

BEHAVIORAL HEALTH MANAGEMENT SERVICES AGREEMENT

This Behavioral Health Management Services Agreement ("**Agreement**") is made and entered into by and between Lakeshore Regional Entity, a Prepaid Inpatient Health Plan pursuant to the laws of the State of Michigan, as amended ("**PIHP**"), and Beacon Health Options, Inc., a Virginia Corporation ("**Administrator**") to be effective as of the date identified on the signature page of this Agreement. PIHP and Administrator may be referred to herein individually as a "**party**" or collectively as the "**parties**".

RECITALS

WHEREAS, PIHP is a Behavioral Health and Intellectual/Developmental Disability Prepaid Inpatient Health Plan authorized by Michigan Department of Health and Human Services (MDHHS) and licensed by the State of Michigan to operate as a PIHP in the State of Michigan;

WHEREAS, Administrator is appropriately licensed or certified in accordance with applicable state laws to provide administrative services as provided for in this Agreement; and

WHEREAS, PIHP desires to contract with Administrator for Administrator's services related to administration of certain Behavioral Health Services and Intellectual/Development Disability Services included in PIHP's and Community Mental Health Service Program (CMHSP) Members' Managed Care Plans, the PIHP's contract with MDHHS and under the terms specified in this Agreement.

NOW, THEREFORE, In consideration of their mutual promises and consideration herein, the sufficiency of which is hereby acknowledged, the parties agree as follows:

ARTICLE 1: DEFINITIONS

Except to the extent otherwise defined in one or more of the Exhibits or Appendices hereto, capitalized terms used in this Agreement and/or in the introductory paragraphs above, all of which are hereby incorporated by reference, shall have the meaning ascribed below.

- 1.1 AAA is the American Arbitration Association.
- 1.2 Agreement is this Behavioral Health Administrative Services Agreement between PIHP and Administrator, and any amendments, exhibits, schedules, appendices, addenda and attachments hereto.
- 1.3 Affiliate means a subsidiary or affiliate which currently is controlled by, controlling, or under common control with PIHP or Administrator, respectively, or which in the future may be controlled by, controlling, or under common control with PIHP or Administrator, respectively.
- 1.4 Behavioral Health Services and Intellectual/Developmental Disability Services are those inpatient and outpatient psychiatric and other mental and behavioral health services, services for the treatment of alcoholism and other substance dependence or abuse and services for Intellectual/Developmental Disabilities that are Covered Services and as described in Exhibit A and any of its subparts, which are attached hereto and incorporated herein by reference.
- 1.5 Case Management is the identification of a Member's treatment needs, referral of a Member to appropriate Providers for assessment and treatment, and consultation with Providers in treatment planning.
- 1.6 Clean Claim is a claim or bill for Behavioral Health Services and Intellectual/Developmental Disability Services that has no defect, impropriety, lack of substantiating documentation, including the information necessary to meet the requirements for encounter data (clinical information and data with content and in a format that comports with the HIPAA 837 requirements), and using a completed UB-04 or CMS-1500 form or their respective successor forms or alternative electronic equivalents (which electronic equivalents must comport with all HIPAA Administrative Simplification Act requirements for electronic transactions), that is received timely, and which complies with standard industry coding guidelines, and/or other government program requirements where applicable, and requires no further documentation, information or alteration in order to be

processed and paid timely. Claims or bills from a Participating Provider who is under investigation for fraud or abuse, or claims or bills under review for Medical Necessity are not Clean Claims.

- 1.7 Clinical Case Manager is a professionally qualified psychiatric social worker, psychiatric nurse, ABA or BCBA professional or other clinical professional who is engaged by Administrator to perform Case Management and Utilization Review functions.
- 1.8 Community Mental Health Services Program (CMHSP) is a program operated under Chapter 2 of the Michigan Mental Health Code - Act 258 of 1974 as amended. CMHSP Members of the Lakeshore Regional Entity PIHP and who are related to this contract and scope of work include provide services to individuals in Lake, Mason, Oceana, Muskegon, Ottawa, Kent, and Allegan counties (i.e., the Western Region). The PIHP has five CMHSP members, including Allegan County Community Mental Health, HealthWest (formerly Muskegon County Community Mental Health), Kent County Mental Health Authority d/b/a Network180, Ottawa Community Mental Health, and West Michigan Community Mental Health.
- 1.9 Confidential Proprietary Information is any non-public proprietary information of the parties respectively, including without limitation, the terms of this Agreement, PIHP developed components of the Managed Care Plan design, PIHP records, PIHP website(s) and passwords to PIHP website(s), information about fees, computer software, business procedures and manuals, data review criteria, manager's website, passwords to Administrator website(s), Administrator Provider Network databases and directories, Administrator Provider Network contract rates, and Administrator Case Management & Utilization Review programs. For purposes of this Agreement, Confidential Proprietary Information does not include: (a) information publicly available by means other than wrongful disclosure or lawfully obtained from third parties without any confidentiality obligations; (b) information which is required by law or by a government agency to be disclosed by a party; provided that such party immediately notifies the other party of the requirements for such disclosure and reasonably cooperates in obtaining any protective order desired by the other party, at the other party's expense, with regard to such information; (c) information independently developed by the other party; (d) Member Protected Health Information; or (e) information provided to the other party with the intention that it be published, disseminated, released or distributed by such other party to Members, Participating Providers, or to the general public.
- 1.10 Covered Services means those Medically Necessary behavioral health care (including alcohol and substance abuse), Intellectual/Developmental Disability and Autism services for which Members are entitled coverage under their respective Managed Care Plan.
- 1.11 HIPAA is the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191), including without limitation its privacy, security and administrative simplification provisions, and the rules and regulations promulgated there under, each as may be amended from time to time.
- 1.12 HMO means health maintenance organization.
- 1.13 JOC means joint operating committee.
- 1.14 Lakeshore Regional Entity means the PIHP with whom this contract shall service. The Lakeshore Regional Entity (LRE) is the PIHP created in the Western Region (MDHHS Region 3) to manage specialty carved out Medicaid mental health, developmental disability, and substance use disorder services for Medicaid and Healthy Michigan enrollees in Lake, Mason, Oceana, Muskegon, Ottawa, Kent, and Allegan counties (i.e., the Western Region).
- 1.15 Level of Care means the duration, frequency, location, intensity and/or magnitude of a treatment setting, treatment plan, or treatment modality, including, but not limited to: (a) acute care facilities; (b) less intensive inpatient or outpatient alternatives to acute care facilities such as residential treatment centers, group homes or structured outpatient program; (c) outpatient visits; (d) medication management; or (e) home and community based services.
- 1.16 Managed Care Plan means the fully insured PIHP benefit plans sponsored and administered by PIHP setting out the scope of covered medical and Behavioral Health Services and Intellectual/Developmental Disability Services, other benefits, or both, that are available to individuals who meet specific PIHP eligibility criteria, and for which PIHP has provided Administrator with copies thereof, including without limitation any limitations or exclusions thereto. Managed Care Plan

