PROVIDER AGREEMENT FOR PROGRAM SUPPORTS/SERVICES

THIS AGREEMENT made and entered into this **1st** day of **October 2024**, by and between **Integrated Services of Kalamazoo**, whose administrative offices are located at **610 S. Burdick Street, Kalamazoo, MI 49007** (hereinafter referred to as "Payor"), and **Centria Healthcare, LLC** whose administrative offices are located at **27777 Inkster Road, Farmington Hills, MI 48334** (hereinafter referred to as "Provider").

WITNESSETH:

WHEREAS, Payor is a Community Mental Health Authority (as defined in the Mental Health Code) created to operate as a Community Mental Health Services Program ("CMHSP") by the Board of Commissioners of Kalamazoo County, pursuant to Act 258 of the Public Acts of 1974, as may be amended from time-to-time (the "Mental Health Code");

WHEREAS, under the authority granted by MCL 330.111 (2)(b) and MCL 330.1116 3(e) the Michigan Department of Health and Human Services (the "MDHHS") has entered into a Managed Mental Health Supports and Services Contract for General Funds (the MDHHS/CMHSP Master Contract for General Fund) with Payor as the CMHSP of Kalamazoo County (the "County"), to provide or arrange for the provision of mental health Supports/Services for Indigent Persons (as such terms are further defined in EXHIBIT A);

WHEREAS, Southwest Michigan Behavioral Health was formed as a regional entity pursuant to MCL 330.1204 (b) and serves as the prepaid inpatient health plan under 42 CFR Part 438 (the "PIHP") in the MDHHS-designated Region 4, where Payor provides services;

WHEREAS, the MDHHS has entered into that certain 1115 Demonstration Waiver, the 1915(c)/(i) Waiver Program(s), the Healthy Michigan Program, the Flint 1115 Waiver and Substance Use Disorder Community Grant Programs Agreement with the PIHP for the provision of mental health and Substance Use Disorder (SUD) Supports/Services in Payor's service area (hereinafter referred to as the "MDHHS/PIHP Master Contract");

WHEREAS, the PIHP has entered into that certain 1115 Behavioral Health Demonstration Waiver, the 1915(c)/(i) Waiver Program(s), the Healthy Michigan Programs, the Flint Waiver and SUD Community Grant Programs Subcontract with Payor, to provide Medicaid mental health specialty Supports/Services, and SUD Services in Payor's service area (the "CMHSP Medicaid Subcontract");

WHEREAS, pursuant to the authorities above, Payor, at its discretion, has the right to directly provide and/or contract for the provision of Medicaid mental health specialty Supports/Services to persons who meet the eligibility criteria in Payor's service area;

WHEREAS, Payor is in need of specific Supports/Services from qualified, licensed, independent contractors for eligible persons who meet the Supports/Services eligibility criteria (the "Payor's Customers") as further defined in the EXHIBIT A to this Agreement; and

WHEREAS, Provider provides such Supports/Services and has represented to Payor that it is duly licensed, qualified, and willing to provide such services as required by Payor, and Payor desires to obtain such services from Provider pursuant to the terms and conditions set forth herein.

NOW, THEREFORE in consideration of the above and in consideration of the mutual covenants hereinafter contained, **IT IS HEREBY AGREED** by Payor and Provider as follows:

PROVIDER AGREEMENT FOR PROGRAM SUPPORTS/SERVICES

I. DEFINITIONS

The terms used in this Agreement shall be construed and interpreted as defined in the attached document labeled EXHIBIT A – Glossary of Terms and Definitions, as incorporated herein by reference.

II. CONTRACT AUTHORITY

This Agreement is entered into pursuant to the authority granted to Payor under the Mental Health Code. This Agreement shall be construed in accordance with the rules, regulations, and standards (herein referred to as the "MDHHS Rules") of the MDHHS adopted and promulgated in accordance with the Mental Health Code; all requirements of 42 CFR Part 438; and all requirements of the MDHHS/PIHP Master Contract.

III. AGREEMENT CONTINGENT UPON FUNDING

This Agreement is contingent upon Payor's receipt of sufficient federal, state and local funds, upon the terms dictated by such funding as appropriated, authorized and amended, upon continuation of such funding, and upon sufficient collections of Customer fees and third-party reimbursements, as applicable. In the event that circumstances occur that are (a) not reasonably foreseeable, and/or (b) that are beyond the reasonable control of Payor such that these circumstances reduce or otherwise interfere with Payor's ability to provide or maintain specified Supports/Services or operational procedures for its service area, Payor shall provide notice within in two (2) days to Provider if it would result in any reduction of the funding upon which this Agreement is contingent.

IV. COMPLIANCE WITH GOVERNING DOCUMENTS

It is expressly understood and agreed by Provider that this Agreement is subject to the terms and conditions of the CMHSP Medicaid Subcontract; the MDHHS/CMHSP Master Contract for General Funds; and the MDHHS/PIHP Master Contract; together with all attachments thereto, which are all incorporated herein by reference and are made a part hereof.

A. Provider shall comply, and shall ensure that its employees, agents, contractors, subcontractors, and all other related parties comply with the following:
   a. All applicable provisions and requirements of the above referenced contracts, including all attachments thereto whether or not specifically referenced in this Agreement;
   b. Applicable provisions of the Medicaid Provider Manual;
   c. The PIHP Provider Manual;
   d. Applicable PIHP and Payor policies and procedures; and
   e. The following guidelines as applicable, which can be found on the MDHHS website at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.html:
      1. Inclusion Practice Guideline
      2. Housing Practice Guideline
      3. Consumerism Practice Guideline
      4. Personal Care in Non-Specialized Residential Settings
      5. Family-Driven and Youth-Guided Policy and Practice Guideline; and
      6. Employment Works! Policy.

f. EXHIBIT B – Compliance with Applicable Laws, Rules, Regulations & Plans, which is attached hereto and incorporated herein by reference.

B. The provisions of this Agreement shall take precedence over the above-referenced 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, a conflict shall not be deemed to exist where this Agreement:
   a. Contains additional provisions and/or additional terms and conditions not set forth in said contract/s:
   b. Restates provisions of said contract/s to afford Payor or the PIHP the same or substantially the same rights and privileges as MDHHS; or
   c. Requires Provider to perform duties and services in less time than required of Payor or the PIHP in said contract/s with the PIHP or MDHHS, respectively.

V. TERM

A. This Agreement shall commence on the 1st day of October 2024 and, unless terminated earlier as provided herein, shall remain in full force and effect until September 30, 2025 (the "Term"), at which time this Agreement shall terminate.

B. Nothing in this Agreement shall be construed as requiring either Payor or Provider to extend or renew this Agreement or to enter into any subsequent agreements beyond the Term.

VI. TERMINATION OF AGREEMENT

A. **Immediate Termination.** Payor may elect to terminate this Agreement immediately upon any of the following:
   a. Revocation, restriction, suspension, termination, discontinuation, or loss of any certification, accreditation, authorization, or license required by federal, state and/or local laws, ordinances, rules and regulations for Provider to participate in Medicaid or any other federal programs, and/or non-Medicaid programs or to provide Supports/Services within in the state of Michigan.
   b. Provider being listed on any of the following:
      1. A federal agency or the state of Michigan as being suspended from participation in the federal Medicare or the Michigan Medicaid Programs (including but not limited to the Michigan Sanctioned Provider List, the U.S. Office of Inspector General ("OIG") Exclusions Databases (LEIE and GSA), and the System for Award Management (SAM)).
      2. MDHHS or agency for the state of Michigan in its registry for Unfair Labor Practices pursuant to 1980 P.A. 278, as amended, MCL 423.321 et. seq.
      3. The OIG in its Excluded Provider List, as to payment made by any federal health care program.
   c. Any failure of Provider to meet the requirements hereunder of solvency and/or if Provider generally fails to pay its debts as they become due.
   d. Cancellation of the Provider's general or professional liability, errors and omissions, or any other insurance policy required to be maintained in accordance with this Agreement.

e. If the Payor determines in its reasonable professional judgment that Provider's continued participation may jeopardize the health or safety of any customer of Payor.
f. Provider has made any untrue statements of material fact or any intentional misrepresentation of any fact, whether or not material to the terms of this Agreement.
g. Provider's receipt of notice from Payor that the funding as set forth in Section III herein has been altered substantially from the original funding amount and/or terminated.

B. **Termination for Material Breach.** Notwithstanding the foregoing breaches that may result in immediate termination, any other material breach of this Agreement which has not been cured within fifteen (15) calendar days of receipt of written notice of such breach, may result in the non-breaching party's immediate termination of this Agreement, with said termination effective as of the date of delivery of written notification from the non-breaching party to the breaching party. The termination of this Agreement shall not be deemed to be a waiver by the non-breaching party of any other remedies it may have in law or in equity.

C. **Voluntary Termination.** Notwithstanding any other provisions in this Agreement to the contrary, either party may terminate this Agreement for any reason by providing the other party with sixty (60) days prior written notice.

D. **Effect of Termination.**
a. Any termination of this Agreement shall not relieve either party of the obligations incurred prior to the effective date of such termination.
b. Upon any termination of this Agreement, the Provider shall promptly, but in no event longer than the timeframes required under Section XVIII(B) herein, supply Payor with all the information necessary for the reimbursement of any outstanding Medicaid, Medicare or any other third-party reimbursement claims and any other required information.
c. In the event of termination of this Agreement and non-renewal, to cooperate fully with Payor in the orderly transfer of the Customer(s), records, programs and services, and other material items hereunder to Payor and/or other contractors of Payor at Payor's direction, as applicable.

VII. SERVICE AREA

Payor's service area for the purposes hereunder is the County of Kalamazoo. Exceptions to this service area and any waiver of the service access/admittance and Supports/Services payment restrictions hereunder may only be granted, with prior authorization, by Payor's Chief Executive Officer (hereinafter referred to as the "Payor's CEO") or their designee.

VIII. TARGET SERVICE GROUP AND ELIGIBILITY CRITERIA FOR SUPPORTS/SERVICES

A. The target populations for the Supports/Services hereunder are Adults with Serious Mental Illness, Children and Adolescents with Severe Emotional Disturbance, and/or Adults/Children with Developmental Disabilities.

B. The target population for Supports/Services under this Agreement shall meet the eligibility criteria established in the Mental Health Code and Medicaid Provider Manual and shall be consistent with the requirements of the MDHHS/CMHSP Master Contract for General Funds and the MDHHS/PIHP Master Contract.

IX. PROVIDER BUSINESS STATUS & SOLVENCY PRIOR TO COMMENCEMENT OF SUPPORTS/SERVICES

A. Provider shall furnish Payor or PIHP with notice of proof of Provider's authority to conduct business in the state of Michigan and such proof shall specify in what capacity (e.g., as a corporation, limited liability company, etc.) prior to commencing the provision of Supports/Services under this Agreement, and with notice of any related organization of Provider per alliance, affiliation, joint venture, parent/subsidiary or other business relationship that Provider is a party to during the Term of this Agreement.

B. Provider shall furnish Payor or PIHP with notice of proof of financial solvency, prior to commencing the provision of Supports/Services hereunder. Subsequently, Provider shall provide immediate written notice to Payor of any change in financial position material to Provider's solvency and to its continuing in operation as a going concern, during the Term of this Agreement.

X. LICENSES, ACCREDITATIONS, CERTIFICATIONS & CREDENTIALING REQUIREMENTS

A. During the Term of this Agreement, the Provider shall obtain and maintain all applicable licenses, certifications, registrations, accreditations, authorizations, and approvals required by federal, state and local laws, ordinances, rules and regulations to practice its profession and provide Supports/Services in the state of Michigan, and, further, to participate in both Medicaid and/or non-Medicaid programs.

B. If any such license, certification, registration, accreditation, or authorization is ever suspended, restricted, revoked, or expires and is not renewed, Provider shall immediately notify Payor, in writing. Such notice shall include an explanation of why such license, certification, registration, accreditation, or authorization has lapsed.

C. **Credentialing and Recredentialing.**

a. Provider shall cooperate with Payor and/or PIHP's credentialing policies and procedures, and the MDHHS Provider Credentialing and Re-Credentialing Process found on the MDHHS website, currently located at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.html. Provider must be properly credentialed by Payor or the PIHP in order to perform Supports/Services under this Agreement. Payor or PIHP revocation of Provider's credentialing is grounds for immediate contract termination pursuant to Section VI (A).

b. Provider shall complete and submit credentialing (or re-credentialing) applications and supporting documentation at all required intervals. Provider's failure to submit documentation necessary for Payor or PIHP to perform recredentialing of the Provider may result in contract action up to and including immediate termination pursuant to Section VI (A).

c. Provider shall complete credentialing activities for its professional staff every two (2) years in accordance with the policies and procedures referenced in Section X (C)(a) above.
   1. Prior to commencing Supports/Services under this Agreement, as needed when professional staff are added, and upon request, Provider shall provide to Payor or PIHP notice of primary verification that its professional staff, if any, have obtained and currently maintain all approvals, accreditations, certifications, and licenses required by applicable laws, ordinances, rules and/or regulations to perform Supports/Services under this Agreement.
   2. Provider shall ensure that its non-professional staff meet Payor's and PIHP's requirements for qualifications and competency standards necessary to perform Supports/Services under this Agreement.
   3. Provider shall cooperate with Payor and PIHP oversight activities on an ongoing basis, including providing credentialing and/or staff training files for review upon Payor or PIHP request.

   Credentialing, qualification, and competency standards are subject to revision by the PIHP and/or Payor at any time. Such revisions will be provided to Provider in writing.

D. **Accreditation.** If Provider has received accreditation by a private independent accrediting entity, it must authorize the private independent accrediting entity to provide the Payor, PIHP and State a copy of its most recent accreditation review, including its accreditation status, survey type and level (as applicable), and recommended actions or improvements, corrective action plans and summaries of findings and the expiration date of the accreditation.

