may be reported to the State Attorney General, the Michigan Health and Human Services Office of Inspector General and/or other applicable investigation and enforcement agencies and personnel.

9. At its sole cost and expense, the AGENCY shall collect and report, in the format specified by the BOARD, performance and outcome measures as required by the BOARD and as described in Section C.

D. **Provider Panel Requirements - Audits**

1. The AGENCY and the BOARD will agree to an appropriate time frame for auditing, monitoring, and evaluating the AGENCY'S performance under this Agreement; provided, however, that in the event of failure to reach agreement, the BOARD's decision shall govern. The AGENCY further agrees to be solely liable for increased audit costs attributable to any rescheduling of audit field work requested by the AGENCY and/or due to the delay in providing required documentation. The AGENCY is required to have an annual financial audit completed by an independent external auditor.

2. The AGENCY shall provide the BOARD with a copy of all audit engagement letters or agreements immediately following execution of such letters or agreements if such letter or agreement is related to financial statement audits of services funded in whole or in part pursuant to this Agreement. The AGENCY shall also provide the BOARD with a copy of all audit reports issued during the term of this Agreement immediately upon receipt of such reports.

3. The AGENCY agrees to permit authorized representatives and designees of the BOARD to review all activities and records of the AGENCY as BOARD deems necessary to satisfy financial audit, claims audit, program audit and program evaluation requirements and purposes of or pertaining to this Contract. The AGENCY shall submit a Plan of Correction within the time established in the BOARD'S notification of audit results to correct any deficiencies noted as a result of site review/audit findings.

E. **Provider Panel Requirements: Quality Improvement.** The AGENCY shall:

1. Maintain a Continuous Quality Improvement (CQI) program leading to practical improvement in service delivery. The AGENCY's continuous quality improvement program shall include ongoing measurement of key performance indicators which, through ongoing measurement and intervention, can be expected to lead to demonstrable and sustained improvement in significant aspects of clinical and non-clinical services affecting health outcomes and consumer satisfaction. The AGENCY will maintain a current copy of the AGENCY CQI plan, and annual evaluation for Quality Improvement/Outcomes (as appropriate to the AGENCY accrediting body findings) on file with the BOARD.

2. Maintain a process for the root cause analysis (RCA) of sentinel events involving consumers, including client deaths, and shall report results of its analysis, including recommendations, to the BOARD promptly upon their completion.

3. Maintain satisfactory compliance with standards for clinical service record documentation as required by federal and state regulations and by the BOARD in the MCCMH MCO Policy Manual. If the AGENCY, with BOARD's prior written consent, is utilizing a Medical Record Package different than the BOARD's system (FOCUS), AGENCY shall provide access to all data specified by BOARD to all individuals specified by BOARD at AGENCY's sole cost and expense. The AGENCY will include periodic systematic review of clinical record quality as part of its Continuous Quality Improvement program.

4. Conduct a measurement of consumer satisfaction and provide outcome results to the BOARD no less than annually.

5. Comply with the BOARD's practice guidelines as provided in the BOARD's MCO Policy Manual.

6. The AGENCY, in its hiring practices, shall ensure that its professional staff providing services meets the current credentialing standards in compliance with Section G of this Contract and the BOARD's MCO Policy Manual.

7. At the time of hire and monthly thereafter, check the sanctioned provider list of the State Medical Services Administration and U.S. Health and Human Services OIG Exclusions list to ensure that each staff person has not been excluded from participation in Federal or State healthcare programs, including Medicaid, Medicare, Children's Special Healthcare Services and State Medical Program. Additionally, at the time of hire and regularly thereafter, the AGENCY will check the license status of each staff through the State of Michigan's Licensing and Regulatory Affairs (LARA) database.

8. At the time of hire and regularly thereafter (at least every two years), perform a criminal background check on each applicant for employment or contract services to avoid negligent hiring practices. Criminal background checks must be completed by an organization, service, or agency that specializes in gathering the appropriate information to review the complete history of an individual, i.e., ICHAT. Use of the State of Michigan Offender Tracking Information System (OTIS) or a county level service that provides information on individuals involved with the court system, alone, is not acceptable for criminal background checks. Persons found to be convicted of any felony charge or of any charge involving patient abuse or neglect are prohibited from providing any direct service or contact with consumers.