also includes additional services funded through non-Medicaid funding sources such as General Fund, block-grants and county funds that are managed by the PIHP and Administrator.

- 1.17 MHP means Medicaid Health Plan. A Medicaid Health Plan is a health maintenance organization providing services to Medicaid beneficiaries in Michigan.
- 1.18 Medically Necessary or Medical Necessity, unless otherwise defined in the applicable Member Managed Care Plan means treatment or services: (a) intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (ICD-9/ICD-10 or DSM-V) that threatens life, causes pain or suffering or results in illness or infirmity; (b) that are individualized, specific and consistent with symptoms and diagnoses, and not in excess of the Member's needs; (c) essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications; (d) reflective of a level of service that is safe, where no equally effective, more conservative and less costly treatment or service is available; and (e) not primarily for the convenience of the Member, caretaker, or provider and not a substitute for non-treatment services addressing environmental factors.
- 1.19 Member means an individual who is enrolled in a Managed Care Plan and meets all the eligibility requirements for membership in the Managed Care Plan and for whom the applicable premium has been received by PIHP and/or who is eligible for services via another funding stream that is managed by the PIHP and Administrator.
- 1.20 Member CMHSP means a Community Mental Health Service Program within the Lakeshore Regional Entity (LRE) seven county region for whom the LRE is the acting PIHP.
- 1.21 Member Expenses means copayments, coinsurance, deductibles and/or other cost-share amounts due from the Member for Covered Behavioral Health Services and Intellectual/Developmental Disability Services pursuant to their Managed Care Plan.
- 1.22 Non-Covered Services means those services specified by PIHP as not covered benefits under a Managed Care Plan.
- 1.23 Operating Year means any calendar year (or portion thereof) in which this Agreement is in effect.
- 1.24 Participating Provider means a properly licensed health care provider and any hospital, ancillary health care facility, institution, or agency who has assumed a contractual obligation to provide covered services to Members, either directly or through an individual practice association, medical group, physician hospital organization or physician organization, which has entered into an agreement with PIHP, and, where required, has been credentialed to provide or arrange for the provision of Covered Services to Members. The term Participating Provider shall include those health care providers, hospitals, ancillary health care facilities, institutions, and agencies who become Participating Providers after the Commencement Date of this Agreement. Providers shall be Participating Providers with respect to the provision of Behavioral Health Services and Intellectual/Developmental Disability Services.
- 1.25 PIHP means Prepaid Inpatient Health Plan. In Michigan and for the purposes of this contract, a PIHP is defined as an organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR Part 438. (In Medicaid regulations Part 438., Prepaid Health Plans (PHPs) that are responsible for inpatient services as part of a benefit package are now referred to as "PIHP" The PIHP also known as a Regional Entity under MHC 330.1204b or a Community Mental Health Services Program also manages the Autism iSPA, Healthy Michigan, Substance Abuse Treatment and Prevention Community Grant and PA2 funds.
- 1.26 PMPM means per Member per month.
- 1.27 Protected Health Information, for purposes of this Agreement, shall have the meaning as defined in 45 C.F.R. §160.103 and/or applicable state law, but shall also include "Patient Identifying Information" as defined in 42 C.F.R. Part 2, Subpart B, §2.11.
- 1.28 Provider means those hospitals, facilities, institutions, physicians, practitioners or other health care providers or

professionals who are appropriately licensed, certified, registered and/or accredited in accordance with applicable laws, rules and/or regulations of the state or state(s) in which services are rendered.

- 1.29 Provider Manual means the document, entitled "Provider Manual" or "Participating Provider Handbook" and prepared by Administrator and containing certain requirements, policies and procedures of Administrator generally applicable to all Providers, as well as any amendments thereto.
- 1.30 Provider Network means a the network of Providers providing Behavioral Health Services and Intellectual/Developmental Disability Services who have: (a) met Administrator's credentialing and re-credentialing standards; (b) contracted as an independent contractor with CMHSP Member, PIHP or Administrator; (c) agreed to accept the rate or fee agreed to with CMHSP Member, PIHP or Administrator as payment in full for Covered Behavioral Health Services and Intellectual/Developmental Disability Services provided to Members; and (d) agreed to cooperate with CMHSP Member, PIHP or Administrator regarding Case Management and Utilization Review procedures incident to Behavioral Health Services and Intellectual/Developmental Disability Services. For purposes of this Agreement, all Providers in the Provider Network are considered PIHP 'Participating Providers'.
- 1.31 Security Event means an unauthorized acquisition of or unauthorized attempts to access individually identifiable information within a party's respective custody or control.
- 1.32 Security Standards means the party's minimum security standards as made available to other party and as implemented to avoid unauthorized access to or use of information and data maintained by the party.
- 1.33 Service Area means the following Michigan counties: Lake, Mason, Oceana, Muskegon, Ottawa, Kent, and Allegan counties (i.e., the Western Region).
- 1.34 Utilization Review means monitoring and evaluating Behavioral Health Services and Intellectual/Developmental Disability Services to determine whether such mental health or substance abuse services are Medically Necessary.