E. **HCBS Approval.**
   a. Provider is either a new provider in Region 4providing Services/Supports covered by the Federal Home and Community Based Services (HCBS) Rule (42 CFR Parts 430,431, 435, 436, 440, 441 and 447) (the "Federal HCBS Rule"), or is an existing Region 4 provider with a new setting that is covered by the Federal HCBS Rule, prior to commencing the provision of Supports/Services under this Agreement, Provider shall furnish Payor with notice of proof that Provider has obtained provisional HCBS approval status through completion of the HCBS New Provider Application, demonstrating that Provider does not require heightened scrutiny.
   b. Provisional approval allows a new provider or an existing provider with a new setting or service to provide services to HCBS participants pending the full survey process. Upon receipt of the comprehensive HCBS survey, Provider shall complete the survey and cooperate with the PIHP to demonstrate 100% compliance with the Federal HCBS rule and State requirements as promulgated by the MDHHS and documented in the Michigan Statewide Transition Plan. Failure to complete the provisional approval process and the ongoing compliance assessments will result in exclusion from participating in Medicaid or Healthy Michigan Plan funded HCBS services.

XI. PROVIDER'S SUPPORTS/SERVICES AND RESPONSIBILITIES

A. The Provider shall perform Supports/Services for reimbursement by Payor hereunder as specified in the attached document labeled Section A – Service/Program Specifications which is incorporated herein by reference and made a part hereof.

B. Supports/Services performed by Provider to the Customer(s) under this Agreement must be in direct accordance with the written individual plan of services of the Customer(s) as developed through a Person-Centered Planning ("PCP") process and a Payor-authorized Supports/Services planning meeting. Provider shall complete Supports/Services and documentation and records thereof that meet Payor's requirements hereunder for reimbursement by Payor. Provider's Supports/Services and documentation/records shall comply with the standards of the PIHP, the MDHHS, and all applicable licensing, MDHHS or agency(ies) of the state of Michigan, Medicaid and Medicare regulations, and/or any third-party reimbursors. Provider shall maintain complete and accurate records of all Supports/Services provided as required under this Agreement and submit them to Payor at such time as may be required by Payor's CEO, or the CEO's designee. Payor and/or PIHP may review such documents/records at any time in its/their sole discretion upon providing reasonable notice.

C. **Behavior Treatment Plans.**

a. Provider agrees that Customer(s) receiving Supports/Services under this Agreement will be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified at 42 CFR 438.00(b)(2)(v).
b. Payor's CEO shall appoint a Behavior Treatment Plan Review Committee which shall review and approve any behavior treatment plans that include limitations on the beneficiary's rights, restrictive and/or intrusive interventions or any use of psycho-active drugs for behavior control purposes.

D. Provider shall perform Supports/Services hereunder at Payor-authorized service locations during this Agreement, as identified in the written plan of services and/or in Section C – Financial & Data Submission Requirements. Provider may have access to Payor's service site(s) and temporary service space therein, if approved by Payor's CEO or the CEO's designee, in order to perform Supports/Services hereunder. Provider shall furnish and utilize Provider's own equipment, tools, materials, and supplies that Provider deems necessary to perform the Supports/Services hereunder.

E. Provider shall exercise independent control over Provider's Supports/Services rendered under this Agreement, including the manner or methods of Supports/Services, service duties or tasks, and the professional procedures thereof. Provider shall use its independent professional judgment consistent with accepted standards of care in rendering Supports/Services to customers under this Agreement and shall be solely responsible to such Customers for the Services/Supports rendered by Provider.

F. Provider shall provide the Supports/Services hereunder in keeping with final results of Supports/Services, deadlines for final results of Supports/Services, and applicable units of Supports/Services, as authorized by Payor's CEO or the CEO's designee.

G. The amounts of service units which Provider shall render hereunder shall be flexible during the period of this Agreement and shall be subject to case-by-case assessments by Payor's CEO or the CEO's designee on the need of Provider's Supports/Services for the Customer(s) and their extent and the service requirements thereof. Provider is not guaranteed a minimum number of Customer cases, Customer appointments, or

Customers to be served under this Agreement. The Payor does not guarantee to the Provider hereunder either the performing of a minimum amount of service units and/or hours of contractual Supports/Services daily, weekly, monthly, or annually during the period of this Agreement.

H. To the extent that Provider delivers Personal Care Services (as defined under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115) and HHCS provided under 1905(a)(7) of the Social Security Act, or a waiver, Provider shall comply with federal requirements regarding the use of electronic visit verification ("EVV") in tandem with the MDHHS implementation timeline. Personal Care Services (as defined above) impacted include, without limitation, community living supports and respite services in a person's home, in a non-licensed setting. Provider shall cooperate with Payor's efforts to verify such compliance. Provider's EVV system must support self-directed arrangements and should be minimally burdensome and/or disruptive to care.

XII. STAFFING AND TRAINING REQUIREMENTS

A. **Staffing Requirements.**

a. Provider shall comply with applicable Payor and PIHP policies, procedures, and shall ensure that its employees and contracted staff meet background checks, applicable licensing, scope of practice, contractual, and Medicaid Provider Manual requirements.

b. Provider shall ensure that each of its staff members, among other applicable requirements, are:
   1. At least eighteen (18) years of age;
   2. Able to perform basic first aid procedures;
   3. Able to prevent transmission of any communicable disease from self to others in the environment in which they are providing Supports/Services;
   4. In good standing according to the MDHHS/PIHP contract; and
   5. At all times in compliance with federal, state, and local laws and regulations.

c. Provider shall make all reasonable efforts to maintain staffing consistency and programming continuity in its provision of Supports/Services hereunder.

d. The Provider shall ensure that all Supports/Services are performed in a manner that demonstrates cultural competence.

e. The Provider shall ensure that it and its staff and contractors comply with the Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans, as referenced in the MDHHS/PIHP Master Contract and which can currently be found at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.html.

f. Provider shall ensure all its job descriptions contain specific language concerning recovery. Provider job responsibilities shall outline recovery-based, person-centered and culturally competent practices. Job qualifications shall specify that lived experiences with behavioral health issues are desired.

g. The Provider shall notify Payor's CEO or the CEO's designated representative immediately whenever:

h. Provider's staffing of Supports/Services required under this Agreement has not been or cannot be provided; and/or

i. The need for Supports/Services to the Customer(s) is otherwise less than or greater than Provider's staffing level(s)

B. **Criminal History Screening.**

a. Provider shall adhere to PIHP and Payor policy on criminal history screening. Employees, contracted staff, and volunteers (including students and interns) of Provider who deliver Supports/Services to Payor's Customers or who have access to their financial or personal information shall be screened for criminal history prior to employment and minimally every two (2) years thereafter. Individuals with disqualifying convictions, as further outlined in this Section, may not provide services to Payor's Customers or have access to their personal or financial information.

b. Provider shall require its employees, contracted staff, and volunteers (including students and interns) who deliver services to Payor's Customers or who have access to their financial or personal information, to notify Provider in writing of criminal convictions (felony or misdemeanor), pending felony charges, or placement on the Central Registry as a perpetrator, at hire or within ten (10) days of the event after hiring.

c. Reporting Requirements:

1. Provider shall promptly notify Payor if Provider:

a. 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 has incurred civil money penalties or assessments imposed under section 1128A of the Social Security Act. (See 42 CFR 1001.1001(a)(1); or

b. Any staff member, director, or manager of Provider, individual with beneficial ownership of five percent or more, or an individual with an employment, consulting, or other arrangement with Provider has been convicted of a criminal offense described under sections 1128(a) and 1128(b)(1), (2), or (3) of the Act, or has had criminal money penalties or assessments imposed under section 1128A of the Act. (See 42 CFR 1001.1001(a)(1).

C. **Exclusions Monitoring.**

a. Provider shall perform exclusions database searches in accordance with Payor and PIHP policies and procedures, of all employees, contracted staff, volunteers (including students and interns), vendors and board members performing Supports/Services under this Agreement, prior to hire, engagement, or service, and at least annually thereafter for non-credentialed individuals.

b. Provider shall perform monthly exclusions database searches for all of its credentialed staff who perform Supports/Services under this Agreement and shall maintain proof of such search results in each credentialed staff's file.

c. Exclusions database searches shall be performed of the following:

d. OIG exclusions database, which can be found at https://www.exclusions.oig.hhs.org.

e. State of Michigan Sanctioned Provider List, which can be found at https://www.michigan.gov/doing-business/providers/providers/billingreimbursement/list-of-sanctioned-providers.

f. System for Award Management (SAM), which can be found at https://www.sam.gov/content/entity-information.
g. Provider shall make exclusions screening results available to Payor and the PIHP upon reasonable request.
h. Provider shall immediately report to Payor if any of its employees, contracted staff, volunteers (including students and interns), vendors, or board members, who perform Supports/Services under this Agreement appear on any of the exclusions database searches, and shall follow applicable Payor and PIHP policies for removing the individual from performing Supports/Services under the scope of this Agreement.

D. **Training Requirements.**

a. Provider shall ensure compliance with Payor, PIHP and MDHHS training requirements. This includes, without limitation, trainings required by the MDHHS PIHP CMHSP Provider Qualifications, the Medicaid Provider Manual, and/or PIHP/Payor policy. Refer to Section G – Training Requirements for additional information. Trainings shall meet content, format, and delivery specifications of the Community Mental Health Association of Michigan's ("CMHAM") State Training Guidelines Workgroup Training/Curriculum Recommendations, as such Recommendations are available. Content of trainings are subject to Payor or PIHP review and approval, upon reasonable request.
b. In the interests of Training Reciprocity, Provider shall accept direct care worker trainings completed at another entity, when the training content has been vetted and approved by the State Training Guidelines Workgroup and completion is current and verified (through a certificate, Improving MI Practices website, or any other related means). Providers may require staff to:
c. Complete a competency test and remedial training if warranted based on test results; or
d. Complete new training if the training provided is expired or unvetted.
e. Provider shall ensure any of its staff providing direct Supports/Services to Customers are trained in the Individual Plan of Service ("IPOS") and any addendums for each individual Customer to whom they provide Supports/Services prior to staff commencing Supports/Services to Customers.
f. Provider shall assure initial and ongoing training and education (at least annually) in the area of Customer Rights/Confidentiality and reporting incidents and Sentinel Events (as defined herein and by Payor's Customer Rights/Confidentiality Procedures) involving Customer(s). Recipient Rights/Confidentiality training shall occur in concert or through technical consultation with Payor's Recipient Rights Office. Payor's staff shall offer continuing education to Provider as needed or when necessitated by changes in Payor's programs, in Recipient Rights requirements, and/or in applicable federal, state, and local laws and regulations.
g. If Provider determines that additional professional training is required in order for its staff to perform Supports/Services or to maintain professional licenses, certifications, and related authorizations required hereunder, Provider shall be solely responsible for obtaining such training and for any costs thereof.
h. Provider shall maintain documentation of attendance and participation in training activities and shall submit this documentation to Payor or PIHP upon request.

i. The Payor will be charging a Provider Network Training Fee to cover the costs of maintaining trainings, tools, and guidance for the Provider Network. The Provider Network Training Fee is calculated at 0.5% of Providers' previous fiscal year revenue. The FY25 Provider Network Training Fee for **Centria Healthcare, LLC** will be **$466.75**. This Provider Network Training Fee will be deducted from Provider fee-for-service payments in May 2025.

E. **Direct Care Worker Rate Increase.**

a. As applicable and based on current year appropriations, Payor shall provide a rate increase to Provider, for the Term of this Agreement, to be used by Provider to increase its eligible direct care work ("DCW") staff wages in accordance with EXHIBIT C – Direct Care Worker Rate Increase, which can be found on the MDHHS website currently at: https://www.michigan.gov/mdhhs/doing-business/providers/providers/medicaid/communicationtraining/173142.

XIII. SERVICE ACCESS, PRE-AUTHORIZATIONS AND UTILIZATION MANAGEMENT

A. Payor is responsible under this Agreement for Supports/Services access assurance, service pre-authorizations, delivery, and utilization management as required under the MDHHS/PIHP Master Contract and the PIHP/CMH Delegation Memorandum of Understanding. Payor policies and procedures pertaining to service access assurance, pre-authorizations, delivery and utilization management are incorporated by reference into this Agreement and made a part hereof.

a. Any Supports/Services by Provider under this Agreement for reimbursement by Payor must receive prior authorization by Payor's CEO or the CEO's designee.
b. Provider shall meet Payor's access standards and treatment deadlines pursuant to this Agreement. Provider also shall meet Payor's duty to treat and all referral requirements.
c. Neither Provider nor any of its subcontracting Providers shall be prohibited from discussing treatment options with a Customer that may not reflect Payor's position or may not be covered by Payor.
d. Provider or any of its subcontracted providers shall not be prohibited from advocating on behalf of a Customer in any grievance or utilization review process, or individual authorization process to obtain necessary health care services.
e. All Supports/Services provided to individuals with mental illness, including those with co-occurring conditions, shall be based on the principles and practices of recovery outlined in the Michigan Recovery Council document "Recovery Policy and Practice Advisory" which is currently located at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900--,00.html.
f. Provider shall meet Medicaid accessibility standards as established in Medicaid policy and this Agreement.

B. Payor and Provider agree that any Supports/Services provided to a Customer who is an Adult with Serious Mental Illness, Child or Adolescent with Severe Emotional Disturbance, and/or an Adult/Child with Intellectual or Developmental Disabilities must be medically necessary and meet the criteria required thereto, as applicable. Medical necessity will be documented in the plan of service by the primary clinician.

C. As authorized by Payor and within Provider's scope of Services/Supports, Provider agrees to make Supports/Services available to Customers referred by a primary Early Periodic Screening, Diagnosis and Treatment ("EPSDT") screener, to correct or ameliorate a qualifying condition discovered through the screening process.

D. Supports/Services to be performed by Provider for a Customer hereunder must be included in an IPOS pursuant to the requirements of MCL 330.1712.

E. Provider, utilizing forms acceptable to Payor, shall forward reports at Payor-designated, periodic intervals to Payor concerning progress toward the goals and objectives set forth in the IPOS of each Customer served hereunder during the service period. Provider shall notify Payor's CEO or the CEO's designee promptly when Provider believes that the IPOS of any Customer is in need of revision or modification because of any of the following:
   a. The Customer has achieved an objective(s) set forth in the IPOS;
   b. The Customer has regressed or lost previously attained skills; and/or
   c. The Customer has failed to progress toward identified objectives despite consistent effort to implement the IPOS.