9. AGENCY shall immediately notify the BOARD through its Business Management Contract Manager when it terminates, suspends, or declines a provider, subcontractor, practitioner, employee, or any member of its workforce from its organization as a result of fraud, integrity, a quality matter, or any criminal conviction described under Sections 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act, or assessment of civil monetary penalty under Section 1128A of the Act.

10. Agency must immediately report to the BOARD all disciplinary actions taken by LARA against any employee, contractor or agent of AGENCY.

11. Services delivered by ineligible staff pursuant to IV.E.6-8 are subject to denial of payment or payment recovery by the BOARD.

F. <u>Provider Panel Requirements - Corporate Compliance</u>

1. The Agency shall maintain and operate a program integrity corporate compliance program designed to detect and guard against fraud, waste, and abuse with respect to the provision of Contracted Services that meets the requirements of the Medicare Managed Care Compliance Program Guidelines and all other applicable federal and Michigan standards and guidelines. The Agency shall furnish the

BOARD with an updated and current copy of the AGENCY 's corporate compliance plan prior to the full execution of this Contract. The AGENCY will provide the BOARD with an annual written report of its compliance related activities. The Agency shall designate, and make known to the BOARD, a Corporate Compliance Officer, Privacy Officer, and Security Officer to provide functions as described in the Agency's corporate compliance plan and HIPAA Privacy and Security policies.

2. The AGENCY shall cooperate with the BOARD's corporate compliance program, including but not limited to, providing required information for completion of compliance audits, reviews, compliance investigations and remediation. The AGENCY will require staff and contractors to attend specialty training as required by the BOARD and shall participate in all mandatory training specified in Section H of this Contract. The AGENCY shall provide to its staff and contractors corporate compliance training at the time of hire, on an annual basis, and as necessary.

G. Provider Panel Requirements - Protected Health Information

The AGENCY shall:

1. The AGENCY shall operate in full compliance with all applicable federal and state laws, rules, and regulations, and all applicable BOARD guidelines and requirements, concerning beneficiaries' health care information confidentiality rights, including without limitation the Health Insurance Portability and Accountability Act of 1996, the HIPAA Omnibus Rule and the Security Rule (collectively, "HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH"), the regulations and standards promulgated pursuant thereto, 42 CFR Part 2, the Michigan Mental Health Code, and the Michigan Public Health Code. If it is determined that, in order to comply with HIPAA and HITECH, the Parties must enter into a business associate agreement, the parties agree to do so on a form specified by BOARD.

2. The AGENCY will require compliance with HIPAA and HITECH in all of its business associate relationships and will provide documentation of same when requested by the BOARD. The AGENCY shall ensure that all staff members and contractors receive appropriate training regarding HIPAA and HITECH requirements and obligations.

3. For purposes of this Contract, "Protected Health Information" shall have the meaning given to such term under HIPAA and HITECH and is hereafter referred to as "PHI". The AGENCY shall: ensure that PHI is protected from unauthorized disclosure; is used or disclosed only for purposes directly connected with its performance and administration of this Contract; not further disclosed except as permitted under the contract or as allowed by law. Applicable State law, including by way of example and without limitation, the

Michigan Mental Health Code, that is more stringent shall supersede as provided under HIPAA and HITECH.

4. The AGENCY shall: have written policies and procedures for maintaining the confidentiality of all PHI; adhere to MCCMH MCO Policies pertaining to confidentiality and PHI; ensure proper safeguards to prevent use or disclosure of PHI other than as provided by this contract; report to the BOARD any known use or disclosure of PHI not provided for by HIPAA or this Contract immediately upon the AGENCY becoming aware of such disclosure, whether the disclosure is intentional or unintentional; ensure that any entity to which it provides PHI agrees to the same restrictions and conditions that apply to the AGENCY with respect to such PHI.

5. The AGENCY shall: afford individuals access to their protected health information, as required by HIPAA and the Michigan Mental Health Code; allow individuals to make amendments to their PHI and incorporate such said amendments as required by HIPAA and the Michigan Mental Health Code; make information available to individuals to provide an accounting of disclosures of their PHI in accordance with HIPAA and the Michigan Mental Health Code.

6. Make its internal practices, books and records relating to the use and disclosures of Protected Health Information received from, or created or received by the BOARD on behalf of the consumer available to the BOARD for the purposes of assessing the AGENCY's compliance with the privacy regulations.