ARTICLE 2: RELATIONSHIP

- 2.1 Relationship of Parties. In the performance of their respective duties and obligations hereunder, the relationship between the parties and their respective employees and agents is that of independent parties contracting with each other solely for the purpose of carrying out the terms of this Agreement. Nothing in this Agreement or otherwise should be construed or is deemed to create any other relationship, including one of employment, agency or joint venture. Except as specifically provided for herein, the parties agree that neither Administrator nor PIHP nor CMHSP Members of PIHP will be liable for the activities of the other nor their respective agents or employees, including, without limitation, any liabilities, losses, damages, injunctions, lawsuits, fines, penalties, claims or demands of any kind or nature by or on behalf of any person, party or government agency arising out of or related to this Agreement.
- (a) The PIHP is authorized by MDHHS to provide managed care services on behalf of the CMHSP members in its region. The PIHP will delegate managed care services to Administrator and may delegate some managed care services to CMHSP members as defined in Exhibit A: PIHP Description of Services and Flow-down terms and Exhibit I: Delegation Grid.
- (b) The parties understand and agree that through this Agreement PIHP will use Administrator exclusively as the administrator for managed care services not otherwise delegated to CMHSP Members of Behavioral Health Services and Intellectual/Developmental Disability Services responsibilities and obligations for those Managed Care Plans in the Service Area.
- (c) Each party respectively shall, at all times, arrange directly with its employed staff (if any) for all salaries and other remuneration; and shall be solely responsible (with respect to its employees) for the payment of all applicable federal, state or local withholding or similar taxes and provision of worker's compensation and disability insurance.

- (d) Each party respectively shall not by entering into and performing this Agreement become liable for any existing obligations, liabilities or debts of the other party and each party respectively shall not by this contract assume or become liable for any of the obligations, debts and liabilities of the other unless otherwise expressly provided herein.
- 2.2 Designated Representatives. Each party shall designate in writing a representative who shall represent it in the day-to-day administration of this Agreement. The parties may change the afore-referenced designations upon prior written notice to the other party as provided for below.
- 2.3 Business Associates. PIHP, as a covered entity under HIPAA, represents that the following individuals and entities are business associates to the PIHP pursuant to HIPAA, and further that all such business associates have signed an agreement containing all HIPAA required terms and provisions for business associates. Should PIHP request that Administrator share or disclose Member PHI with any of the other PIHP business associates, PIHP shall provide Administrator with written direction of same indicating the name of the entity, confirmation that such entity is a business associate with a written business associate agreement with PIHP and the specific information and/or data PIHP desires Administrator to disclose to or share with such other business associate and the parties agree to execute any such additional agreements as necessary to complete such activities.
- 2.4 Marketing. PIHP is solely responsible for any marketing activities of its Managed Care Plans. Administrator agrees that PIHP may use Administrator's name, address and telephone number when referencing Behavioral Health Services and Intellectual/Developmental Disability Services and associated Providers in the Provider Network in PIHP's marketing and informational materials.
- 2.5 Benefit Design and Interpretation; Coverage Decisions. PIHP and Member CMHSPs shall be responsible for the communication of benefit designs from MDHHS and local county programs such as block grants, etc. of all Managed Care Plans to Administrator, including benefits, premiums and Member Expenses.
- 2.6 Authority. Administrator does not have discretionary authority or responsibility in the administration of the Managed Care PIHP(s), except to the extent same are responsibilities or obligations of Administrator under this Agreement.
- 2.7 Administration and Provision of Data. PIHP shall perform administrative, accounting, enrollment, and other functions necessary for the administration and operation of the Managed Care Plans. PIHP shall provide Administrator with management information and data reasonably necessary to carry out the terms and conditions of this Agreement and for the operation of the Managed Care Plans.
- 2.8 Behavioral Health Services and Intellectual/Developmental Disability Services Management. Subject to approval by PIHP of Administrator policies and processes and in accordance with this Agreement, PIHP hereby delegates to Administrator those administrative functions and/or activities as are necessary for the administration of Behavioral Health Services and Intellectual/Developmental Disability Services covered under Managed Care Plans, including, without limitation, Provider Network strategy and network management; credentialing and re-credentialing of the Provider Network, customer service, claims processing and adjudication; quality assurance; and utilization review and management.
- (a) Prior to the earlier of the Commencement Date: (i) Administrator will provide PIHP with access to its utilization management, quality management, credentialing and re-credentialing, and claims processing policies, processes and guidelines, and (ii) PIHP will approve such policies, processes and guidelines and/or identify with specificity additional activities or functions or changes to existing practices or policies required by applicable law. The parties agree to negotiate in good faith and document in a mutually agreed written amendment any changes or additions required by applicable or regulatory agency to which PIHP or Administrator is or may be subject.
- (b) In the event of any changes to the PIHP policies, procedures or practices that impact or are a part of those administrative and management services delegated by PIHP to Administrator hereunder, PIHP will notify Administrator of such changes in writing. To the extent such changes have or may have an adverse financial impact on Administrator and/or require additional services or reports beyond those required upon execution of this Agreement, the parties agree to negotiate in good faith an amendment to this Agreement.

(c) If during any delegation oversight review, PIHP identifies any deficiencies in Administrator performance of delegated activities hereunder, PIHP will provide details of such deficiencies to Administrator in writing. Thereafter: (i) the parties will meet and confer or include on the agenda for the next regularly schedule JOC meeting to discuss a mutually agreeable solution to correct such noted deficiencies; or (ii) Administrator will develop an action plan to correct agreed upon material or significant deficiencies in performance of delegated activities for implementation within thirty (30) days of development.

2.9 Agent. Administrator may act as an agent of PIHP authorized to perform specific actions or conduct specified transactions as provided in this Agreement.

2.10 Funding. Managed Care Plan benefits for Behavioral Health Services and Intellectual/Developmental Disability Services shall be funded exclusively through the PIHP. Administrator is not responsible for providing funds to pay Managed Care Plan benefits.

2.11 Third Party Beneficiaries. Except as specifically provided herein, the terms and conditions of this Agreement shall be for the sole and exclusive benefit of Administrator and PIHP. Nothing herein, express or implied, is intended to be construed or deemed to create any rights or remedies in any third party, including, without limitation, a Member CMHSP or Member.