F. Upon the revocation, restriction, suspension, discontinuation, or loss of any certification, authorization, or license required by federal, state and local laws, ordinances, rules and regulations for Provider to participate in Medicaid, and/or non-Medicaid programs and/or provide Supports/Services for Payor in the State of Michigan, Payor's CEO or the CEO's designee may remove the Customer(s) from Provider's Supports/Services immediately, without prior notification to Provider, and this Agreement shall terminate immediately as provided in Section VI (A).

G. Payor's CEO or the CEO's designee may remove the Payor's Customer(s) from Provider's Supports/Services, upon notification to Provider, for any violation or reasonable suspicion of a violation of Recipient Rights which in the sole discretion of Payor's CEO or the CEO's designee has caused or may cause physical or emotional harm to the Customer(s) and/or, in the sole discretion of Payor's CEO or the CEO's designee, there is a failure by Provider to provide the Supports/Services required by this Agreement. Such a violation, if substantiated by Payor, may be regarded by Payor as a material breach of this Agreement, which in addition to Payor's other legal remedies may result in immediate cancellation of this Agreement with said termination to be effective as of the date of delivery of written notice to Provider.

H. The Provider shall render medically necessary services that the provider is required by law to provide, customarily provides and has the capacity to provide as per Payor criteria and treatment standards. The provider shall not distinguish between referrals from the Payor and other individuals receiving provider services in the quality of or access to the services rendered by the provider. If the Provider has the capacity to accept referrals from the Payor, but refuses to do so, in order to avoid non-compliance with any other term of the agreement, the Payor may take appropriate actions to sanction the provider.

I. Providers shall immediately report capacity issues which potentially could negatively affect individuals receiving services. Capacity issues can include, but are not limited to, barriers to accepting new referrals, staff shortages and/or lack of qualified staff to

perform contracted services. Provider shall ensure continuity of care of individuals served in accordance with each individual's IPOS when Provider incurs staff turnover. Providers shall communicate a plan to Payor inclusive of a timeline addressing reported capacity issues. When applicable, advanced notification shall be timely and communicated to the Payor's Clinical Director and Access staff in writing.

XIV. CUSTOMER HEALTH & SAFETY, RECIPIENT RIGHTS, & GRIEVANCE PROCEDURES

A. **Customer Health & Safety.**

a. Provider shall monitor the health, safety, and welfare of any Customer while they are under its service supervision pursuant to this Agreement. Provider shall provide immediate comfort and protection to and secure immediate medical treatment for a Customer if they suffer physical injury. Provider shall notify Payor's CEO or said CEO's designee immediately of any event or information that raises questions regarding the health and safety of any Customer being served hereunder.

b. The Payor may remove the Customer(s) immediately from Provider's Supports/Services hereunder without prior notification to the Provider whenever, in the judgment of Payor's CEO or said CEO's designee, the health or safety of the Customer(s) is in jeopardy.

c. Each party hereto agrees that if the health and safety of any Customer is in jeopardy, Provider shall arrange for the immediate transfer of that individual to another service site of Provider or to another provider entirely.

d. Transporting Customer(s). Provider shall permit only responsible staff with an appropriate valid driver's license, as required by state law, to operate motor vehicles while transporting Customer(s) hereunder. Provider shall conduct primary source verification of state driving infractions, prior to hire and annually thereafter, for staff who transport customers. Provider shall have policies and procedures in place to ensure safe transportation of Customers receiving Supports/Services.

B. **Recipient Rights.**

a. Provider shall strictly comply with all recipient rights provisions of the Mental Health Code and the MDHHS Rules. Provider agrees:

1. To post a copy of a Payor-provided Summary of Rights, as guaranteed by the Mental Health Code and the MDHHS Rules, in a conspicuous place at its headquarters and/or places of service.
2. The Customers shall be protected from rights violations while receiving Supports/Services under this Agreement.
3. Provider shall report alleged rights violations regarding any Customer hereunder to Payor-designated staff representatives immediately by telephone and then, in writing on Payor-designated forms, within twenty-four (24) hours of such occurrence.
4. All newly hired employees shall receive and have recorded for Payor's Rights Office, approved MDHHS-ORR Recipient Rights Training within the first thirty (30) days of hire and annually thereafter.
5. All newly hired employees working within contracted site shall have a Recipient Rights violation check done by Payor's Office of Recipient Rights, on a provided form.

b. Provider shall comply with the mechanisms established by Payor for protecting Recipient Rights and shall accept the final jurisdiction of Payor's Recipient Rights policies, procedures, and processes and agrees to implement appropriate remedial action for substantiated violations of rights guaranteed by the Mental Health Code and related rules. Payor shall furnish Provider with copies of applicable Recipient Rights policies of Payor.
c. Provider agrees that Payor's Recipient Rights Office representatives shall have unimpeded access at any time to the Customers and all applicable staff, service records and records of Supports/Services of Provider performed under this Agreement, in order for them to fulfill the monitoring function of that office and/or to conduct a thorough investigation. Provider shall have policies and procedures for or shall provide assurance that appropriate action is taken to ensure protection for complainants and rights of staff if evidence of harassment or retaliation occurs regarding alleged rights violations or rights complaint. Access to Provider's training records shall also be provided to Payor's Recipient Rights Officer annually and upon request.
d. Provider shall coordinate with Payor's Office of Recipient Rights in matters pertaining to rights, health, and safety of Customers served under this agreement, and shall forward copies of incident reports related to Payor's Customers to Payor's Office of Recipient Rights, regardless of the County location of Provider, within twenty-four (24) hours.

C. **Reporting.**

a. Provider shall report any incidents and Sentinel Events (as defined herein and by Payor's Customer Rights/Confidentiality Procedures, as incorporated herein by reference) involving the Customer(s) immediately to Payor's CEO or the CEO's designee and as appropriate to the applicable licensing MDHHS or agency of the state of Michigan (Adult and Children Protective Services Divisions), law enforcement, and other public agencies, as required by law. Provider agrees to allow individuals who properly identify themselves as representatives of Michigan Protection and Advocacy Services access during reasonable hours to applicable premises, the recipient of Supports/Services, and service records in compliance with MCL 330.1748(7) and MCL 330.1931. Provider shall provide Payor's Recipient Rights Officer with copies of all investigative reports and summary reports involving Payor's Customers.
b. Provider will report all requests for grievances, requests for formal appeals, and requests for administrative fair hearings to Payor. Standards for customer services are in Schedule A, Section 1(B) of to the MDHHS/PIHP Master Contract.
c. Provider shall inform, in writing, Payor's CEO or their designee of any notice to, inquiry from, or investigation by any federal, state, or local human services, fiscal, regulatory, investigatory, prosecutory, judicial, or law enforcement agency or protection and/or advocacy organization regarding the rights, safety, or care of any Customer served under this Agreement. Provider also shall inform, in writing, Payor's CEO or their designee immediately of any subsequent findings, recommendations, and results of such notices, inquiries, or investigations.

Any breach of this Section shall be regarded as a material breach of this Agreement and may be a cause for termination hereof by Payor.

XV. QUALITY IMPROVEMENT.

A. Provider agrees to participate in and cooperate fully in Payor's implementation of:
   a. Performance Improvement Projects
   b. Quantitative and qualitative member assessments periodically, including Customer surveys, focus groups, and other Customer feedback methodologies
   c. Regular measurement, monitoring, and evaluation mechanisms as to services, utilization, quality, and performance
   d. Systems for periodic and/or random compliance review for audit
   e. Studies to regularly review outcomes for service recipients as a result of programs, treatment, and community services rendered to individuals in community settings
   f. Any other quality review or utilization review programs initiated by the Payor or the PIHP

Any breach of this Section shall be regarded as a material breach of this Agreement and may be a cause for termination hereof by Payor.

XVI. REPORTING REQUIREMENTS.

A. **General.**
   a. Provider shall report financial, program, service and Customer data and additional statistical or other management information in the manner and at the times prescribed by Payor's CEO or designee.
   b. Provider's accounting procedures and internal financial controls shall conform to Generally Accepted Accounting Principles (hereinafter referred to as "GAAP") to ensure all costs allowed by this Agreement can be readily ascertained and expenditures verified therefrom. Provider shall maintain accounts and source records in which any and all revenues received pursuant to this Agreement, and costs allowed by this Agreement, are ascertainable and verifiable and include date of receipt and sources of funds. Provider understands and acknowledges that its accounting and financial reporting under this Agreement must be in compliance with the MDHHS accounting and reporting requirements. Accrual accounting and reporting shall be the methodology implemented by Provider for the purposes of this Agreement.
   c. Provider shall maintain payroll records and other time keeping records sufficient to document the provision of Supports/Services performed under this Agreement.

B. **Immediate Event Notification.**
   g. In addition to other reporting requirements outlined in this Agreement, Provider shall immediately notify Payor of the following events:
      1. **Death.** 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 electronically to Payor within twenty-four (24) hours of either the death, or Provider's receipt of either notification of the death or of notification that a recipient rights, licensing and/or police investigation has commenced, whichever occurs first. Payor shall immediately notify the PIHP which will then report the event to

MDHHS via the Customer Relationship Management (CRM) portal. The report shall include the following information:

a. Date of the incident
b. Provider name
c. Contact person name and contact email address
d. Place/address of incident
e. Name of beneficiary
f. Preliminary cause of death
g. Medicaid ID

h. **Member Relocation.** Relocation of a Customer's placement due to licensing suspension or revocation.
i. **Provider Relocation.** An occurrence that requires the relocation of Provider or Provider panel service site, governance, or administrative operation for more than twenty-four (24) hours.
j. **Convictions.** The conviction of Provider or a Provider staff member for any offense related to the performance of their job duties or responsibilities, in accordance with Section XII (A) of this Agreement, and applicable Payor and PIHP policies and procedures.
k. Except for deaths, notification of the remaining events shall be made telephonically or via other forms of communication within two (2) business days to Payor who shall then immediately provide notice to the PIHP.

C. **Critical Incidents.**

Pursuant to the requirements contained in Section XIV herein, Provider shall cooperate with Payor's preparation and filing of reports of critical incidents, as defined in the MDHHS/PIHP Master Contract and PIHP's Critical Incident Policy. Provider shall fully cooperate with Payor's processes related to sentinel events, which includes all of the following components:

a. Payor determination whether critical incidents are sentinel events within three (3) business days.
b. Following identification as a sentinel event, Payor must ensure that a root cause analysis or investigation begins within two (2) subsequent business days.
c. Based on the outcome of the analysis or investigation, Payor must ensure that a plan of action is developed and implemented to prevent further occurrence of the sentinel event. The plan must identify clear and specific actions to be taken, who is responsible for implementing the plan, the timeline for implementation, and how implementation will be monitored. Alternatively, Provider may prepare a rationale for not pursuing a preventive plan. Corrective action plans or rationale for not pursing a preventive plan are subject to Payor's review and approval.

D. **Ownership & Control Disclosures.**

a. Provider shall comply with the federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions as specified in 42 CFR §455.104-106. This includes providing a complete and accurate Ownership & Control Disclosure form (as defined therein) to Payor at required intervals.
b. Provider shall not knowingly have a relationship (as further defined below), with an individual or entity:
    1. Debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from

participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

2. Who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in paragraph (1) above.
3. Who is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act.
4. Who is excluded from participation in any state healthcare program.

c. The relationships referred to in this Section are as follows:
   1. Any director, officer, or partner;
   2. Any subcontractor;
   3. Any person with an ownership interest of 5% or more of Provider; and/or
   4. Any party with an employment, consulting, or other agreement with Provider for the provision of contract items or services.

d. Provider shall immediately notify Payor, in writing, upon discovery of any prohibited relationship as described in this Section.

E. **Material Breach.** Any breach of this section shall be regarded as a material breach of this Agreement and may be a cause for termination herein by Payor.

XVII. CUSTOMER RECORDS & CONFIDENTIALITY REQUIREMENTS

A. Provider shall establish and maintain a comprehensive individual service record system consistent with the provisions of Payor and PIHP policy, the Medicaid Provider Manual, Medical Services Administration Policy Bulletins, and appropriate state and federal statutes. Provider shall maintain in a legible manner, via hard copy or electronic storage/imaging, recipient service records necessary to fully disclose and document the quantity, quality, appropriateness and timeliness of Supports/Services provided. The records shall be retained according to the retention schedules in place by the MDHHS Department of Management and Budget's ("DTMB") General Schedule #20 at: DTMB – General Schedules for Local Government (michigan.gov). Provider must comply with 45 CFR Part 164 requirements to allow Customers to inspect and obtain a copy of Protected Health Information (as defined by the Health Insurance Portability and Accountability Act of 1996 or "HIPAA"). Provider shall maintain on file during the term of this Agreement a current copy of the IPOS of each Customer receiving Supports/Services from Provider under this Agreement.

B. Payor shall have the sole and exclusive right to retention of all records pertaining to its Customers and Supports/Services rendered pursuant to this Agreement, while providing the ability for Provider to retain copies of related records for purposes of business for the retention period required by applicable law. All such records and reports still in Provider's possession at the termination of this Agreement shall be submitted to Payor's CEO or their designee, as permitted by law.

C. Provider shall comply with, and maintain the confidentiality, security and integrity of Customer record information that is used in connection with the performance of this Agreement to the extent and under the conditions specified in, HIPAA, HITECH, the Mental Health Code, the Public Health Code, 1978 PA 368, as amended and 42 CFR Part 2 (as applicable).

D. It is the intent of the parties to promote broader sharing of behavioral health records, including mental health records for the purposes of payment, treatment, and coordination of care in accordance with Public Act 559 of 2016, and substance use disorder records via electronic health information exchange environments pursuant to 42 CFR Part 2. To accomplish these ends, Provider shall honor, accept and use MDHHS-5515 Permission to Share Behavioral Health Information for the electronic and non-electronic sharing of all behavioral health and SUD information, in accordance with 2014 PA 129. No other consent forms may be used for such treatment-related purposes. Provider shall adhere to the written policy of Payor regarding the use, acceptance and honoring of the Standard Consent Form created by MDHHS under 2014 PA 129.