7. At the termination of this Contract and upon request by the Board, AGENCY shall return to the BOARD copies of all PHI relating to consumers served by the AGENCY under this Contract including PHI created by the AGENCY or received from the BOARD or other sources on behalf of the consumer. Further, upon request by the BOARD, the AGENCY will make available to the BOARD all originals of all PHI.

8. In the event and to the extent of any conflict between any provision of this Contract relating to PHI and the provisions of HIPAA, HITECH or any other applicable federal or state statute or regulation, the terms of the applicable federal or state statute or regulation shall supersede and govern. In the event and to the extent of conflict between any provision of HIPAA or HITECH and any provision of any applicable Michigan statute or regulation, the statute or regulation providing more stringent protection for PHI shall supersede and govern.

H. Provider Panel Requirements - Liability

Coverage The AGENCY shall:

1. Procure, maintain in force and supply to the BOARD evidence of professional

liability (malpractice) insurance protection and with coverage and limits of at least $200,000.00 per occurrence, $200,000.00 annual aggregate or such higher limits as reasonably required by the BOARD for the type of services performed by the AGENCY. Evidence of such insurance will be verified through the submission of Provider Profile and in the form of a certificate of insurance. The AGENCY shall provide thirty (30) days prior written notice of any material change or cancellation of professional liability insurance to the Macomb County Director of Risk Management and Safety, c/o Macomb County Community Mental Health Services Department, 22550 Hall Road, Clinton Township, Michigan, 48036.

2. Procure, maintain in force and supply to the BOARD evidence of a commercial general liability policy with coverage and limits of at least $1,000,000.00 per occurrence, $2,000,000.00 annual aggregate limit, and providing the BOARD with indemnification for any liability arising out of AGENCY's performance or breach of this Contract.

3. The insurance requirements of subsections H.1 and H.2 may be satisfied by a commercially reasonable program of self-insurance only if deemed satisfactory by the BOARD in writing in advance of its coverage, and the AGENCY shall provide the BOARD a letter or such other documentation as the BOARD may reasonably require certifying the existence and coverage limits of the AGENCY's self-insurance.

4. If the AGENCY operates a motor vehicle in the transport of consumers, then, the AGENCY shall procure, maintain in force and supply to the BOARD evidence of Michigan No-Fault Motor Vehicle Liability Insurance with coverage and limits required by law or such higher limits as reasonably required by the BOARD for the type of services performed by the AGENCY.

5. Procure, maintain in force and supply to the BOARD evidence of Workers' Compensation insurance in compliance with the State of Michigan Worker's Compensation statute.

6. Notify the BOARD immediately when there is any litigation initiated against the AGENCY or when any consumer asserts any claim against the AGENCY.

I. Record Retention

1. The AGENCY shall comply with the record retention requirements outlined by the Michigan Department of Technology, Management, and Budget, and by the BOARD's MCO Policy Manual.

J. Federal E-Verify Policy

1. The AGENCY shall comply with the Macomb County Federal E-Verify Program Policy as adopted by the Macomb County Board of Commissioner in 2009, and as

applicable to all contractors and sub-contractors of the BOARD.

2. A copy of the Federal E- Verify Policy is located in the BOARD' S MCO Policy Manual.

V. BOARD RESPONSIBILITIES

A. Managed Care Organization Assurances

The BOARD shall:

1. Provide payment of Clean Claims submitted for the Contracted Services designated in Section B of this Contract in accordance with Section D of this Contract and within thirty (30) days after receipt of such Clean Claims.

2. Monitor the AGENCY's compliance with the requirements of this Contract, and the AGENCY's adherence to federal, state and local laws, guidelines, rules, and regulations. This monitoring may include but is not limited to conducting fiscal and/or program audits, as required by contract with the Michigan Department of Health and Human Services.

3. Designate a Recipient Rights Officer as required by BOARD policy and as referenced in the BOARD's MCO Policy Manual. The Recipient Rights Officer shall respond to and investigate all alleged violations of recipients rights, as delineated in chapter seven (7) of the Michigan Mental Health Code and provided in applicable BOARD MCO Policies.

4. Designate a Corporate Compliance Officer, Privacy Officer and Security Officer to implement Corporate Compliance and HIPAA policies of the BOARD. The Corporate Compliance Officer, Privacy Officer and Security Officer shall respond to reports and inquires as provided in applicable MCO policies of the BOARD.