2.12 Conflict of Interest. PIHP and Administrator respectively represent that to the best of their respective knowledge and belief at the time of signature to this Agreement, neither Administrator nor PIHP, respectively, nor their respective affiliates, subsidiaries or parent companies, has financial, legal, contractual or other business interests that would conflict with their respective participation and performance under this Agreement.

2.13 No Indemnification. PIHP shall not require Administrator to indemnify PIHP for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against PIHP based on PIHP management decisions, utilization review/management provisions, or other policies, guidelines or actions.

2.14 Providers. Regardless of any provision to the contrary, the parties agree that Providers in the Provider Network are not the agents of Administrator or PIHP and in no event shall Administrator or PIHP be obligated to indemnify or hold the other harmless against any acts or omissions of Providers in the Provider Network or other providers.

2.15 Cooperation. During the term of this Agreement and subject to any legal or contractual restrictions, the parties agree to reasonably cooperate to address litigation and risk management issues associated with claims with dates of service during the term of this Agreement.

2.16 Joint Operating Committee. PIHP and Administrator agree to develop a JOC to include representatives of both parties with the authority to make decisions and/or provide administrative, operational and/or clinical expertise regarding their respective obligations under this Agreement and any other services agreements executed between the parties and/or their respective Affiliates. The JOC will meet and confer on a regular basis, but in any event at least once each quarter, or during such other interval as may be agreed to by the parties. The parties may bring operational, administrative and/or other business related issues to the JOC for negotiation and in furtherance of seeking resolution and/or common ground on such issues.

(a) In the avoidance of doubt and while the JOC may resolve certain business or operational issues as between the parties, the parties agree that the JOC is advisory in nature.

(b) Regardless of any provision to the contrary herein or extraneous written, electronic or verbal communications between the parties, the creation of and participation on and with the JOC by the parties does not affect any legal or equitable remedies available to the parties for resolution of disputes provided for under this Agreement.

(c) The participants in the JOC may be any natural persons, but a Beacon Health Options Manager and at least one other Manager from the LRE and at least one Manager from each of the CMHSP Members must serve on the JOC. The

Beacon Health Options Manager shall serve as chairperson of the JOC. The responsibilities of the JOC may include, but are not limited to, the following matters, as designated by the LRE, Member CMHSP(s) and Administrator:

- i. Clinical Operations including Utilization Management
- ii. Customer Service
- iii. Financial Management
- iv. Information Management Services – Reporting/Analytics
- v. Network Strategy and Management
- vi. Quality Management

ARTICLE 3: DATA SHARING AND OWNERSHIP

- 3.1 Data Sharing & Ownership. All information and materials, including computer software, provided by a party to the other party in connection with performance of services, including modifications, changes and derivatives thereto are and shall remain the property of providing party or the providing party's licensors, who shall retain all intellectual property rights therein. The receiving party obtains no right, title, or interest therein, except that receiving party may use the information and materials made available by the providing party for the sole, exclusive and limited purpose of performing services under this Agreement. Each party, respectively, shall comply with the terms of any license or other agreement applicable to the disclosing party. A receiving party shall not encumber a disclosing party's information and materials in any way, and promptly shall return to the materials in the receiving party's possession or control upon the disclosing party's request and in any event upon termination or expiration of this Agreement.
- 3.2 Virus Protection. The system and any software/hardware used by either party, respectively, in the performance of services hereunder shall not, to the best of such party's knowledge, contain any program routine, device, or other undisclosed feature, including, without limitation, a time bomb, virus, software lock, drop-dead device, malicious logic, worm, Trojan horse, bug, error, defect or trap door, that is capable of deleting, disabling, deactivating, interfering with, or otherwise harming the other party's hardware, data, or computer programs or codes, or that is capable of providing unauthorized access or produce unauthorized modifications.
- 3.3 Access. Each party: (a) will provide the other with a copy of their respective terms of use and/or security guidelines applicable to any use or access to the party's system or any software/hardware, respectively; and (b) agrees that any of its employees or independent contractors that access the other's systems shall access only information, reports and data applicable to performance under this Agreement; and (c) shall follow procedures and guidelines established by the other regarding access to their systems and/or software/hardware. In addition, each party agrees to implement necessary security controls and adhere to and comply with, in all material respects, the other's Security Standards. Each party shall comply with any amended Security Standards of the other party as soon as possible but in no event later than the time period required for compliance indicated in any law, rule, regulation, order, judgment or decree.
- 3.4 Security Breaches/Events. In the event that a party learns or has reason to believe that its Security Standards have been breached or the other party's Confidential Proprietary Information has been disclosed or accessed by an unauthorized party, each party will immediately give notice of such event to the other party. Furthermore, in the event that either party has access to or acquires individually identifiable information in relation to this Agreement, the following shall apply: Each party acknowledges and agrees: (a) that upon a Security Event, the law may require that party to notify the individuals whose information was compromised or disclosed that a Security Event has occurred; (b) each party will notify the other immediately if either party learns or has reason to believe a Security Event has occurred; and (c) where applicable, each party will provide the other with a copy of the individual notice of Security Event prior to mailing same to involved individuals.
- 3.5 Security and Supervision. Each party's personnel, when on the other's premises or accessing the other's networks or providing services hereunder, will comply with all of the other party's security, supervision and other standard procedures applicable to such personnel.
- 3.6 Data Collection/Sharing for Reports. The parties shall cooperate with each other in collecting and sharing data that PIHP or Administrator requires in order to perform services hereunder or to report to regulators, accreditation entities, and other

third parties. Without limiting the generality of the foregoing, required data includes member experience, clinical performance data, claims, pharmacy, or medical data feeds.