E. Any breach of this Section shall be regarded as a material breach of this Agreement and may be a cause for termination herein by Payor.

XVIII. BILLING & PAYMENT FOR VALID SUPPORT/SERVICE REIMBURSEMENT CLAIMS

A. For the Term of this Agreement, Provider shall be paid by Payor as reimbursement for Payor-authorized Supports/Services rendered by Provider hereunder as specified below. Payor shall make contractual payments to Provider in accordance with the requirements of the Mental Health Code, the MDHHS Rules, the MDHHS/CMHSP Master Contract for General Funds, the MDHHS/PIHP Master Contract, and applicable state and federal laws, including Medicaid regulations.

B. **Claims.**

a. Provider shall submit Clean Claims for Payor-authorized services rendered to Customers hereunder. In order to be considered valid claims for which payments from Payor may be made, Provider's billing of a service claim must be received by Payor within:

1. Sixty (60) calendar days after the date of service, for a Payor-authorized Customer whose eligibility status has been established without third-party approval; or
2. Ninety (90) calendar days after the date of service, for a Payor-authorized Customer whose eligibility status has been established for ABA Supports/Services.

b. Payor shall conduct verification reviews to substantiate claims received by Provider. Only those Supports/Services in which appropriate authorizations were obtained and appropriate documentation was completed and submitted shall be reimbursed by Payor. Provider shall be reimbursed for services only if Provider meets Payor's credentialing and competency requirements. Payor shall ensure payment to Provider of Clean Claims within thirty (30) days of receipt of a complete and accurate claim.

c. The per unit rate to be paid by Payor to Provider as reimbursement for valid claims for Payor-authorized Supports/Services rendered by Provider during the term of this Agreement shall be as outlined on Section C (Financial & Data Submission Requirements, Claims Submission Reporting & Compensation).

d. It is expressly understood and agreed by Payor and Provider that any payment of claims reimbursement fees hereunder is based upon the intent and the belief that their relationship is that of an independent contractor.

C. **Determination of Financial Status and Benefits Status of the Customer.**

a. For the Customer(s) served under this Agreement, Provider's staff shall complete an initial determination and periodic redeterminations of financial status and public and/or private benefits status. Provider is responsible for determining Customer's coverage for each service. Services billed to Payor incorrectly are subject to recoupment and further contract action.

b. Provider shall be responsible for establishing the Customer(s)' eligibility for third-party reimbursement status, Supplemental Security Income benefit status, and other benefits status, Supplemental Security benefit status, and other benefits status, if any. Provider's staff will assist Payor's staff, when possible, in securing and maintaining such benefits status of the Customer(s) hereunder.

c. Provider's staff shall make pertinent sections of recipient program records available to appropriate staff of Payor as required to meet the obligations hereunder.

D. **Coordination of Benefits.**

a. For the purposes of this Agreement, Provider shall solely be responsible for the coordination of public and private benefits of the Customer(s) hereunder.

b. Provider acknowledges that the Payor shall be the payor of last resort for Payor-authorized Supports/Services to Payor-authorized Customer(s) under this Agreement subject to the terms and conditions herein.

c. The payments from Payor to Provider under this Agreement are intended only to cover the allowable costs of the specialty Supports/Services net of and not otherwise covered by payments provided by other funding, entitlements, or benefits and by liable third parties, as applicable, for which each recipient or services hereunder may be eligible.

d. Provider shall secure an Explanation of Benefits (EOB) from any primary payor (prior to submitting a claim for secondary payment to Payor,) and provide EOBs to Payor according to applicable Payor policies and procedures.

E. **Third Party Liability Requirements.** Provider is required to identify and seek recovery from all liable third parties, consistent with the requirements of the Mental Health Code, the Medicaid Provider Manual, the MDHHS/CMHSP Master Contract for General Funds, and with the MDHHS/PIHP Master Contract. Provider shall be responsible under this Agreement for seeking Supports/Services reimbursements, if applicable, from third party liability claims for the Customer(s) hereunder, pursuant to federal and state requirements.

F. **Payment in Full**

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

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

1. Provider and/or its subcontractors shall not require any co-payments, recipient pay amounts, or other cost sharing arrangements for Provider's Supports/Services required hereunder and/or for Supports/Services of a subcontractor, unless specifically authorized by Payor, the state or federal regulations and/or policies thereof;
2. Provider and/or its subcontractors shall not bill individuals for any difference between a Supports/Services charge of Provider or of a subcontractor and Payor's payment, including Payor's denial of payment, for Provider's Supports/Services required hereunder; and
3. Provider and/or its subcontractors shall not seek nor accept additional supplemental payments from the Customer, their family, or representative, for Provider's services required hereunder and/or for the Supports/Services of a subcontractor.

G. **Refunding of Payments Pursuant to 42 CFR 401.305.**

a. Provider shall not bill Payor for Supports/Services rendered hereunder in any instances in which Provider received monies directly for Supports/Services from another funding source or from another party that provides for, reimburses, offsets, or otherwise covers payment retroactively, currently, or subsequently for such Supports/Services. If, at any time, it is determined, after Supports/Services claims reimbursement has been made by Payor to Provider, that Provider received monies directly for the Supports/Services from another funding source or from another party that provides for, reimburses, offsets, or otherwise covers payment retroactively, currently, or subsequently for such Supports/Services, Provider shall refund to Payor an amount equal to the sums reimbursed by third party payors and/or paid by any other source. Provider shall notify Payor within five (5) business days of identification of receipt of any such payments.

b. When Provider identifies an overpayment for any reason, including an overpayment as described in subpart (G)(A) above, Provider shall:
   1. Notify Payor in writing within five (5) business days of the amount and reason for the overpayment and the date that the overpayment was identified; and
   2. Return the overpayment to Payor within sixty (60) calendar days of the date the overpayment was identified.

c. This requirement shall survive the termination of this Agreement. An overpayment must be reported and returned in accordance with this subsection if the overpayment is identified within six (6) years of the date the overpayment was received.

H. **Unallowable Costs/Claims and Financial Paybacks.** Should Provider fail to fulfill its obligations as specified in this Agreement, thereby resulting in unallowable Supports/Services or costs/claims, it shall not be reimbursed by Payor hereunder for any such costs/claims and shall reimburse Payor as financial paybacks of any claims payments made by Payor for unallowable costs/claims. Repayment shall be made by Provider to Payor within sixty (60) calendar days of Payor's final disposition notification to Provider that Payor has made unallowable payments to Provider for unallowable Supports/Services and/or costs/claims and, thereby, financial payback by Provider is required. This requirement shall survive the termination of this Agreement.

I. **Disallowed Expenditures and Financial Repayments.** In the event that the MDHHS, Payor, the state of Michigan, or the federal government ever determines in any final revenue and expenditure reconciliation and/or any final finance or service audit that Provider has been paid inappropriately per Payor's expenditures of federal, state, and/or local funds under this Agreement for fees, Supports/Services claims, and/or costs/claims which are later disallowed, the Provider shall fully repay Payor for such disallowed payments within sixty (60) days of notification of the disallowances. This requirement shall survive the termination of this Agreement.

XIX. FINANCIAL RECORDS & AUDITS

A. In compliance with MDHHS Policy Bulletin MSA 21-39 (and any related guidance promulgated thereafter) establishing annual cost reporting requirements for behavioral health service providers contracted with a CMHSP, Provider shall cooperate with MDHHS cost reporting policy and complete, as applicable, the MDHHS cost reporting survey process by all required deadlines.

B. Provider will annually obtain an independent financial audit when any of the following conditions are met:
   a. Provider's total fiscal year revenue received from Payor is at least $500,000; or
   b. Provider's total fiscal year revenue received from Payor in the form of Federal grants is at least $100,000; or
   c. Provider's total fiscal year revenue received from all sources in the form of federal grants is at least $750,000.

C. If an audit is required, the following items are specific requirements:
   a. To use the accrual method of accounting.
   b. Provider will follow any applicable Accounting and Audit Guides issued by the American Institute of Certified Public Accountants (AICPA), such as Not-for-Profit Organizations or Health Care Organizations.
   c. The audit will cover Provider's fiscal year and must be received electronically within one hundred fifty (150) days following the fiscal year end and directed to the attention of the ISK Lead Financial Analyst at jbest@iskzoo.org. The audit must be performed by a certified public accountant to assure the financial statements are presented in conformance with accounting principles generally accepted in the United States of America.
   d. The audit must include the required internal control and compliance reports when Government Auditing Standards or Single Audit requirements apply.
   e. Provider cash advances must be identified as a liability and correspond to Payor amount.
   f. The audit must comply with regulations set forth in the Title 2 U.S. Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance), when applicable. The Single Audit threshold is $750,000 for the total amount of Federal Grant funding received by a Contractor.
   g. The audit report must include supplemental schedules of Functional Revenue and Expenses that identify each Payor's program separately for both mental health services and substance abuse services, if applicable. The supplemental schedules must be subjected to the procedures applied in the audit of the financial

statements. Reference Section H – Financial Audit Example for additional information.

h. Payor must receive either a management letter issued by the independent auditor or a letter stating a management letter was not issued.

i. All consolidated audits must contain sufficient detail to identify Provider's balance sheet and operating expenses.

j. If required to file a Form 990 (Return of Organization Exempt from Income Tax) under Internal Revenue Service (IRS) regulations, the Provider must submit an electronic copy of the Provider's Federal Form 990 within thirty (30) days of the submission to the IRS. The Provider's Federal Form 990 should be sent to the ISK Lead Financial Analyst at jbest@iskzoo.org.

k. To permit Payor's auditors and other authorized representatives of the Board or the State to review Provider's financial records as may be deemed necessary within normal business hours and with or without advance notification.

XX. RELATIONSHIP OF THE PARTIES

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

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

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

D. Provider shall be responsible for paying all salaries, wages, or other compensation due its officers, employees, servants and agents for performing Supports/Services under this Agreement, and for the withholding and payment of all applicable taxes, including, but not limited to, income and Social Security taxes, to the proper federal, state and local governments. Provider shall be responsible for providing workers' compensation coverage and unemployment insurance coverage for its employees, as required by law.

E. **Relationship with Other Contractors of the Payor.** The relationship of Provider, pursuant to this Agreement, with other contractors of Payor shall be that of independent contractor. Provider, in performing its duties and responsibilities under this Agreement, shall fully cooperate with the other contractors of Payor. Payor's requirements of such cooperation shall not interfere with Provider's performance of Supports/Services required under this Agreement.

XXI. CONFLICT OF INTEREST

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

XXII. INDEMNIFICATION AND HOLD HARMLESS

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

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

XXIII. INSURANCE REQUIREMENTS

A. Provider shall procure, pay the premium on, and maintain during the term of this Agreement, the following liability insurance coverage for all Supports/Services to be performed under this Agreement, unless authorized in writing by Payor's CEO, or designee. All required insurance must protect Payor, the PIHP, and the State from claims that arise out of, are alleged to arise out of, or otherwise results from Provider's or Provider's subcontractors' performance.

Required Limits	Additional Requirements
Commercial General Liability Insurance	
Minimum Limits: $1,000,000 Each Occurrence $1,000,000 Personal & Advertising Injury $2,000,000 General Aggregate $2,000,000 Products/Completed Operations	
Automobile Liability Insurance	
If a motor vehicle is used in relation to Provider's performance under this Agreement, Provider must have vehicle liability insurance on the motor vehicle for bodily injury and property damage as required by law.	

Worker's Compensation Insurance	
Minimum Limits: Coverage according to applicable laws governing work activities	Waiver of subrogation, except where waiver is prohibited by law
Employer's Liability Insurance	
Minimum Limits: $500,000 Each Accident $500,000 Each Employee by Disease $500,000 Aggregate Disease	
Privacy and Security Liability (Cyber Liability) Insurance	
Minimum Limits: N/A	See Paragraph E below
Professional Liability (Errors and Omissions) Insurance	
Minimum Limits: $1,000,000 Each Occurrence $3,000,000 Annual Aggregate	

B. Payor and the PIHP, their directors, officers, employees, employees, servants and agents shall be named as Additional Insureds on Provider's insurance coverage required above. It is expressly understood and agreed that Provider's liability coverage required above shall be primary to the Additional Insureds and not contributing with any other insurance or similar protection available to the Additional Insureds, whether said other available coverage be primary, contributing or excess.

C. If any required policies provide claims-made coverage, Provider must:
   a. Provide coverage with a retroactive date before the Effective Date of this Agreement.
   b. Maintain coverage and provide evidence of coverage for at least three (3) years after completion of the Agreement activities; and
   c. If coverage is cancelled or not renewed, and not replaced with another claims-made policy form with a retroactive date prior to the effective date of this Agreement, Provider must purchase extended reporting coverage for a minimum of three (3) years after completion of work.

D. Provider shall submit certification of its insurance coverage to Payor or PIHP prior to the execution of this Agreement. The certificates of insurance for Provider shall contain a provision stating that coverages afforded under the policies will not be changed or cancelled until at least thirty (30) days prior written notice has been given to Payor. Provider shall provide Payor with written notification at least thirty (30) days prior to any reduction or termination of the insurance coverage required herein.

E. Provider shall maintain higher coverage limits and/or such other insurance (e.g., Cyber Liability Insurance, Disability Insurance) as shall be necessary to insure Provider against any claim(s) arising from this Agreement, including but not limited to claim(s) for damages. In the event Provider's insurance policies are inadequate to cover financial losses sustained, Provider shall suffer the loss separately and indemnify Payor from any claims and damages.

F. Any breach of this Section shall be regarded as a material breach of this Agreement and may be cause for termination herein by Payor. Provider shall indemnify Payor for any loss incurred as a result of Provider's failure to maintain coverage, which obligation to indemnify shall survive the termination of this Agreement.

G. This section is not intended to and is not to be construed in any manner as waiving, restricting, or limiting the liability of either party for any obligation under this Agreement.