5. Provide a hearing with AGENCY representatives prior to denying payment, for noncompliance with the provisions of this contract, of Clean Claims in accordance with the BOARD's MCO Policy Manual.

6. The effective date for compliance with policies, regulations or contractual requirements shall be determined by the BOARD and issued with a minimum written thirty (30) day notice to the AGENCY, or such lesser period of time as may be required for compliance with applicable federal and state law.

7. Nothing in this Contract shall be construed as a waiver of any governmental immunity of the County, the BOARD, its agencies or employees, as provided by statute or modified by court decisions.

8. Provide the AGENCY with notice of any reduction or restriction of its funding allocation for performance of this Contract at least thirty (30) days in advance of such reduction or restriction, unless the BOARD receives a shorter period of notice of the cause for such reduction or restriction in which case, such shorter period of notice shall be given.

9. Maintain responsibility for a Quality Assessment and Performance Improvement Program (QAPIP), including performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcome and consumer satisfaction.

10. The BOARD will perform Utilization Management and shall assure that service eligibility and medical necessity determination decisions are conducted using defined criteria and standardized service selection guidelines, where available, and shall assure that utilization management of services are instituted as a formal process for ongoing monitoring of care determination decisions with mechanisms to correct for under and over utilization of services. The AGENCY shall assure that consumers located in the service area have clear and identifiable access to needed supports and services when they are needed, and that supports and services are of high quality and delivered according to established regulations, standards, and practice guidelines. The AGENCY shall also perform utilization management functions sufficient to control costs and minimize risk while assuring quality care. In the performance of this function, the AGENCY shall adhere to any additional requirements according to federal, state and local laws, guidelines or regulations.

11. Evaluate and monitor the AGENCY's performance on an ongoing basis and subject the AGENCY to formal review of any functions delegated to AGENCY including, but not limited to, Utilization Management, Claims Payment, Coordination of Care, Credentialing and Privileging, Corporate Compliance, Service Authorization, Customer Satisfaction according to a periodic schedule established by the State, consistent with industry standards or State Managed Care Organization law and regulations.

12. If, after BOARD evaluation, the AGENCY's performance of any delegated function is deemed to be inadequate, the AGENCY shall take corrective action. Should AGENCY's performance remain inadequate, the BOARD may revoke any delegation of responsibilities to the AGENCY and//or may impose other sanctions.

13. The BOARD may recover payments based on audit exceptions, overpayment, inadequate documentation of services provided, non-compliance with contractual staffing expectations or failure to comply with all applicable service and billing requirements. BOARD's recovery may include full extrapolation of dollars based on audit sample findings. The methodology used for sample selection (random sample with 95% confidence and 1% materiality) allows the audit exceptions to be

extrapolated to the entire claims population. For example, a five percent exception (error) rate found in the audited sample would be applied to the entire population of claims dollars. In circumstances of suspected fraud, audit findings may be reported to the State Attorney General, the Michigan Department of Health and Human Services Office of Inspector General and/or other applicable investigation and enforcement agencies and personnel.

VI. MUTUAL RESPONSIBILITIES

A. Both parties agree:

1. Program outcome measures for each fiscal year outlined in Section B and Section C of this Contract will be reviewed for compliance by the BOARD and shall be one consideration for decisions relative to re-contracting with the AGENCY.

2. If the BOARD identifies deficiencies or areas for improvement following an evaluation of the Agency's performance, including the performance of delegated Managed Care functions, clinical service delivery or documentation, the AGENCY must take corrective action. BOARD may take progressive corrective action of a type and nature it deems appropriate, up to and including termination of this Contract. Should performance remain inadequate following corrective action, delegation of responsibilities to the Agency under this Contract may be revoked and other sanctions imposed, up to and including contract termination.

3. This Contract shall not be construed to establish any employer-employee, master-servant, or principal-agency relationship between the BOARD and the AGENCY or any agent or employee of the AGENCY.

4. A written request to re-examine, interpret or re-negotiate provisions of this Contract may be made by either party. Notification of receipt of the request shall be provided by the recipient party and shall be made by certified mail within thirty (30) calendar days of original request.