ARTICLE 4: INDEMNIFICATION AND INSURANCE

4.1 Indemnification.

- (a) In the event that PIHP, its officers, directors, employees or agents (Reference to 'agent' does not mean or include any Providers contracted with Administrator in the Provider Network.) are made parties to any judicial or administrative proceeding arising in whole or in part out of the non-compliant or breaching performance by Administrator of its obligations under this Agreement, then Administrator shall indemnify and hold PIHP harmless for any and all judgments, settlements, and costs (including reasonable attorneys' fees) which PIHP incurs or pays in connection therewith except that Administrator shall not be required to reimburse for such amounts if the court rendering the judgment or the agency making the award determines that the liability underlying the judgment or award (or attorneys' fees with respect thereto) was caused by the gross negligence, fraud or criminal conduct of PIHP, its agents, employees, officers or directors. This provision is not intended to obligate Administrator to compensate PIHP for claims for Covered Services or attorneys' fees that PIHP may pay as a result of judicial or administrative proceedings contesting a denial of benefits based on Administrator's good faith recommendation that payment be denied because services were not Medically Necessary.
- (b) In the event that Administrator, its affiliates, subsidiaries, officers, directors, employees or agents are made parties to any judicial or administrative proceeding arising in whole or in part out of the non-compliant or breaching performance by PIHP of any of its obligations under this Agreement, then PIHP, shall indemnify and hold Administrator, its affiliates, subsidiaries, officers, directors, employees or agents harmless for any and all judgments, settlements and costs (including reasonable attorneys' fees) which Administrator incurs or pays in connection therewith except that PIHP shall not be required to reimburse for such amounts if the court rendering the judgment or the agency making the award determines that the liability underlying the judgment or award (or attorneys' fees with respect thereto) was caused by the gross negligence, fraud or criminal conduct of Administrator, its affiliates, subsidiaries, employees, officers or directors.
- (c) In no event shall either party be liable to the other, whether in contract, tort (including non-compliance or breaching performance), warranty or otherwise, for any indirect, incidental, special, exemplary or punitive damages (including without limitation, damages for loss of profits) arising out of or relating to this Agreement, even if it has been advised of the possibility of such damages. The foregoing limitations of liability shall not apply to claims arising from: (i) a party's indemnification obligations under this Agreement; (ii) a breach by a party of its confidentiality obligations under this Agreement; or (iii) a party's gross negligence or willful misconduct.
- (d) Administrator and PIHP will promptly notify one another of any complaint or litigation of which each becomes aware in connection with any transaction covered by this Agreement. Within forty-eight (48) hours of receipt, each will forward to the other any notice of litigation or document referencing litigation or any complaint letter from any state insurance department or other governmental body.
- (e) Except as provided in this Section 4.1 and its subparts, each party shall be responsible at its own expense for defending itself in any litigation brought against it, whether or not the other party hereto is also a defendant, arising out of any aspect of activities engaged in connection with this Agreement. Subject to any legal restrictions, each party agrees to provide to the other party information in its possession which is essential to the other party's defense in such litigation.
- (f) The Section 4.1 and its subparts shall survive any expiration or termination of this Agreement.

4.2 Administrator Insurance. Administrator shall maintain (or cause to be in effect) comprehensive general liability and errors and omissions insurance or self-insurance with limits of not less than one million dollars (\$1 million) per occurrence/three million dollars (\$3 million) in the aggregate. Upon reasonable written request, Administrator shall or shall cause its insurance

carrier to give PIHP a certificate of insurance, stating that the carrier will give PIHP at least thirty (30) days advance notice of cancellation or material adverse changes in the amount of such general liability coverage.

- 4.3 PIHP Insurance. The PIHP, at its sole cost and expense, shall maintain comprehensive general liability and errors and omissions insurance or self-insurance with limits not less than one million dollars (\$1 million) per occurrence and three million dollars (\$3 million) in the aggregate. Upon reasonable written request, PIHP shall or shall cause its insurance carrier to give Administrator a certificate of insurance, stating that the carrier will give Administrator at least thirty (30) days advance notice of cancellation or material adverse changes in the amount of such general liability coverage.
- 4.4 Notice. Administrator and PIHP will promptly notify one another of any complaint or litigation of which each becomes aware in connection with any transaction covered by this Agreement.
- 4.5 Defense of Litigation. Except as provided in this Article 4, each party shall be responsible at its own expense for defending itself in any litigation brought against it, whether or not the other party hereto is also a defendant, arising out of any aspect of activities engaged in connection with this Agreement. Each party agrees to provide to the other party information in its possession which is essential to the other party's defense in such litigation.

ARTICLE 5: SERVICES

- 5.1 Identification of Benefit Plan Requirements. PIHP will provide Administrator with current copies of all documents constituting and/or describing the Managed Care Plans and/or Behavioral Health Services and Intellectual/Developmental Disability Services as defined by MDHHS and/or specific county or CMHSP Member programs such as Block-Grants, along with other materials governing the administration and/or implementation and associated requirements applicable to Administrator under the Managed Care Plans under this Agreement. These documents and materials may include Member booklets, summary descriptions, Member communications significantly affecting Administrator and/or Behavioral Health Services and Intellectual/Developmental Disability Services, and any amendments or revisions; and should include at a minimum, a detailed description of any exclusions, limitations and/or exceptions to Behavioral Health Services and Intellectual/Developmental Disability Services, and information regarding applicable Member Expenses due from Members for Behavioral Health Services and Intellectual/Developmental Disability Services, if any.
- (a) PIHP will provide Administrator with at least thirty (30) days, or such shorter period as required by a change in law or regulation, prior written notice of any change or modification in the Managed Care Plans, applicable regulatory requirements, and/or PIHP policies and procedures, which alters benefits, payments, requirements, and/or administration for Behavioral Health Services and Intellectual/Developmental Disability Services or reduces incentives to Members to cooperate in Administrator Case Management program, if any, and/or the requirements or required management policies and procedures, and/or associated administrative or financial obligations, activities, functions and/or services of PIHP or Administrator as applicable to this Agreement.
- 5.2 Eligibility Verification. PIHP will provide Administrator with a monthly electronic Member eligibility file, full build and daily updates thereto, in a manner and using processes mutually agreed upon by the parties. PIHP will assure that these listings of Members are accurate to the best of PIHP's knowledge at the time and are updated daily and in a manner as necessary for Administrator and/or Providers to verify the eligibility of Members. Administrator will rely on the eligibility information provided by PIHP to verify coverage and eligibility for Members.
- (a) PIHP will provide Administrator with changes in the eligibility status of Members (to include the addition of new Members or to delete individuals previously identified as Members) within thirty (30) days of the effective date of the change in the eligibility status of the Member. PIHP agrees that payments made to Administrator hereunder shall be adjusted on a PMPM basis to account for new and terminated Members in the time period provided for above.