XXIV. MISCELLANEOUS PROVISIONS

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

B. **Informational Requirements.**

a. Informative materials intended for distribution through written or other media to Customers or the broader community that describe the availability of covered Supports/Services and how to access those Supports/Services pursuant to this Agreement, must meet the following standards:

1. All such materials shall be written at the 6th grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis and conditions that do not meet the 6th grade level criteria).
2. All such materials must be in an easily understood language and use font size no smaller than 12 point.
3. All such materials shall not contain false, confusing, and/or misleading information.
4. For consistency in the information provided to enrollees, Provider must use the state developed definitions for managed care terminology as defined in the PIHP contract and/or Medicaid Provider Manual.

C. **Media Campaigns.** Payor or PIHP shall be notified at least sixty (60) days prior to the initiation of any Provider-sponsored media campaign regarding the availability of Supports/Services related to this Agreement. A media campaign, as referenced herein, is a message or series of messages conveyed through mass media channels including print, broadcast, and electronic media. The Provider shall not include Payor's, the PIHP's, or MDHHS's information (e.g. name, logo, staff names, contact number(s), etc.) in its medica campaign without prior written approval of Payor and/or PIHP.

D. **Return of Property.** Immediately upon termination of this Agreement, and/or removal of Customers from its Supports/Services hereunder, Provider shall return the following to Payor: 1) all original documents or copies of the clinical records of the Customers; 2) all personal property of Customers; and 3) all other documents, files, correspondence, papers or records of Customers.

E. **Notice.** Any and all notices, designations, consents, offers, acceptances or other communications, including this Agreement, shall be delivered to either party, in

writing, by facsimile, electronic transmission, personal delivery or deposited in certified mail addressed to the addressee shown below (unless notice of a change of address is furnished by either party to the other party hereto) and with return receipt requested, effective upon receipt:

Notice to Payor should be addressed to:
Director of Network Compliance
610 S. Burdick St.
Kalamazoo MI 49007
P: (269) 364-6986
F: (269) 364-6989
Contracts@iskzoo.org

Notice to Provider should be addressed to:
Centria Healthcare, LLC
27777 Inkster Rd.
Farmington Hills, MI 48334
P: (248) 767-5476

XXV. SANCTIONS

A. Payor may utilize a variety of means, such as formal written notice of contract violation, plan of correction, or referral moratorium, to assure Provider's compliance with the requirements set forth in this Agreement. Payor may pursue remedial actions and possible sanctions as needed to resolve outstanding contract violations and performance concerns. Sanctions will be based on the severity and frequency of the violation(s). Typically, sanctions will be progressive in nature, but can begin at any level depending on the severity and frequency of the violation. Actions taken during the sanction process may include but are not limited to:

a. Notice of the contract violation and conditions issued to the Provider.
b. A plan of correction with specified objectives and status reports is required.
c. A referral moratorium is instituted.
d. Funds are withheld pending correction of contract violation(s).
e. Initiation of Agreement termination.

B. The following are examples of compliance or performance problems for which remedial actions including sanctions may be applied to address repeated or substantial breaches, patterns of non-compliance or substantial poor performance. This listing is not meant to be exhaustive and includes but is not limited to the following:

a. Reporting or documentation timeliness, quality and accuracy
b. Compliance with performance indicator standards
c. Repeated or substantial site-review non-compliance
d. Substantial or repeated health and/or safety violations
e. Substantial or repeated failure to initially and periodically verify member insurance coverage and/or coordinate benefits, including seeking payment from primary payors prior to seeking payment from Payor.

C. Provider may utilize the dispute resolution process set forth in this Agreement to dispute a contract compliance notice issued by Payor.

D. **Uncured Deficiencies.** Substantial failure by Provider to fulfill its obligations hereunder, which is not cured within the time period specified in Section VI, Subsection B ("Uncured Deficiencies"), may result in the termination of this Agreement for material breach as provided in Section VI or sanctions as provided in this Section.

XXVI. MONITORING OF THE AGREEMENT

A. **Oversight & Monitoring.**

a. The performance of the terms of this Agreement shall be monitored on an ongoing basis by the designated representatives of Payor and of Provider. Payor's CEO shall appoint administrative and program liaisons to be available to communicate with Provider's liaisons.

b. Provider agrees to provide access to Provider's Executive Officer or their designee to evaluate, through survey, inspection or other means on a retrospective or current basis, the appropriateness, quality, and timeliness of services performed and compliance with program/service standards required hereunder.

c. Payor shall conduct or cause to be conducted annual on-site reviews of Provider to determine compliance with Payor's provider network requirements, as applicable, including without limitation Provider's compliance with Recipient Rights and confidentiality requirements under the Mental Health Code. In that regard, Provider agrees to the following:

1. Provider shall reasonably cooperate with all site reviews.
2. Payor or its designee shall prepare a written report of its site review findings. Said report shall not contain any information prohibited from use or disclosure under the Mental Health Code, HIPAA, HITECH, 42 CFR Part 2, or the Public Health Code 1978 PA 368, as amended (the "Public Health Code").
3. Payor or its designee may share its site review findings and written report, and any written response from Provider, with other PIHPs or CMHSPs as determined by Payor, without approval from Provider.
4. Notwithstanding anything to the contrary contained in this Agreement, Payor may also obtain site review findings and reports regarding Provider from other PIHPs or CMHSPs, and Payor may utilize such information in the exercise of its rights under this Agreement.
5. Payor retains the right to seek additional information or take further actions following Provider site review, including without limitation, conducting follow-up site reviews.
6. All final determinations, management actions and network status decisions concerning Provider that are based on or related to site review findings, shall be made exclusively by Payor.
7. Provider, its attorneys, assignees, transferors, transferees, principals, partners, officers, directors, employees, servants, subsidiaries, parent corporations, affiliates, successors, agents, and representatives, agree not to pursue any and all claims, demands, damages, debts, liabilities, obligations, contracts, agreements, causes of action, suits and costs, of whatever nature, character or description, whether known or unknown, suspected or unsuspected, anticipated or unanticipated, which Provider may claim to have against Payor arising out of the site review, the site review report or the

sharing of the site review findings or site review report, except for those claims directly related to payment from Payor to Provider.

B. **Access**

a. Provider agrees to provide access to Payor's CEO or said CEO's designee to evaluate, through inspection or other means on a retrospective or current basis, the appropriateness, quality, and timeliness of Supports/Services performed hereunder by Provider and Provider's compliance with program service standards required thereto.

b. The Provider agrees that the Michigan Medicaid Agency and the U. S. Department of Health and Human Services may evaluate, through inspection or other means, the appropriateness, quality, and timeliness of Supports/Services performed under this Agreement.

c. For purposes of the MDHHS/PIHP Master Contract and the MDHHS/CMHSP Master Contract for General Funds, Payor, the CMS, the HHS Inspector General, the Comptroller General, the state of Michigan, or designated representatives, shall be allowed to inspect, review, copy, and/or audit the following at any time, to the full extent permitted by applicable federal and State law:
   1. All financial records.
   2. License, accreditation, certification, and program reports of the Provider.
   3. All clinical records of Provider pertaining to performance of this Agreement.
   4. Provider's premises and physical facilities.
   5. Equipment, books, records, and contracts.
   6. Computers and other electronic systems relating to Provider's Medicaid enrollees.

d. The right to audit may be exercised at any time ten (10) years from the final date of the contract period or from the date of completion of any audit that occurs during such 10-year period, whichever is later.

e. If Payor, PIHP, state of Michigan, CMS, or the DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, that entity may inspect, evaluate and audit Provider at any time.

f. All financial, administrative, and clinical records pertaining to this Agreement must be retained according to the retention schedules in place by DTMB's General Schedule #20 at: DTMB – General Schedules for Local Government (Michigan.gov) unless these records are transferred to a successor organization or as otherwise directed in writing by MDHHS.

g. All enrollee grievance and appeal records in 42 CFR 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR 438.8(k), and the data, information and documentation specified in 438.604, 438.606, 438.608 and 438.610 shall be retained for a period of no less than 10 years.

h. Refusal by Provider to allow Payor, the parties to the MDHHS/PIHP Master Contract, the MDHHS/CMHSP Master Contract for General Funds, and the federal government, the state of Michigan, or their designated representatives access to Provider records, programs and services for audit, review, or evaluation shall be regarded as a material breach of this Agreement and may be a cause for termination thereof by Payor.

C. **Dispute Resolution**

a. Provider agrees to adhere to Payor's policies and procedures governing provider grievances, disputes and appeals, including without limitation any grievance,

dispute or appeal of changes in Provider's status as a provider in Payor's provider network.

b. Contract issues between Payor and Provider as to specific provisions of this Agreement and implementation thereof and/or service disputes hereunder shall be addressed by the designees of each party. Unresolved contract issues, as to specific provisions of this Agreement and implementation thereof, and/or service disputes hereunder shall be referred to Payor's CEO or designee for a final determination. Payor's CEO or designee shall furnish Provider with written notice of any such final determination hereunder.

c. In situations requiring corrective action, the designee of Payor's CEO and Provider's designee shall meet to enable Payor's staff to finalize a Payor-authorized plan of corrective action for a contractual service resolution. Such a corrective action plan must be approved by a designee of the Payor's CEO before being implemented. If Provider objects to Payor-authorized corrective action plan involving Supports/Services to be provided hereunder to the Customers, Provider may appeal any such determination to Payor's CEO within twenty-four (24)-hours after notification of the corrective action plan. The parties hereto agree that implementation of any such Payor-authorized plan of corrective action must begin within twenty-four (24)-hours after Payor's staff has notified Provider of the plan of corrective action unless Payor's CEO specifies, in writing, a greater or less time period for implementation of said plan.

XXVII. WAIVERS

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

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

XXVIII. AMENDMENT

Modifications, amendments, or waivers of any provision of this Agreement may be made only by a writing signed by both parties hereto.

XXIX. ASSIGNMENT

A. Neither this Agreement nor any rights or obligations hereunder shall be assignable by Provider without the prior written consent of Payor, nor shall the duties imposed herein be subcontracted or delegated without the prior written consent of Payor. Any attempted assignment in violation of this section shall be void at initiation.

B. This Agreement shall be binding upon Payor and Provider and their respective successors and permitted assigns.

C. **Subcontracts.**

a. If Provider, with Payor's prior consent, subcontracts any Supports/Services required of Provider under this Agreement, any such subcontract must:
   1. Be in writing and include a full specification of the subcontracted Supports/Services;
   2. Contain a provision stating that this Agreement is incorporated by reference into the subcontract and made a part thereof;
   3. Contain a provision stating that the subcontract is subject to the terms and conditions of this Agreement. Any such subcontract shall not terminate the legal responsibility of Provider to assure that Supports/Services required of the Provider hereunder are fulfilled;
   4. Ensure, as applicable, that the professional staff, if any, meet Payor's credentialing and privileging requirements, including privileging and competency standards and/or that its non-professional staff meets Payor's requirements for qualifications and competency standards, necessary to perform the subcontracted Supports/Services.

b. Prior to the execution of any such subcontract, Provider shall furnish Payor with notice verifying that:
   1. The 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 for Customers.
   2. The subcontractor is not listed by a MDHHS or agency of the federal government or the State of Michigan as being suspended from participation in Medicaid or Medicare Programs.
   3. The subcontractor is not listed by a MDHHS or agency of the State of Michigan in its registry for unfair labor practices.
   4. The subcontractor is not listed by the U.S. General Services Administration in its "Excluded Parties List" as to federal funding.
   5. The subcontractor maintains workers compensation and unemployment insurance coverage for its employees.
   6. The subcontractor maintains liability insurance coverages required by the Payor for the Supports/Services.

c. Provider shall immediately notify Payor, in writing, if, subsequent to execution of any such subcontract, Provider discovers that any of the above cited verifications are no longer true.

D. Should Provider enter into a contract with a third party, including, without limitation, a subcontractor for Supports/Services under this Agreement that requires the generation, receipt, maintenance, use, disclosure, or transmission of Protected Health Information in the course of the third party's performance of its duties, to the extent that Provider determines that the third party is a HIPAA Business Associate of Provider, Provider shall enter into a HIPAA Business Associate Agreement with the third party and shall provide an executed copy of said Business Associate Agreement to Payor and/or PIHP upon request.

XXX. DISREGARDING TITLES

The titles of the Sections in this Agreement are inserted for the convenience of reference only and shall be disregarded when construing or interpreting the validity of this Agreement.

XXXI. ENTIRE AGREEMENT

This Agreement, the attached Exhibits, and the additional and supplementary documents incorporated herein by specific reference contain all the terms and conditions agreed upon by Payor and Provider and no other agreements, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity to bind either Payor or Provider. The agreements, exhibits, and additional and supplementary documents referenced herein shall be governed in the priority outlined in Section IV.

XXXII. SEVERABILITY AND INTENT

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

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

XXXIII. CERTIFICATIONS

A. **Debarment and Suspension.** The person signing this Agreement on behalf of Provider hereby represents, warrants, and certifies, by signing, to the best of his or her knowledge and belief, that it and its principals, officers, employees, and contractors:
   a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or excluded from any state and/or federal healthcare program.
   b. 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 under a public transaction, violation of federal or state anti-trust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property.
   c. Are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses enumerated in the above cited subsection XVII(a)(ii) of this Section.
   d. Have not within a three (3) year period preceding the commencement of this Agreement had one (1) or more public (federal, state, or local) transactions terminated for cause or default; and,
   e. Are not currently excluded from participation in any federal or state healthcare program.

B. **Authority to Sign.** The persons signing this Agreement on behalf of the parties hereto certify by said signatures that they are duly authorized to sign this Agreement on behalf of said parties and that this Agreement has been authorized by said parties. 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. Provider certifies that all supplemental material reference within this agreement has been electronically reviewed and Provider consents to the information contained in the applicable sections based on the services rendered by the Provider.