5. Pursuant to Section 1932 (d)(1) of the Social Security Act, the AGENCY shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than five (5) percent of the entity's equity who is currently disbarred, sanctioned, or suspended by any state or federal agency. The AGENCY is also prohibited from having an employment, consulting, or other agreement with a currently disbarred, sanctioned, or suspended person for the provision of items or services that are significant and material to the contractual obligations with the Board / State of Michigan. By executing this Agreement, AGENCY represents and warrants to the BOARD that the AGENCY is in full compliance with this subsection VI.A.5.

6. At the time of contracting, re-contracting, when there is a change in ownership, or upon request of the BOARD, AGENCY shall submit full disclosures identified in 42 C.F.R. Part 455 Subpart B. Disclosures statements shall include:

a. Name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include primary business address, every business location, and P.O. Box location.

b. Date of birth and Social Security number of each person with an ownership or control interest in the disclosing entity.

c. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five percent or more interest.

d. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with an ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child, or sibling.

e. The name or any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.

f. The name, address, date of birth, and Social Security number of any managing employee of the disclosing entity.

g. The identity of any individual who has an ownership or control interest in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

7. AGENCY shall ensure that any and all contracts, agreements, purchase orders, or leases funded under the MDHHS-MCCMH Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs Agreement are compliant with 42 C.F.R. §455.104-106.

8. AGENCY shall immediately notify the BOARD through its Business Management Division contract manager of any staff member, director, or manager; individual with a beneficial ownership of five (5) percent or more; or an individual with an employment, consulting, or other arrangement with AGENCY has been convicted of a criminal offense described under Sections 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act or who has had civil money penalties or assessments imposed under Section 1128A of the Act.

9. Both parties shall provide and facilitate ready access to information for referral of clients and for transmittal of information, as required between the AGENCY and other appropriate services, to assure continuity of services to the consumer.

10. The MCCMH contract manager will meet quarterly with the AGENCY to discuss issues related to the implementation of this Contract. In the event of a dispute related to the operating procedure, the resolution will be managed as follows.

Step # 1: The MCCMH Business Management Division representative will meet with the AGENCY supervisor in attempt to resolve the dispute within fourteen (14) calendar days of request by either party to meet.

Step # 2: If still unresolved, the MCCMH Business Management Director will meet with the AGENCY Director within seven (7) additional days, in attempt to bring resolution to the dispute. If unresolved, the MCCMH Business Management Director and AGENCY Director will, within fourteen (14) additional calendar days, submit written recommendations to the MCCMH Deputy Director for resolution.

Step # 3: The MCCMH Deputy Director will meet with the AGENCY within fourteen (14) calendar days after receipt of written recommendations to determine resolution of the dispute.

Step # 4: If the BOARD or AGENCY is dissatisfied with the resolution of the Deputy Director, either party may initiate termination of the Contract in accordance with Section VIII.

Operating procedures do not include denials or reductions of service authorization or denial of payment. Refer to the BOARD's MCO Policy 2-006 "Service Provider Appeals" for resolution of denials or reductions of service authorizations or denial of payment.

VII. RE-CONTRACTING REQUIREMENTS

The BOARD will consider the AGENCY'S performance in a number of areas prior to determining whether to re-contract with the AGENCY for the subsequent service contract. Re-contracting approval by the Board is dependent on and contingent upon satisfactory performance of the AGENCY in the areas of contract compliance, corporate compliance, quality improvement, financial compliance, consumer satisfaction outcome and recipient rights, with particular attention to the areas outlined below.

A. <u>Contract Compliance</u>

1. The AGENCY demonstrates an ability to execute a contract, with AGENCY representative signature, within ninety (90) days of the original date of issuance. If

the AGENCY does not return the contract within ninety (90) days, all claims after that time will be pended until the contract is signed and executed.

2. The AGENCY demonstrates adherence to the provisions of the contract between the BOARD and the AGENCY.

3. The AGENCY demonstrates compliance with BOARD requirements for the maintenance of all required insurance, pursuant to all provisions within its Contract with the BOARD, including provisions of notification of material change and/or cancellation of insurance.

B. Corporate Compliance

1. The AGENCY demonstrates adherence to a formally adopted Corporate Compliance Plan, including conducting investigations, submitting required annual compliance reports to the BOARD, and taking corrective action, as required. The Agency shall maintain a current copy of the Corporate Compliance Plan on file with the Board.

2. The AGENCY demonstrates cooperation with the corporate compliance activities of the BOARD, including cooperation in compliance investigations conducted by the Board, submission of required material, and taking corrective actions required as a result of BOARD investigation findings.