- 5.3 Utilization Review Services. Administrator, acting through its Clinical Case Managers, will provide Utilization Review for Behavioral Health Services and Intellectual/Developmental Disability Services rendered to Members in accordance with Exhibit C.
- 5.4 Claims Processing. If mutually agreed upon by Plan, Member CMHSPs and Administrator, Administrator may provide Claims processing for Behavioral Health Services and Intellectual/Developmental Disability Services rendered to Members in accordance with Exhibit D after Commencement Date and as defined in: Exhibit D: Claims Processing and Encounter Submission and Exhibit I: Delegation Grid.
- 5.5 Credentialing/Re-Credentialing. Administrator will provide credentialing and re-credentialing for Providers in the Provider Network in accordance with Exhibit E.
- 5.6 Customer Service. Administrator will provide customer services activities related to Behavioral Health Services and Intellectual/Developmental Disability Services rendered to Members in accordance with Exhibit F.
- 5.7 Network. Administrator will provide Provider Network strategy and management services for Behavioral Health Services and Intellectual/Developmental Disability Services in accordance with Exhibit G.
- 5.8 Performance. Administrator will perform its duties under this Agreement using the same degree of ordinary care, skill, prudence, and diligence that a reasonable provider of administrative services would use in similar circumstances. This includes making a good faith effort to correct any mistake or clerical error which may occur due to action or inaction by Administrator undertaken in good faith once the error or mistake is discovered.
- 5.9 Quality Management and Improvement. Administrator shall maintain an ongoing quality management and improvement program to assess and improve the quality of clinical care and the quality of Behavioral Health Services and Intellectual/Developmental Disability Services provided to Members under the Managed Care Plans and in accordance with applicable state and federal laws, rules and regulations.
- 5.10 Reports. Administrator will provide PIHP with standard Administrator Behavioral Health Services and Intellectual/Developmental Disability Services quarterly and annual reports. Special or customized Behavioral Health Services and Intellectual/Developmental Disability Services reports may be provided by Administrator, if requested by the PIHP and the contents, composition, and cost is mutually agreed upon in advance.
- 5.11 Cooperation. Administrator shall: (a) upon request, participate in any internal or external quality assurance reviews, utilization reviews, quality improvement initiatives, peer review and/or grievance procedures established by PIHP; (b) monitor the quality of Behavioral Health Services and Intellectual/Developmental Disability Services delivered to Members by Providers and initiate corrective action where necessary for that level of care within the professional practices and standards; and (c) cooperate with PIHP's cultural competency plan as made available by PIHP to Participating Providers.
- 5.12 Delay in Furnishing Information. Regardless of any provision to the contrary, Administrator will not be responsible for delay in the performance or nonperformance of services to the extent caused by or contributed to by the failure of PIHP to furnish any required information promptly.

ARTICLE 6: COMPENSATION

- 6.1 Payments. PIHP shall compensate Administrator for services in accordance with the provisions of Exhibit B.
- 6.2 Taxes, Assessments & Surcharges. Each party shall be solely responsible for its respective state and/or federal tax obligations arising from or relating to this Agreement. Notwithstanding the above and/or anything to the contrary in this Agreement, in those states in which there is a tax, assessment, fee, or surcharge: (a) on medical, behavioral health and/or chemical dependency services, and/or claims costs, whether inpatient or outpatient; (b) surcharge imposed upon plans operating and/or claims for services rendered by providers in that state; and/or (c) for covered lives within a state, PIHP is and shall remain responsible for registration, calculation, payment and any associated reporting for these taxes,

assessments, fees, and/or surcharges, whether imposed upon the PIHP directly or upon Administrator as an administrator of the PIHP. Administrator will work cooperatively with PIHP in providing requested claims payment and/or covered lives information, if any, necessary for PIHP to register, calculate, pay and/or report in accordance with applicable laws, rules and regulations.

- (a) In those instances where Administrator processes and/or pays claims and a state imposes any such tax, assessment, fee, surcharge or additional payment upon Administrator, Administrator will submit a detailed invoice to PIHP. PIHP will reimburse Administrator within thirty (30) calendar days of receipt of such invoice.
- (b) Should PIHP desire Administrator to calculate, pay and/or submit reports required under applicable law for such taxes, assessments, fees, and/or surcharges, the parties agree to negotiate the terms of such additional activities and the associated payment rate and document same through a written amendment to this Agreement.

ARTICLE 7: TERM AND TERMINATION

- 7.1 Term. The term of this Agreement shall commence on January 1st, 2019. (the “**Commencement Date**”) and continue through September 30th, 2019 (Initial Term) and renew annually for an annual period of October 1st – September 30th subject to the availability of funds to the PIHP and renewal of the LRE PIHP contract by MDHHS. Thereafter, the term of this Agreement shall be automatically extended for a one year term every October 1st, unless either party provides the other with written notice of non-renewal no later than one hundred eighty (180) days prior to the end of the initial term or annual renewal term thereafter, or the Agreement is otherwise terminated as provided for herein.
- 7.2 Termination With Cause. Either party may terminate this Agreement for cause at any time by giving the other party at least one hundred and eighty (180) days prior written notice of a material breach hereunder, provided that the party seeking termination for cause will allow the breaching party ninety (90) days in which to cure such breach. Should the breaching party cure such breach to the reasonable satisfaction of the terminating party on or before the end of the above referenced ninety (90) day period, then this Agreement shall remain in full force and effect.
- 7.3 Termination Without Cause. Subsequent to the Initial Term, either party may terminate this Agreement without cause by giving the other party at least one hundred eighty (180) days prior written notice.
- 7.4 Automatic Termination. This Agreement shall automatically terminate upon: (1) the revocation, suspension or restriction of any license, certificate, or other authority required to be maintained by Administrator or PIHP in order to perform the services required under this Agreement or upon the Administrator’s or PIHP’s failure to obtain such license, certificate or authority; (2) either party’s conviction of a felony or other crime involving dishonesty; or (3) either party having a civil judgment entered against it for fraudulent activities.
- 7.5 Termination by Administrator. At the option of Administrator, Administrator may terminate this Agreement upon written seven (7) business days from the time PIHP fails to respond to a request to deposit funds necessary to maintain the claims account stated in this Agreement.
- 7.6 Termination Resulting From Insolvency. At the option of a party, on the date or within sixty (60) days of the other party becomes insolvent, is adjudicated as a bankrupt entity, has its business come into the possession or control of a trustee in bankruptcy, has a receiver appointed for it, or makes a general assignment for the benefit of creditors. If any of these events occurs: (a) no interest in the Agreement may be deemed as an asset of creditors; (b) no interest in this Agreement may be deemed an asset or liability of PIHP; and (c) no interest in this Agreement may pass by the operation of law without the consent of the other party.
- 7.7 Rights and Obligations Upon Termination.
 - (a) The right to terminate this Agreement shall be in addition to any other remedy available on account of any breach or default.