XXXIV. SECTION AND ATTACHMENTS

Payor and Provider agree this contract and its referenced sections and attachments are intended to constitute the entire and integrated understanding between them. No oral amendment will be made to this contract. The referenced contract Sections and Attachment are located on the ISK portal:

https://iskzoo.sharepoint.com/sites/Providers/Contracts/Forms/AllItems.aspx

Section A
Service Specifications/Program Specifications (Services, Credentials, Training, Service Eligibility, Access & Authorization)

Section B
Allowable Place of Service Codes

Section C
Financial & Data Submission Requirements

Section D
Agency Performance Indicators and Services Outcome

Section G
Training Requirements

PROVIDER AGREEMENT FOR PROGRAM SUPPORTS/SERVICES

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

INTEGRATED SERVICES OF KALAMAZOO

Signed by:
Jeff Patton
63D50C801ACB4C8...

Signature

10/24/2024 | 9:22 AM EDT

Date

By: Jeff Patton
Its: Chief Executive Officer

CENTRIA HEALTHCARE, LLC

DocuSigned by:
Jason Turk
49C290E52308414...

Signature

10/24/2024 | 6:10 AM PDT

Date

By: Jason Turk

Its: CFO

EXHIBIT A – GLOSSARY OF TERMS AND DEFINITIONS

Capitalized terms used in this Agreement shall be construed and interpreted as defined below:

Agreement

This Agreement whereby Payor purchases services on a subcontracted basis from the party designated as "Provider" in the introductory paragraph (i.e., on page 1) of this Agreement.

Clean Claim

A clean claim is defined by the Michigan Insurance Code, Chapter 500, Act 218 of 1956, Section 500.2006(14), and in short is a claim that can be processed without obtaining additional information from Provider of the service or a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

CMHSP

An abbreviation for the Community Mental Health Services Program operated under Chapter 2 of the Mental Health Code Act 258 of 1974, as amended.

Customer

An individual who is a Medicaid Eligible, Indigent person or qualifies for Priority Population designation, and who is a service area resident who meets the service eligibility criteria and is receiving or may receive specialty Supports/Services under this Agreement.

Employee

An individual classified or unclassified, of the executive branch of this state. For the purpose of section 2b of MCL 15.341, employee shall include an employee of this state or a political subdivision of this State.

HCBS

An abbreviation for Home and Community-Based Services.

Healthy Michigan Program

The Healthy Michigan Program is a new category of eligibility authorized under the Patient Protection and Affordable Care Act and Michigan Public Act 107 of 2013 that began April 1, 2014.

Indigent Person

An individual who is not a Medicaid Eligible, who is unable to pay for Supports/Services covered under this Agreement and is not eligible for any public or private health care coverage program, pursuant to the ability to pay determination requirements and other related requirements under Chapter 8 (Financial Liability for Mental Health Services) of the Mental Health Code.

Material Breach

Material breach is defined as the substantial failure of a party to fulfill its obligations under this Agreement, including without limitation, Provider's failure to comply with Payor's Compliance Plan.

Medicaid Eligible

An individual who has been determined to be entitled to Medicaid and who has been issued a Medicaid card.

MDHHS

An abbreviation for the Michigan Department of Health and Human Services.

MDHHS/CMHSP Master Contract for General Funds

The current Managed Mental Health Supports and Services Contract for General Funds between the MDHHS and Payor.

MDHHS/PIHP Master Contract

The 1115 Waiver Demonstration, the 1915(i)/(c) Waiver Program(s), the Healthy Michigan Program, the Flint 1115 Waiver and Substance Use Disorder Community Grant Programs Agreement between the MDHHS and the PIHP.

Medicaid Managed Specialty Service and Supports Program (MMSSSP)

This includes the following: 1115 Behavioral Health Demonstration Waiver and the 1915(c) Habilitation Supports Waiver, Children's Waiver Program (CWP), Serious Emotional Disturbance (SED), the MIChild program, MOMS program, and the 1115 Healthy Michigan Plan.

Maternity Outpatient Medical Services (MOMS)

A health coverage program operated by the state.

Potential Customer

An individual who is a Customer residing in Payor's service area. A Potential Customer is not a person receiving specialty Supports/Services under this Agreement.

Priority Population

An individual who meets the eligibility criteria under the Mental Health Code for priority population designation.

Professional Staff

An individual who is required to credentialed pursuant to MDHHS policy. This includes the following individuals:

- Physicians (M.D. or D.O.)
- Physician Assistants
- Psychologists (Licensed, Limited License, or Temporary License)
- Licensed Mater's Social Workers, Licensed Bachelor's Social Workers, Limited License Social Workers, and Registered Social Service Technicians
- Licensed Professional Counselors
- Board Certified Behavior Analysts
- Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses
- Occupational Therapists and Occupational Therapist Assistants
- Physical Therapists and Physical Therapist Assistants
- Speech Pathologists
- Licensed Marriage and Family Therapists
- Other behavioral healthcare specialists licensed, certified, or registered by the state

Public Officer

A person appointed by the governor or another executive MDHHS official. For the purpose of section 2b of MCL 15.341, public officer shall include an elected or appointed official of this state or a political subdivision of this state.

Rules

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

Sentinel Events

Events which include but are not limited to, death of the recipient, any accident or physical illness that requires hospitalization, major or permanent loss of functioning, suspected abuse and neglect of a recipient, serious challenging behaviors (e.g., property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence), medication errors, and arrest/convictions. Michigan law and rules promulgated thereto require the mandatory reporting of such matters within 48 hours.

Service Area

The County of Kalamazoo, the Payor's service area for this Agreement.

Supports/Services

The Medicaid Mental health specialty supports/services as described in this Agreement including the Exhibits attached hereto.

EXHIBIT B – COMPLIANCE WITH APPLICABLE LAWS, RULES, REGULATIONS & PLANS

A. **Compliance Generally.** Provider, its officers, employees, servants, and agents shall perform all their respective duties and obligations under the Agreement in compliance with all applicable federal, state, and local laws, ordinances, rules and regulations, sub-regulatory guidance, administrative procedures, and applicable contract provisions, whether referenced herein or not, including but not limited to the following:
   a. **Michigan Laws.** The Agreement shall be construed in accordance with the laws of the state of Michigan as to the interpretation, construction and performance.
   b. **Venue.** CMHSP and Provider agree that the venue for bringing any legal or equitable action under the Agreement shall be established in accordance to the statutes of the state of Michigan and/or Michigan Court Rules. In the event that any legal action is brought under the Agreement in Federal Court, the venue for such legal action shall be the Federal Judicial District of Michigan, Western District, Southern Division.
   c. **Medicaid**. Provider shall comply with Michigan's State Plan under Title XIX of the Social Security Act and Michigan's Medicaid Provider Manual and Medicaid Policies and Guidelines. (Schedule A, Section (1)(Q)(14)).
   d. **Michigan Mental Health Code and Administrative Rules.**
   e. **Michigan Public Health Code and Administrative Rules.** Provider agrees to comply with the Michigan Public Health Code and administrative rules in effect during the Term of this Agreement, including, without limitation, health reporting requirements.
   f. **MDHHS Appropriations Acts.** The parties shall comply with those acts in effect during the Term.
   g. **Mental Health/SUD Laws.** When providing Mental Health Services and/or SUD Services under the Agreement, Provider, its officers, employees, servants, and agents shall abide by all applicable provisions and requirements as set forth in the Mental Health Code, including 2012 P.A. 500, MDHHS Rules, Medicare and Medicaid laws and regulations, including the Balanced Budget Act of 1997 and the Final Rule, 42 CFR Part 438, and in policies, procedures, standards, and guidelines established by CMHSP and the PIHP.
   h. **CMHSP Policies and Procedures.** The CMHSP's policies and procedures, including those governing provider grievances, disputes and appeals, including without limitation any grievance, dispute or appeal of changes in Provider's status as a provider in the CMHSP's provider network.
   i. **CMHSP's Compliance Plan.** Provider, its principals, officers, employees, contracted and subcontracted providers, servants and agents are subject to and shall comply with all applicable requirements of CMHSP's Compliance Program Plan, as annually approved by CMHSP's Board. Failure to do so will result in remediation action and/or termination of the Agreement for material breach, as provided in Section V. Paragraph (b) of the Agreement.
   j. **Confidentiality.** To the extent that CMHSP and Provider are HIPAA Covered Entities and/or Programs under 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 and as may be later amended) with respect to all Protected Health Information and substance use disorder treatment information that it generates, receives, maintains, uses, discloses or transmits in the performance of its functions pursuant to the Agreement. To the extent that Provider determines that it is a HIPAA Business Associate of CMHSP and/or a Qualified Service Organization of CMHSP, then CMHSP and Provider shall enter into a HIPAA Business Associate Agreement and a Qualified Service Organization Agreement that complies with applicable laws and is in a form acceptable to both CMHSP and Provider. CMHSP and Provider shall maintain the

confidentiality, security and integrity of beneficiary information that is used in connection with the performance of this contract to the extent and under the conditions specified in HIPAA, the Michigan Mental Health Code (PA 258 of 1974, as amended), the Michigan Public Health Code (PA 368 of 1978 as amended), and 42 C.F.R. Part 2.

k. **Programs.** Provider shall comply under the Agreement with the 1115 demonstration waiver, the Concurrent 1915 (i) and 1915 (c) Waiver Programs, the Healthy Michigan Program and the SUD Community Grant Programs.
l. **Waivers.** Approved Medicaid Waivers and corresponding CMS conditions, including 1915(i), (c) and 1115 Demonstration Waivers.
m. **Whistleblower.** Provider shall abide by and post a copy of the Whistleblower's Protection Act (Act 469 of the Public Acts of 1980) in a conspicuous place at its public and/or licensed service location(s) and its headquarters.
n. **Federal False Claims Act.**
o. **Michigan Medicaid False Claim Act.**
p. **Michigan Social Welfare Act.**
q. **Deficit Reduction Act (DRA).** 2005, PL 109-17, section 6032 codified at Section 1902(a)(68) of Title XIX (Social Security Act) requires Employee Education About False Claims Recovery.
r. **New Rules or Regulations.** If any laws or administrative rules or regulations that become effective after the date of the execution of the Agreement substantially change the terms and conditions of the Agreement, they shall be binding on the parties, but the parties retain the right to exercise any remedies available to them by law or by any other provisions of the Agreement.

B. **Laws Pertaining to Non-discrimination.** In performing its duties and responsibilities under this Agreement, Provider shall comply with all applicable federal and State laws, rules and regulations prohibiting discrimination. Notwithstanding the foregoing, as it relates to the Supports/Services, Provider, specifically, shall:

a. Not discriminate against any employee or applicant for employment with respect to hire, tenure, terms, conditions, or privileges of employment or a matter directly or indirectly related to employment because of race, color, religion, national origin, age, sex (as defined in Executive Directive 2019-09), height, weight, marital status, partisan considerations, any physical or mental disability, or genetic information that is unrelated to the individual's ability to perform the duties of the particular job or position, as required pursuant to: the Elliott Larsen Civil Rights Act of 1976 PA 453, as amended; the Persons with Disabilities Civil Rights Act, 1976 PA 220, as amended; and Section 504 of the Federal Rehabilitation Act 1973, P.L. 93-112;
b. Comply with the provisions of the Michigan Persons With Disabilities Civil Rights Act of 1976 PA 220, as amended, and Section 504 of the Federal Rehabilitation Act of 1973 P.L. 93-112, 87 Stat 394, as amended. Provider shall comply with MCL 15.342 Public Officer or Employee prohibited conduct, the Americans with Disabilities Act of 1990 (ADA), P.L. 101-336, 104 Stat 328 (42 USCA S 12101 et. seq.), as amended; the Age Discrimination Act of 1973; the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964; and Title IX of the Education Amendments of 1972;
c. Not refuse to treat nor will it discriminate in the treatment of any patient or referral, under this Agreement, based on the individual's source of payment for services, or on the basis of age, sex, height, weight, marital status, arrest record, race, creed, handicap, color, national origin or ancestry, religion, political affiliation or beliefs, involuntary patient status, gender, sexual orientation, or gender identity; and

d. Comply with the: Title VI of the Civil Rights Act of 1964 (42 USC 2000 D et. seq.) and Office of Civil Rights Policy Guidance on the Title IV Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency; Title IX of the Education Amendment of 1972, as amended (20 USC 1681-1683; and 1685-1686) and the regulations of the U. S. MDHHS of Health and Human Services issued thereunder (45 CFR, Part 80, 84, 86 and 91).

C. **Additional Federal Provisions.**

a. **Davis-Bacon Act.** For all contracts in excess of $2,000 Pursuant to 40 U.S.C. 276a to a-7 and as supplemented by Department of Labor regulations (29 CFR Part 5), "Labor Standards Provisions Applicable to Contracts Governing Federally Financed and Assisted Construction, contractors shall, among other requirements, be required to pay wages to laborers and mechanics at a rate not less than the prevailing wages specified in a wage determination made by the Secretary of Labor. In addition, contractors shall be required to pay wages not less than once a week. The recipient shall place a copy of the current prevailing wage determination issued by the Department of Labor in each solicitation and the award of a contract shall be conditioned upon the acceptance of the wage determination. The recipient shall report all suspected or reported violations to the federal awarding agency.

b. **Contract Work Hours and Safety Standard.** If a contract is in excess of $100,000 and involves the employment of mechanics or laborers, the contractor must comply with 40 USC 3702 and 3704. If a contract is in excess of $2,000 for construction and $2,500 employing mechanics or laborers, the contractor must comply with the requirements of40 U.S.C. 327 - 333 -- Where applicable, all contracts awarded by recipients in excess of $2,000 for construction contracts and in excess of $2,500 for other contracts that involve the employment of mechanics or laborers shall include a provision for compliance with Section 102 and 107 of the Contract Work Hours and Safety Standards Act (40 U.S.C. 327 - 333), as supplemented by Department of Labor regulations (29 CFR part 5), as applicable, and during the performance of this Contract the Contractor agrees as follows:

1. Overtime requirements. No Contractor or Subcontractor contracting for any part of the contract work which may require or involve the employment of laborers or mechanics shall require or permit any such laborer or mechanic in any workweek in which he or she is employed on such work to work in excess of forty hours in such workweek unless such laborer or mechanic receives compensation at a rate not less than one and one-half times the basic rate of pay for all hours worked in excess of forty hours in such workweek.
2. Violation; liability for unpaid wages; liquidated damages. In the event of any violation of the clause set forth in paragraph (1) of this section the Contractor and any Subcontractor responsible therefor shall be liable for the unpaid wages. In addition, such Contractor and Subcontractor shall be liable to the United States (in the case of work done under contract for the District of Columbia or a territory, to such District or to such territory), for liquidated damages. Such liquidated damages shall be computed with respect to each individual laborer or mechanic, including watchmen and guards, employed in violation of the clause set forth in paragraph (1) of this section, in the sum of $27 for each calendar day on which such individual was required or permitted to work in excess of the standard workweek of forty hours without payment of the overtime wages required by the clause set forth in paragraph (1) of this section.
3. Withholding for unpaid wages and liquidated damages. The State shall upon its own action or upon written request of an authorized representative of the Department of

Labor withhold or cause to be withheld, from any moneys payable on account of work performed by the Contractor or Subcontractor under any such contract or any other Federal contract with the same prime contractor, or any other federally-assisted contract subject to the Contract Work Hours and Safety Standards Act, which is held by the same prime contractor, such sums as may be determined to be necessary to satisfy any liabilities of such contractor or subcontractor for unpaid wages and liquidated damages as provided in the clause set forth in paragraph (2) of this section.