3. The AGENCY demonstrates compliance with the administrative rules pursuant to HIPAA and HITECH and the regulations promulgated pursuant thereto.

4. The AGENCY complies with all applicable local, state and federal laws governing the delivery of behavioral health services. The AGENCY will provide supportive evidence and documentation of such compliance upon reasonable request by the BOARD.

C. Quality

1. The Agency maintains a Continuous Quality Improvement (CQI) program leading to practical improvement in service delivery. The AGENCY's continuous quality improvement program includes ongoing measurement of key performance indicators which, through ongoing measurement and intervention, can be expected to lead to demonstrable and sustained improvement in significant aspects of clinical and non-clinical services affecting health outcomes and consumer satisfaction. The AGENCY maintains a current copy of the AGENCY CQI plan, and annual evaluation for Quality Improvement/Outcomes (as appropriate to the AGENCY accrediting body findings) on file with the BOARD.

2. The AGENCY demonstrates compliance with timeliness and accuracy standards in submitting required data reports. In particular, the AGENCY will have demonstrated the timely submission of reports and information related to mortality review, sentinel event review, performance indicators, and customer satisfaction assessment reports.

3. The AGENCY maintains satisfactory compliance with standards for clinical service record documentation as required by federal and state regulations and by the BOARD in the MCCMH Managed Care Organization Manual. The AGENCY includes periodic systematic review of clinical record quality as part of its Continuous Quality Improvement program.

4. The AGENCY demonstrates participation in the BOARD's Quality Assessment and Performance Improvement Program (QAPIP), including the maintenance of an internal Quality Improvement program in conformance with national standards for Quality Improvement Programs, including those standards in 42 CFR, Part 438, Managed Care. The AGENCY maintains a current copy of the AGENCY Quality Improvement Plan and Annual Evaluation for Quality Improvement/Outcomes (as appropriate to the AGENCY accrediting body findings) on file with the BOARD.

5. The AGENCY demonstrates compliance with performance measures established by the BOARD in the areas of timely consumer access, program effectiveness and efficiency, performance outcomes and staff credentialing, privileging, and performance monitoring. The AGENCY demonstrates an ability to provide timely, valid, and reliable data to the BOARD in support of the Michigan Department of Health and Human Services - Key Performance Indicators (KPI's) reporting requirements for the then-current Contract period.

6. The AGENCY demonstrates compliance with standards for those Managed Care functions delegated by the BOARD to the AGENCY, including remedial action taken as a result of BOARD initiated corrective action plans.

D. Financial Compliance

1. The AGENCY maintains substantial compliance in the timely submission of Clean Claims to the BOARD, in accordance with Section D.

2. The AGENCY maintains satisfactory and timely resolution of financial restitution as required resulting from AGENCY audits and corporate compliance investigations conducted by the BOARD.

3. The AGENCY maintains financial solvency and demonstrates adherence to acceptable financial accounting practices.

E. Consumer Satisfaction Outcome

1. The AGENCY continuously measures consumer satisfaction and reports outcomes to the BOARD on a regular basis and provides satisfaction outcome reports to the BOARD on an annual basis.

F. Recipient Rights

1. The AGENCY demonstrates adherence to the BOARD's MCO Policy 9-100 and all accompanying MCCMH MCO Recipient Rights Policies as contained in Chapter 9 - Recipient Rights Protection requirements contained in Section F of this Contract. Repeated failure or non-compliance shall subject continuation of the AGENCY's Contract to review, possible revocation, and/or denial of re-contracting.

2. The AGENCY demonstrates adherence to Recipient Rights Protection requirements contained in Section F of this Contract.

VIII. TERM AND TERMINATION

A. Term

1. The term of this Contract commences on October 1, 2016, and ends on September 30, 2018, unless it is sooner amended, terminated in accordance with its terms or replaced by execution of a new contract between the parties.

B. Termination

1. This Agreement may be terminated by either party at any time, with or without cause, upon sixty (60) days' prior written notice to the other party.

2. Either party may terminate this Agreement if the other party materially breaches this Agreement and such breach is not cured within sixty (60) days after the breaching party receives from the non-breaching party written notice specifying the claimed material breach and including sufficient factual detail to permit the breaching party to clearly identify and investigate the claimed breach.