(b) Upon termination or expiration of this Agreement for any reason, Administrator will reasonably cooperate with and assist PIHP in effecting an orderly transfer of services and obligations under this Agreement to PIHP or PIHP's designee so as to prevent disruption of PIHP's operations. This subsection 7.7(b) shall survive any expiration or termination of this Agreement.

7.8 Notice to Members. Following notice of termination or non-renewal of this Agreement by either party, PIHP will notify Members and Participating Providers, and other persons and entities that it deems to have an interest herein of such termination. PIHP agrees to provide Administrator with an advance copy of such notice(s).

ARTICLE 8: GOVERNING LAW AND COMPLIANCE

8.1 Governing Law. This Agreement shall be governed by, and construed in accordance with, the laws of Michigan, excluding any conflicts of law, rules or principles that might otherwise refer the same to the law of another jurisdiction.

8.2 Operations of Parties. PIHP and Administrator agree to comply with all applicable state and/or federal laws, rules, and/or regulations, as may be amended, including without limitation: (a) those applicable requirements of the Americans with Disabilities Act; and (b) those designed to prevent or ameliorate fraud, waste and abuse.

8.3 Member Hold Harmless. Administrator acknowledges and agrees that in no event, including but not limited to, the insolvency of PIHP, breach of the Agreement and/or non-payment for services by PIHP, shall Administrator bill, charge or seek compensation, remuneration or reimbursement from, or assert any legal action against members for payment of any fees or amounts that are the legal obligation of PIHP. Members shall be held harmless from and shall not be liable for any such amounts.

8.4 PIHP Compliance.

(a) PIHP is responsible for compliance with all applicable provisions of state and federal law, rules and/or regulations governing, affecting and/or regarding PIHP licensure, certification and/or accreditation, the Managed Care Plan(s) and PIHP rights, duties and/or obligations, except to the extent the same are responsibilities or obligations of Administrator under this Agreement. This includes compliance with all legal reporting and disclosure requirements, adoption and approval of all required documents respecting the Managed Care Plans.

(b) In addition, PIHP shall: (i) ensure that it is duly organized, validly existing and in good standing under the laws of the State of Michigan; (ii) maintain all requisite federal, state and local authority, permits and licenses necessary or appropriate to operate and to carry out its obligations hereunder; (iii) monitor Administrator's performance of management and administrative functions on an ongoing basis; and (iv) anything contained herein to the contrary notwithstanding, PIHP shall remain ultimately responsible for assuring that the PIHP is operated in accordance with all applicable federal, state and local laws, rules and regulations.

8.7 Delegation. The parties agree that any delegation of functions hereunder shall be in accordance with the provisions of this Agreement. Administrator understands and agrees that: (a) Administrator may not sub-delegate, transfer or assign any of administrative activities delegated by PIHP to Administrator under this Agreement without PIHP's prior written consent; and (b) any permitted delegation shall be set forth in writing and specify the delegated activities and reporting responsibilities. PIHP shall monitor any and all delegated functions and shall ultimately be responsible for the performance of all delegated functions.

8.8 Compliance with Physician Incentive Plan (PIP) Regulations. PIHP and Administrator shall comply with any applicable provisions of the Physician Incentive Plan (PIP) regulations set out in 42 C.F.R §§417.479 and 434.70.

8.9 Non-Discrimination. The parties will perform their respective obligations under this Agreement in manner so as not to discriminate against Members on the basis of color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment, or type of illness or condition.

- 8.10 Excluded Individuals/Entities. PIHP and Administrator respectively represent that neither is knowingly employing nor knowingly employs or contracts with individuals or entities excluded from or ineligible for participation in any government sponsored health care program.
- 8.11 Direction. Neither party shall knowingly direct the other to act or refrain from acting in any way that would violate any applicable law, rule or regulation. Neither party shall knowingly behave in any way that is intended to implicate or involve the other in a violation of these laws.
- 8.12 Payments. The parties agree that nothing contained in this Agreement nor any payment made by PIHP to Administrator, or by Administrator to any Provider, is a financial incentive or inducement to reduce, limit or withhold Medically Necessary services to Members.