4. Subcontracts. The Contractor or Subcontractor shall insert in any subcontracts the clauses set forth in paragraph (1) through (4) of this section and also a clause requiring the Subcontractors to include these clauses in any lower tier subcontracts. The prime contractor shall be responsible for compliance by any subcontractor or lower tier subcontractor with the clauses set forth in paragraphs (1) through (4) of this section.

c. **Rights to Inventions Made Under a Contract or Agreement.** (All contracts containing experimental, developmental, or research work). Contracts or agreements for the performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and the recipient in any resulting invention in accordance with 37 CFR part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations issued by the awarding agency.

d. **Clean Air Act.** Provider shall comply with all applicable standards, orders, or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401 et seq.) and the **Federal Water Pollution Control Act,** as amended (33 U.S.C. 1251 et seq.).

e. **Byrd Anti-Lobbying Amendment.** 31 U.S.C. 1352 and 45 CFR Part 93. No appropriated funds may be expended by the recipient of a Federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any award covered by 31 USC 1352, including the following covered Federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. Provider shall also disclose any lobbying with non-federal funds that takes place in connection with obtaining any Federal award.

f. **Political Activity.** Provider shall comply with the Hatch Political Activity Act, 5 USC 1501-1508, and Intergovernmental Personnel Act of 1970, as amended by Title VI of the Civil Service Reform Act, P. L. 95-454, 42 USC 4728.

g. **Pro-Children.** Provider shall comply with Public Law 103-227, also known as the Pro-Children Act of 1994, 20 USC 6081 et seq., which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, and Children (WIC) coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary

penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity. Provider also assures that this language will be included in any sub-awards that contain provisions for children's services.

h. Provider also assures, in addition to compliance with Public Law 103-227, any service or activity funded in whole or in part through the Agreement will be delivered in a smoke-free facility or environment. Smoking shall not be permitted anywhere in the facility, or those parts of the facility under the control of Provider.

D. **Breach.** Any breach of this Exhibit D shall be regarded as a material breach of the Agreement and may be cause for termination herein.

EXHIBIT C – DIRECT CARE WORKER RATE INCREASE

A. **Purpose.**
   a. In accordance with current year appropriations, the MDHHS Direct Care Worker increase provides funds to increase hourly wages by $0.20 per hour for direct care workers providing applicable Medicaid behavioral health supports and services, and to provide an additional 12% to cover employer-related costs associated with implementing the Direct Care Wage increase. This $0.20 per hour wage increase is in addition to continued funding for the previous $2.35 per hour and $0.85 per hour wage increases. This Exhibit sets forth the specific requirements applicable to these funds.

B. **Employment Roles.**
   a. Provider acknowledges and agrees that neither Payor, nor the PIHP, are co-employers with Provider nor have the power to:
      1. direct, control, or supervise Provider's direct care staff,
      2. determine the work to be performed by Provider's direct care staff,
      3. hire or fire, or modify the employment conditions of Provider's direct care staff,
      4. set the wage rate, or determine compensation paid, for a direct care staff member,
      5. determine where work is to be performed by a direct care staff member,
      6. determine the skills required to perform the duties of a direct care staff member,
      7. determine whose equipment a direct care staff member uses,
      8. perform payroll and human resources functions, and/or
      9. have any expressed or implied authority to oversee any other aspect of the employment relationship between Provider and its direct care staff not otherwise identified in this Agreement.

C. **Process.**
   a. As required by MDHHS, Payor will increase rates paid to Provider, as applicable for the following services codes, for services provided during the term of this Agreement. Provider shall utilize this rate increase to pay an additional $0.20 hourly wage increase to its direct care worker staff who are providing the applicable services provided for below:

Program Name	Services	Related HCPCS Codes
Behavioral Health	Community Living Supports Overnight Health and Safety Supports Personal Care Prevocational Services Respite Skill Building ABA Adaptive Behavior Treatment ABA Group Adaptive Behavior Treatment ABA Exposure Adaptive Treatment Crisis Residential Services Residential Services – SUD Residential Services – Co-occurring SUD/MH Withdrawal Management – SUD Supported Employment	97153, 97154, 0373T, H0043, H0019, H0010, H0012, H0014, H0018, H2014, H2015, H2016, T2027, T1020, T2015, S5151, T1005, H2023

b. The applicable Direct Care Wage increase rates are reflected in **Section C: Financial and Data Submission Requirements.**
c. Provider shall apply the $0.20 per hour Direct Care Wage increase entirely to the hourly wages of the direct care worker, paid in addition to the hourly wage the direct care worker was earning.
d. Payor shall not be held responsible for Provider benefits owed to employees related to Direct Care Wage increase payments, including, but not limited to healthcare benefits or paid time off.
e. Provider is responsible for and shall adhere to all applicable tax requirements, including withholding payroll taxes related to the Direct Care Wage increase.

D. **Limitations.**
a. Any of the applicable codes are excluded when delivered via telehealth.
b. Owners/Supervisors/Managers are not eligible to receive the Direct Care Wage increase unless:
1. They are non-salary;
2. They provide direct care for the majority of their work; and
3. Their wages are comparable to the Provider's other direct care workers' wages.
c. Pursuant to applicable MDHHS L-Letters, if a direct care employee chooses not to receive the Direct Care Wage increase, in addition to documenting this choice in writing pursuant to F(c) below, Provider shall cooperate with the Payor in calculating and refunding to the Payor any funds allocated for the applicable employee's wage increase.

E. **Documentation & Auditing**.
a. Provider shall maintain records and supporting documentation of fund distribution to employees (time sheets, pay stubs, job descriptions, etc.), sufficient to evidence the provision of the direct care payment to applicable employees. Provider shall provide documentation to Payor and/or the PIHP upon request.
b. Provider agrees that Payor, the PIHP, and/or MDHHS may audit employee files to validate the accuracy of wages reported and to confirm the distribution of rate increases to direct care employees. Provider shall cooperate with said audits and will make records available upon request.
c. If a direct care employee chooses not to receive the Direct Care Wage increase, Provider shall ensure the employee's choice is evidenced in writing (including electronically) and shall notify the Payor as soon as possible, but in no event longer than five (5) calendar days.

1.0 FINANCIAL REQUIREMENTS

I. Financial Eligibility

A. A person eligible for ISK services is defined as an individual who receives or is eligible to receive an ISK subsidy or who is eligible for Medicaid services according to the Medicaid Provider Manual or who is enrolled in Healthy Michigan. ISK is the payor of last resort.

B. The Provider shall follow SWMBH policies and ISK policies and procedures for eligibility and authorization of services. The Provider shall follow the access system procedures of the referring CMHSP.

Access, referral, authorization, and re-authorization procedures are described in Section A. ISK may pay for services when the individual is prior authorized or re-authorized and served in accordance with criteria described in Section A.

C. ISK is responsible for the initial financial eligibility determination, referral, authorization, and re-authorization of individuals referred to the Provider. Provider services must be prior authorized by ISK.

The Primary Clinician/Primary Provider will determine the continuing financial eligibility of the individual for ISK services, based on the individual's insurance and ability to pay. The financial eligibility information must be updated annually or when there is a change.

D. The Primary Provider is responsible for identifying individuals who are eligible for Medicaid or Healthy Michigan and providing assistance to complete the application for securing and maintaining benefits. The Primary Provider is responsible in working with ISK to identify any Medicaid status changes. The Primary Provider is responsible for monitoring any status changes in an individual's commercial insurance coverage. The Provider shall contact the ISK Utilization Management Department immediately if an individual served were to experience a loss of insurance to determine eligibility criteria and authorization for all services. If the Provider determines that the individual does not have insurance prior to the start of the service provision, the Provider shall contact the ISK Utilization Management Department for authorization consistent with Section A – Service/Program Specifications.

II. Insurance and Ability to Pay Fees Process for Providers

A. The Provider shall reference SWMBH policy and ISK policies and procedures for determining the rate to charge a person receiving services.

B. Primary Clinicians/Primary Providers are responsible for determining financial liability, completion of the annual Ability to Pay (ATP) form and collection of applicable fees from the individual as specified in the ISK procedure for Financial Liability Determination/Payment Agreements and Ability to Pay. The requirement to maintain a current Financial Determination form does apply in all instances except when an individual has Medicaid (however, a Medicaid spenddown is not considered Medicaid in this instance and thus the Financial Determination form is required). Fees determined to be the individual's responsibility will be deducted from reimbursement due the Provider same as other Coordinated Benefits. Primary Clinicians/Providers are expected to maintain/update insurance information, enter the required ATP information into ISK's information system, maintain a signed copy of the ATP within the individual's electronic health record as applicable and notify the Payor of any changes to the ATP. Primary Clinicians/Providers are responsible for providing a copy of the ATP to individuals they serve.

C. The Provider will maintain current information on all individuals covered by Medicaid or Healthy Michigan as indicated by using ISK's electronic eligibility lookup, CHAMPS, or other system that provides current Medicaid status. If an individual has Medicaid, the Provider will provide an itemized statement to the individual upon request.

III. Coordination of Benefits

A. ISK's payment liability for beneficiaries with private commercial health insurance and Medicaid secondary is the lesser of the appropriate co-insurance amounts, co-payment amounts and deductibles up to the individual's financial obligation to pay or the Medicaid allowable amount (less other insurance payments). If the other insurance has negotiated a rate for a service that is lower than the Medicaid allowable amount, that amount must be accepted as payment in full and neither the individual served, nor the Payor can be billed. Primary insurance payment information (EOB's) must be entered into the ISK EHR/Billing system. EOB information must be entered into claims by the Provider, or the claim will pay at zero (deny) per ISK policy.

B. Providers may enter into agreements with other insurers to accept payment that is less than their usual and customary fees. Known as "Preferred Provider" or "Participating Provider" Agreements, these arrangements are considered payment in full for services rendered. Neither the individual served, nor the Payor has any financial liability in these situations.

IV. Claims Processing and Payment Compensation

A. Providers are encouraged to submit claims for services rendered as expeditiously as possible; however, the Provider must submit claims for services rendered within sixty (60) calendar days after the date of service. The Payor shall conduct verification reviews to substantiate claims received by the Provider. Only those services in which appropriate authorizations were obtained and appropriate documentation was completed and submitted shall be reimbursed by the Payor. The Provider shall be reimbursed for services only if the Provider meets the Payor's credentialing and competency requirements.

B. Upon receipt of a clean claim, ISK will compensate the Provider within the timeframes established. A clean claim is one completed in the format specified by the Payor and that can be processed without obtaining additional information from the Provider of service or a first or third party. The Provider shall be paid for covered services by ISK, in accordance with the applicable payment rates under the contract. The Payor shall ensure payment to the Provider of claims within thirty (30) days of receipt of a complete and accurate claim.

C. At least monthly, the Provider will submit claims electronically. Upon receipt of a clean claim, the Payor will compensate the Provider within thirty (30) calendar days (90% of the time) and within sixty (60) calendar days (at least 99% of the time). All claims for services rendered must be received within sixty (60) calendar days of the date of service. Claims received beyond sixty (60) calendar days from the date of actual service will not be considered for payment.

D. All claims for services rendered must be received within sixty (60) calendar days of the date of service, even if primary payment information has not been received. Claims received beyond the sixty (60) calendar days from the date of actual service will not be considered for payment. For those claims missing primary payment information, the claim will pay at zero stating COB information is required. Provider will need to rebill the claim entirely and request the filing limit error be manually overridden.

E. The following restrictions apply to mental health services funded through Medicaid, Healthy Michigan, or any other funding originating from MDHHS:

1. Funds shall not be used to make cash payments to intended recipients of services.
2. Funds shall not be used to purchase or improve land, purchase, construct or permanently improve (other than minor remodeling) any building or any other facility or purchase major medical equipment.
3. Funds shall not be used to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funding.
4. Funds shall not be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

5. Funds shall not be used to enforce state laws regarding the sale of tobacco products to individuals under the age of 21.
6. Funds 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 $246,400 annually.

V. Disallowance of Claims

This section applies to all funding paid by ISK to the Provider

A. In the event that the MDHHS, the Payor, the State of Michigan, or the federal government ever determines in any final revenue and expenditure reconciliation and/or any final finance or service audit that the Provider has been paid inappropriately per the Payor's expenditures of federal, state, and/or local funds under this Agreement for fees, Supports/Services claims, and/or costs/claims which are later disallowed, the Provider shall fully repay the Payor for such disallowed payments within sixty (60) days of notification of the disallowances. This requirement shall survive the termination of this Agreement.

B. The Provider is responsible for compliance with all Medicaid and other fees (e.g., private pay, Medicare, etc.) regulations, guidelines, and mandates, inclusive of those concerning fraud, waste, and abuse. Failure of the Provider to reimburse ISK for a claim that has been paid by ISK then determined by another insurance company as not payable for non-compliance may be construed as fraud under the Medicaid False Claim Act.