3. Anything in this Contract to the contrary notwithstanding, the BOARD my revoke any delegated function and/or terminate this Contract effective immediately upon written notice to the AGENCY in the event of any of the following:

   a. a serious violation of this Contract by the AGENCY including but not limited to any violation that places the life or safety of any consumer in jeopardy or failure to properly perform any delegated function;

   b. the AGENCY fails to maintain all licenses, certifications, permits,

certificates of authority or registrations required by law;

c. the AGENCY is excluded, suspended or terminated from any federal program or any state or federal health care program;

d. the AGENCY is convicted of or pleads no contest to a felony of any kind or a misdemeanor related directly or indirectly to the provision of health care services;

e. the AGENCY is required to terminate this Contract pursuant to the directive of an applicable regulatory agency;

f. the AGENCY files a certificate of dissolution;

g. any insurance required by this Contract to be maintained by the AGENCY is terminated or reduced below the minimum levels required by this Contract without immediate replacement by insurance of the type and levels required by this Contract;

h. the AGENCY applies for or consents to the appointment of a receiver, trustee or liquidator of all or substantially all of its assets, or files a petition or an answer seeking reorganization or to otherwise take advantage of any insolvency law;

i. the AGENCY files a voluntary petition in bankruptcy, admits in writing its inability to pay its debts as they become due, or makes a general assignment for the benefit of creditors;

j. the AGENCY is adjudicated bankrupt or insolvent by a court of competent jurisdiction or is the subject of such a court's order, judgment or decree approving a petition seeking its reorganization; or

k. the AGENCY has a receiver or trustee appointed by a court of competent jurisdiction to manage its assets, and such receiver or trustee has not been discharged within forty-five (45) days after appointment;

provided, however, that the AGENCY shall be required to continue to furnish Contracted Services to consumers to the minimum extent required by law or by order of any court of competent jurisdiction.

4. Upon the expiration or termination of this Contract for any reason, the AGENCY shall cooperate with the BOARD in the orderly transfer of consumers to other providers so that consumers will have timely access to medically necessary services and appropriate continuity of care.

5. No expiration or termination of this Contract shall affect the obligations of either

party under this Contract accruing prior to such expiration or termination if such obligations remain unsatisfied at the date of expiration or termination. If either party breaches this Contract, the other party's termination of the Contract for that reason shall not limit such other party's rights to obtain damages or enforcement of those obligations which continue after termination.

C. Amendment

1. The BOARD may amend the MCO Policy Manual and initiate and implement Executive Directives and Compliance Alerts from time to time during the term of this Contract and shall give notice of such amendments, Executive Directives, and Compliance Alerts in writing or by positing same on the BOARD or MCCMH website. All such amendments, Executive Directives, and Compliance Alerts shall constitute a part of this Contract and shall be deemed to be incorporated herein.

2. This contract shall be amended to comply with State and Federal statutes and regulations. Any such amendment of the contract must be approved in writing by only the BOARD. Schedules, appendices and attachments to this Contract relevant to State and Federal statutes and regulations can be amended in writing by the BOARD without necessity of AGENCY approval or signature.

3. Anything in this Contract to the contrary notwithstanding, if the funding to the BOARD, in its capacity as the PIHP, is terminated or materially reduced by State action, then by written notice to the AGENCY the BOARD may terminate payment under this Agreement and require that the AGENCY continue to provide all or some designated portion of the Contracted Services in return for payment by the BOARD in its CMHSP capacity, under an alternative reimbursement methodology the financial terms of which shall be dependent upon the funding received by the CMHSP from the State of Michigan directly or through an intermediary including, but not limited to, a State-contracted health plan.

IX. GENERAL PROVISIONS

1. This contract will be governed and interpreted by Michigan law. Any lawsuit arising directly or indirectly out of the contract will be litigated in the Circuit Court for Macomb County, Michigan or, if original jurisdiction can be established, in the United States District Court for the Eastern District of Michigan.

2. This Contract, including the schedules, appendices and other attachments hereto, and the statutes, regulations, policies, procedures and manuals referenced herein constitutes the entire agreement between the parties and supersedes any and all prior agreements and understandings, oral and written, relating to the subject matter hereof.

3. Except as expressly provided elsewhere in this Contract, the Contract can be amended only by a written document signed by duly authorized representatives of both parties.