C. Federal regulations and state law preclude reimbursement for any services ordered, prescribed, or rendered by a Provider who is currently suspended or terminated from direct and indirect participation in the Michigan Medicaid program or the Federal Medicare program.

D. In the event of disallowance of claims due to the Provider's non-compliance, the Provider is solely responsible for repayment of any disallowed claims. Failure of the Provider to repay disallowed claims may be construed as fraud under the Medicaid False Claims Act.

E. Providers have the right to appeal disallowance of claims following ISK's policy and processes for Provider grievance and appeals (non-clinical).

VI. Provider Claims Verification

Providers will have fourteen (14) calendar days from the date of the Claims Verification Review report within which to file a dispute with ISK. ISK shall consider all information and disagreement provided by the Provider with the dispute and will issue a decision on the dispute after such consideration, with such decision being final. ISK will issue an invoice or electronically reprocess claims for any amount due to ISK sixty (60) calendar days after ISK has notified the Provider of the audit appeal findings.

VII. Electronic Record Keeping

A. All information for persons served which includes demographic information, service authorizations, fee determinations and service activity is entered into ISK's information system. Unless otherwise specified in writing, service activity reporting must be made using the electronic claims submission procedures.

B. Demographic Maintenance
ISK is obligated through its contract with MDHHS to report on demographic and required Quality Improvement (QI) elements. ISK holds the Primary Clinician/Provider responsible to obtain, maintain, and enter into ISK's information system all essential demographic information in a timely manner. ISK expects all demographic and financial information to be entered whenever there is a change. ISK reports are available for Providers to view compliance with BH TEDS and with Michigan's Mission Based Performance Indicator System (MMBPIS).

VIII. Direct Care Wage

A. Process and Considerations:
1. Payor will maintain increased rates paid to Provider for the following service codes, for services provided, to enable Provider to provide an hourly wage increase to its Direct Support Professionals providing said codes under this Agreement as identified in below rate table(s).
    i. 0373T ABA Exposure Adaptive Behavior Treatment (as provided by a Behavior Technician)
    ii. 97153 ABA Adaptive Behavior Treatment (as provided by a Behavior Technician)
    iii. 97154 ABA Group Adaptive Behavior Treatment (as provided by a Behavior Technician)
2. Any of the above eligible codes are excluded when delivered via telehealth.
3. Owners are not eligible to receive the Direct Care rate increase.
4. Supervisors/Managers are not eligible to receive the Direct Care rate increase unless:
    i. They are non-salary;
    ii. They provide direct care for the majority of their work; and
    iii. Their wages are comparable to the Provider's other Direct Support Professionals' wages.
5. Payor shall not be held responsible for Provider benefits owed its employees related to payments made through this Agreement, including, but not limited to healthcare benefits or paid time off.
6. Mandatory payroll taxes shall be withheld by Providers from funds distributed to Provider staff relate to this Agreement.
7. To receive the Direct Care Wage rate increase, Provider will provide written attestation to Payor stating that Provider's Direct Support Professionals providing the Support/Services listed above in VIII(A)(1) are receiving a minimum of $14.48 per hour base wage.
8. Provider shall maintain records and supporting documentation of fund distribution to employees (timesheets, paystubs, job descriptions, etc.,) for auditing purposes.
9. Pay may audit random samples of employee files to validate the accuracy of wages reported and to confirm the distribution of rate increase(s) to Direct Support Professionals. Provider will cooperate with said audits and will make records available to Payor upon request.

IX. Reimbursement

A. The Payor shall make contract payments to the Provider in accordance with Section XVIII – Billing & Payment for Valid Support/Service Reimbursement Claims of this Agreement and the requirements of the MDHHS/PIHP Master Contract, and applicable State and federal laws, including Medicaid regulations.

B. The methodology/rate(s) for reimbursement from the Payor to the Provider for valid claims for authorized covered services rendered by the Provider under this Agreement shall be on a per unit rate. The per unit rate(s) is subject to modification via formal Amendment to this Agreement through written mutual consent of the Parties.

C. The per unit rate(s) to be paid by the Payor to the Provider as reimbursement for valid claims for Payor-authorized covered services rendered by the Provider during the term of this Agreement shall be as follows:

FY25 ABA Fee Schedule													
		LP/LLP	BCaBA/ALBA	QBHP					BT	Spclty Phy.	Reg. Nurse		
Service Code	Reporting Units	HO/HP	HN	AG	SA	AH	HP	HO	HM	AF	TD		
97151:U5	15 minutes	$ 30.00	$ 21.25	$ 30.00	$ 30.00	$ 30.00	$ 30.00	$ 30.00					
0362T	15 minutes	$ 30.00	$ 21.25	$ 30.00	$ 30.00	$ 30.00	$ 30.00	$ 30.00		$ 30.00			
97153	15 minutes	$ 15.00	$ 14.03	$ 15.00	$ 15.00	$ 15.00	$ 15.00	$ 15.00	$ 14.03	$ 15.00	$ 15.00		
97155	15 minutes	$ 30.00	$ 21.25	$ 30.00	$ 30.00	$ 30.00	$ 30.00	$ 30.00					
97156	15 minutes	$ 30.00	$ 21.25	$ 30.00	$ 30.00	$ 30.00	$ 30.00	$ 30.00					
0373T	15 minutes	$ 30.00	$ 22.20	$ 30.00	$ 30.00	$ 30.00	$ 30.00	$ 30.00	$ 28.45	$ 30.00			

Group Modifiers - 97154:HM/HN	
Service Code	Rate
97154:HM:UN	$ 2.64
97154:HM:UP	$ 1.76
97154:HM:UQ	$ 1.32
97154:HM:UR	$ 1.06
97154:HM:US	$ 0.88

Group Modifiers - 97157:HN	
Service Code	Rate
97157:UN	$ 4.25
97157:UP	$ 2.83
97157:UQ	$ 2.13
97157:UR	$ 1.70
97157:US	$ 1.42

Group Modifiers - 97158:HN	
Service Code	Rate
97158:UN	$ 3.04
97158:UP	$ 2.02
97158:UQ	$ 1.52
97158:UR	$ 1.21
97158:US	$ 1.01

Group Modifiers - 97154	
Service Code	Rate
97154:UN	$ 2.19
97154:UP	$ 1.46
97154:UQ	$ 1.10
97154:UR	$ 0.88
97154:US	$ 0.73

Group Modifiers - 97157	
Service Code	Rate
97157:UN	$ 6.00
97157:UP	$ 4.00
97157:UQ	$ 3.00
97157:UR	$ 2.40
97157:US	$ 2.00

Group Modifiers - 97158	
Service Code	Rate
97158:UN	$ 4.29
97158:UP	$ 2.86
97158:UQ	$ 2.14
97158:UR	$ 1.71
97158:US	$ 1.43

Education Modifiers	
Modifier	**Description**
AF	Specialty Physician
AG	Physician
AH	Clinical Psychologist
HM	Less than Bachelors
HN	Bachelors Degree
HO	Masters Degree
HP	Doctoral Degree
SA	PA/ANP/CRNFA
TD	RN

Place of Service	
Place of Service	**Description**
2	Telehealth (Outside of Client's Home)
3	School
10	Telehealth (Client's Home)
11	Office
12	Home
99	Other Place of Service not Identified; "Community," Multiple Locations

Other Modifiers	
Modifier	**Description**
U5	Use only for 97151
UN	1:2 Clinician to Client Ratio
UP	1:3 Clinician to Client Ratio
UQ	1:4 Clinician to Client Ratio
UR	1:5 Clinician to Client Ratio
US	1:6+ Clinician to Client Ratio

Pursuant to the MDHHS Bureau of Specialty Behavioral Health Services Telemedicine Database, the following codes are able to be rendered via simultaneous audio/visual telehealth. Audio-only service delivery is disallowed. Provider must include POS 02/10. No modifier required. No change in rate.	
Code	**Description**
97155	ABA Clinical Observation and Direction of Adaptive Behavior Treatment
97156	ABA Family Behavior Treatment Guidance
97157	ABA Multiple Family Behavior Treatment Guidance
97158	ABA Adaptive Behavior Treatment Social Skills Group

Integrated Services of Kalamazoo
FISCAL YEAR 24/25
Direct Care Wage Premium Pay Attestation

Provider Organization:	Centria Healthcare LLC
Service Site (as applicable):	Resource Center
Service Site Address:	27777 Inkster Rd Ste 100 Farmington Hills, MI 48334
Completion Date: mm/dd/yy:	10/24/2024 | 6:10 AM PDT

Attestation: As an authorized representative for Centria Healthcare LLC, I attest that Integrated Services of Kalamazoo (ISK) has offered to maintain our organization's contractual service rates effective **October 1, 2024 through September 30, 2025**, for the Supports/Services listed below (Covered Services), as applicable to our organization, to allow for our organization to provide a Direct Care Wage increase to eligible Direct Support Professionals. As part of this funding increase, our organization agrees to provide a permanent base wage for all eligible Direct Support Professionals of $14.48 per hour. In order to cover the costs, ISK agrees to increase the Direct Care Wage portion of the unit rate and as budgets allow, provide additional unit rates increases to further cover costs.

Please check one:

___ I agree to receiving Direct Care Wage funding to support paying a minimum of $14.48 per hour for all eligible Direct Support Professionals. I also understand that this wage increase does not apply to telehealth services.

___ I do not agree to receiving Direct Care Wage funding to support paying a minimum of $14.48 per hour for all eligible Direct Support Professionals.

By signing below, I hereby acknowledge that Centria Healthcare LLC has chosen one of the above options.

Signature of Authorized Individual: DocuSigned by: Jason Turk 49C290E52308414...

Title of Authorized Individual: CFO

Date: 10/24/2024 | 6:10 AM PDT

Covered Services:

i. 0373T ABA Exposure Adaptive Behavior Treatment (as provided by a Behavior Technician)
ii. 97153 ABA Adaptive Behavior Treatment (as provided by a Behavior Technician)
iii. 97154 ABA Group Adaptive Behavior Treatment (as provided by a Behavior Technician)
iv. H0018 Crisis Residential Services
v. H2014 Skill Building Assistance
vi. H2015 Community Living Supports (15 minutes)
vii. H2016 Community Living Supports (per diem)
viii. H2023 Supported Employment Services
ix. S5150 Respite Care
x. S5151 Respite Care
xi. T1005 Respite Care
xii. T1020 Person Care in Licensed Specialized Residential Setting
xiii. T2027 Overnight Health and Safety

Please email form back to Jena Kidney (JKidney@iskzoo.org)

DocuSign

Certificate Of Completion

Envelope Id: A0FC919BBA2E4A67861D32DF00C9F4D3
Subject: Please Sign - FY25 Centria Healthcare Contract
Source Envelope:
Document Pages: 50
Certificate Pages: 5
AutoNav: Enabled
EnvelopeId Stamping: Enabled
Time Zone: (UTC-05:00) Eastern Time (US & Canada)

Signatures: 3
Initials: 0

Status: Completed

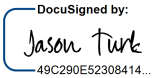
Envelope Originator:
Daniel Damaska
610 S. Burdick Street
Kalamazoo, MI 49007
ddamaska@iskzoo.org
IP Address: 216.59.31.251

Record Tracking

Status: Original
10/11/2024 11:47:04 AM

Holder: Daniel Damaska
ddamaska@iskzoo.org

Location: DocuSign

Signer Events	Signature	Timestamp
Jason Turk Contracts@centriahealthcare.com CFO Centria Healthcare LLC Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Accepted: 10/14/2024 11:00:16 AM ID: 952f6c57-e4e0-4e2d-96b6-e6eb2f126cde	DocuSigned by:  49C290E52308414... Signature Adoption: Pre-selected Style Using IP Address: 76.255.205.80	Sent: 10/11/2024 11:50:48 AM Viewed: 10/14/2024 11:00:16 AM Signed: 10/24/2024 9:10:11 AM
Jeff Patton contracts@iskzoo.org CEO Integrated Services of Kalamazoo Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign	Signed by:  63D50C801ACB4C8... Signature Adoption: Pre-selected Style Using IP Address: 216.250.150.2	Sent: 10/24/2024 9:10:15 AM Viewed: 10/24/2024 9:22:05 AM Signed: 10/24/2024 9:22:10 AM

In Person Signer Events	Signature	Timestamp

Editor Delivery Events	Status	Timestamp

Agent Delivery Events	Status	Timestamp

Intermediary Delivery Events	Status	Timestamp

Certified Delivery Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp
Daniel Damaska ddamaska@iskzoo.org Program Coordinator of Contracts Integrated Services of Kalamazoo Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign	COPIED	Sent: 10/24/2024 9:22:13 AM

Witness Events	Signature	Timestamp

Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	10/11/2024 11:50:48 AM
Certified Delivered	Security Checked	10/24/2024 9:22:05 AM
Signing Complete	Security Checked	10/24/2024 9:22:10 AM
Completed	Security Checked	10/24/2024 9:22:13 AM

Payment Events	Status	Timestamps

Electronic Record and Signature Disclosure

ELECTRONIC RECORD AND SIGNATURE DISCLOSURE

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If you decide to receive notices and disclosures from us electronically, you may at any time change your mind and tell us that thereafter you want to receive required notices and disclosures only in paper format. How you must inform us of your decision to receive future notices and disclosure in paper format and withdraw your consent to receive notices and disclosures electronically is described below.

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You may contact us to let us know of your changes as to how we may contact you electronically, to request paper copies of certain information from us, and to withdraw your prior consent to receive notices and disclosures electronically as follows:
To contact us by email send messages to: ddamaska@iskzoo.org

To advise Integrated Services of Kalamazoo of your new email address

To let us know of a change in your email address where we should send notices and disclosures electronically to you, you must send an email message to us at ddamaska@iskzoo.org and in the body of such request you must state: your previous email address, your new email address. We do not require any other information from you to change your email address.

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i. decline to sign a document from within your signing session, and on the subsequent page, select the check-box indicating you wish to withdraw your consent, or you may;

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- Until or unless you notify Integrated Services of Kalamazoo as described above, you consent to receive exclusively through electronic means all notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you by Integrated Services of Kalamazoo during the course of your relationship with Integrated Services of Kalamazoo.