4. It is expressly understood and agreed that this Contract is not intended to be exclusive. Either party may enter into agreements with other persons or entities for the provision of services that are the same or similar to those provided under this Contract.

5. The failure of either party at any time to require performance by the other party of any provision hereof shall not affect in any way the full right to require such performance at any time thereafter. The waiver by either party of a breach of any provision hereof shall operate as a waiver of the provision itself, nor of any other provision of this Contract, unless each such waiver is made in writing.

6. Except as specifically provided in this Contract with respect to dispute resolution, all rights and remedies provided to either party under this Contract are cumulative, are not exclusive, and are in addition to other rights and remedies provided by Law.

7. This Contract shall be governed by and interpreted in accordance with the laws of the State of Michigan without regard to its principles of conflict of laws. Each provision of this contract shall be interpreted in a way that is valid under applicable law.

8. If any provision of this Contract is determined by a court of competent jurisdiction to be void or unenforceable to any extent, such part or provision shall be deemed severable and the remaining provisions shall continue in full force and effect, unless severance would materially adversely affect the obligations or rights of a party, in which case the party may terminate this Contract in accordance with Article VIII.

9. The BOARD and the AGENCY are the only parties to this Contract. This

Contract does not create and shall not be construed to confer any rights or benefits upon any other person as a third-party beneficiary of this Contract. This contract shall inure in all particulars to the benefit of the parties hereto, and to their respective agents, successors, and permitted assigns, to the fullest extent permitted by law.

10. The relationship between the BOARD and the AGENCY is solely that of independent contractors and nothing in this Contract or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency, partnership or joint venture.

11. All schedules, appendices and attachments referred to herein are incorporated by reference as though fully set forth herein. All references in the schedules, appendices and attachments to "the Contract" shall be deemed to refer to this Contract.

12. The headings herein are inserted as a matter of convenience and for reference only and in no way define, limit or describe either the scope of this Contract or the intent of any of the provisions hereof. When required by the context, the singular number used in this Contract includes the plural. The word "including" or "includes" used in this Contract means including without limitation. This Contract is the subject of negotiation and contribution by both parties. No presumption shall exist that either party is the drafter of the Agreement, or of any specific language in the Contract, and no presumption shall be permitted against either party if a dispute, disagreement or litigation develops over the intent, terms or language of this Contract.

13. The AGENCY cannot assign this Contract or any right or obligation hereunder without the prior written consent of the BOARD and the COUNTY. Any attempted assignment without such consent shall be deemed void and of no effect. Any such consent given in one instance shall not relieve the AGENCY of its obligation to obtain prior written consent of the BOARD and the COUNTY to any further assignments.

14. The AGENCY may subcontract specific services to another provider only upon express written approval of the BOARD and only in strict accordance with the terms of this Contract; provided, however, that the AGENCY shall at all times remain responsible for full compliance with the terms of this Contract and shall ensure that each of its subcontractors also complies with the terms of this Contract.

15. This Contract may be signed in counterparts, each of which shall be an original and all of which together shall constitute one and the same instrument.

Signature Page and Contract Review Signature Page follow.
Remainder of this page intentionally blank.

FISCAL YEAR 2016/2017 - 2017/2018

SIGNATURE PAGE FOR SPECIALTY SERVICES CONTRACT

MACOMB COUNTY COMMUNITY MENTAL HEALTH BOARD

_____
Executive Director

Date: _____

_____
Witness

Date: _____

CONTRACTOR

_____
Agency Name

_____
Executive Director

Date: _____

_____
Witness

Date: _____

COUNTY OF MACOMB

_____
Office of County Executive

Date: _____

PANELED PROVIDER APPROVED BY THE MACOMB COUNTY MENTAL HEALTH SERVICES BOARD ON: _____

FISCAL YEAR 2016/2017 - 2017/2018
SIGNATURE PAGE FOR CONTRACT REVIEW

Initial and Date each section.

By initialing and dating each area below, you are agreeing with the language and content for each area.

_____ Specialty Services Contract

_____ Section A (Provider Profile Application)

_____ Section B (all attachments)

_____ Section C

_____ Section D

_____ Section E

_____ Section F

_____ Section G

_____ Section H*

_____ Section I

_____ Section J

_____ _____
Executive Director Agency Name

Date: _____

* Section H is a part of this Contract only if attached Section H is signed by both BOARD and AGENCY.