ARTICLE 9: DISPUTE RESOLUTION

- 9.1 Dispute Resolution. The parties agree to attempt to resolve any disputes arising with respect to the performance or interpretation of this Agreement promptly by negotiation between the parties. The exclusive remedy for unresolved disputes between the parties under this Agreement, including without limitation a dispute involving interpretation of any provision of this Agreement, questions regarding application and/or interpretation of applicable state and/or federal laws, rules or regulations, the parties' respective obligations under this Agreement, or otherwise arising out of the parties' business relationship, shall be resolved by binding arbitration.
- (a) The party initiating binding arbitration shall provide prior written notice to the other party identifying the nature of the dispute, the resolution sought, the amount, if any, involved in the dispute, and the names and background of at least two (2) potential arbitrators.
 - (b) The submission of any dispute to arbitration shall not adversely affect any party's right to seek available preliminary injunctive relief.
 - (c) Any arbitration proceedings shall be held in a mutually agreed upon location in Michigan in accordance with and subject to the Commercial Arbitration Rules of the AAA then in effect, or under such other mutually agreed upon guidelines and before a single arbitrator selected by the parties. Discovery shall be permitted in the same manner, types and times periods provided for by the Federal Rules of Civil Procedure.
 - (d) To the extent the parties are unable to agree upon an arbitrator, the parties agree to use an arbitrator chosen by the parties as individuals with knowledge and expertise in the area or issue in dispute. If the Parties cannot agree on the arbitrator, the arbitrator shall be selected from among a list of three (3) qualified individuals provided by the AAA from their commercial litigation list as potential arbitrators. Each party shall strike one (1) name from the list and the remaining individual shall serve as the arbitrator.
 - (e) The arbitrator: (i) may construe or interpret but shall not vary or ignore the terms of this Agreement; (ii) shall be bound by Michigan state and/or federal controlling laws, rules and/or regulations; and (iii) shall not be empowered to certify any class or conduct any class based arbitration or award any punitive damages.
 - (f) The decision of the arbitrator shall be final, conclusive and binding to the extent that it is compliant with these terms. Judgment upon the award rendered in any such arbitration may be entered in any court of competent jurisdiction, or application may be made to such court for judicial application and enforcement of the award, as applicable law may require or allow.
 - (g) Each party shall assume its own costs (including without limitation its own attorneys' fees and such other costs and expenses incurred related to the proceedings), but the compensation and expenses of the arbitrator and any administrative fees or costs of any arbitration proceeding(s) hereunder shall be borne as directed by the arbitrator based on the arbitrator's decision or ruling of cause.

- (h) Nothing contained in this provision shall be construed to give any Member any rights to arbitrate any dispute with PIHP or Administrator regarding benefits payment or any other matter related to administration of the PIHP.
- (i) This Section 9.1 shall survive any expiration or termination of this Agreement.

ARTICLE 10: GENERAL PROVISIONS

- 10.1 Records. Administrator agrees to maintain records related to Behavioral Health Services and Intellectual/Developmental Disability Services rendered by Providers for time periods set out in Administrator's established policies and procedures, or such longer period(s) of time as may be required by applicable law.
- 10.2 Access. Subject to any legal restrictions, Administrator to provide the Department of Health and Human Services (DHHS), the Office of Inspector General (OIG), the General Accounting Office (GAO), the Comptroller General, and/or other applicable regulatory agencies, or their respective designees with timely access to any contracts, books, financial records, medical records, documents, papers and other records and information, including without limitation financial or otherwise, and their respective facilities, as they apply to Administrator's obligations under the Agreement and/or as related to services rendered to Members. Administrator agrees to cooperate in investigations conducted by the above noted authorized regulatory agencies and any resulting legal actions.
- 10.3 Audits. Each party shall have the right upon reasonable notice and at reasonable times to audit and examine the records of the other insofar as such examination relates to, and is limited by, the transactions involving the services and compensation rendered under the terms of this Agreement. Such audits may involve the reconciliation of eligibility, claims funding, compensation and fees, as applicable. This right of exercise may be exercised by the party, or by its duly authorized employee or agent or by an independent consultant designated by such party. The party requesting and conducting the audit shall bear all expenses of the audit. Following written request for an audit, the parties will agree upon the time, place and scope of any such audits. Should PIHP be subject to audits by regulatory authorities, Administrator agrees to provide reasonable cooperation to PIHP with respect to such audits.
- 10.4 Confidentiality of Clinical Records & HIPAA. The parties agree to maintain processes designed to protect the confidentiality of Member medical information, personally identifiable information and Protected Health Information as required by applicable Michigan state and/or federal laws, rules and/or regulations, including, without limitation, HIPAA (including its privacy, security and administrative simplification rules and acts), and to execute a separate 'business associate agreement' (as that term is defined under HIPAA) prior to or concurrent with the execution of this Agreement.
- 10.5 Confidential Proprietary Information. Each party shall hold Confidential Proprietary Information of the other in the strictest confidence and shall not disclose it to anyone other than those employees and agents performing services for or in support of this Agreement and who have a need to know, and then only to the extent necessary, in order to carry out the terms of this Agreement, or to accreditation authorities, to the extent necessary. Confidential Proprietary Information may not be used in any way not specifically allowed under this Agreement, including in each party's own business, whether or not competitive with the other party. The party in possession of or otherwise with access to the other party's Confidential Proprietary Information shall employ such processes and take such care as to safeguard the confidentiality of such Confidential Proprietary Information. Each party will promptly notify the other of any loss or accidental or unauthorized disclosure of the other's Confidential Proprietary Information. Upon termination of this Agreement, the recipient of Confidential Proprietary Information shall promptly deliver to the other party any and all such Confidential Proprietary Information of the other party in its possession or under its control, and any copies made thereof, except as otherwise provided for by the express prior written permission of the party to whom the Confidential Proprietary Information belongs. The parties recognize that no remedy of law may be adequate to compensate a party for a breach of the provisions of this Section 10.5; therefore, the parties agree that a party may seek temporary or permanent injunctive relief against the party breaching this provision, in addition to all other remedies to which either is otherwise entitled, and this provision in no way limits such other remedies of the parties. Such temporary or permanent injunctive relief may be granted without bond, which each party waives.

- 10.6 Member Communications. The parties acknowledge and agree that nothing contained in this Agreement is intended to interfere with or hinder communications between Providers and Members regarding a Member's medical condition or mental health or substance use disorder or available treatment options. The parties agree that all patient care and related decisions are the responsibility of the treating Provider and that, regardless of any coverage or payment determination(s) made or to be made by PIHP or Administrator, neither PIHP nor Administrator dictates nor controls clinical decisions with respect to the medical and/or behavioral health care or treatment of Members.
- 10.7 Notice. Any notice required by this Agreement shall be given in writing to the liaison person designated by a party, sent by United States mail, return receipt requested, or by Federal Express, UPS, or other overnight mail service, with postage prepaid, signature required, and addressed to each party at the addresses set forth below their respective signatures to this Agreement, or at any other address of which a party has given notice in accordance with this Section. Notice shall be deemed given on the date of delivery or refusal as shown on the return receipt if delivered by mail or the date upon which such notice is personally delivered in writing to the designated liaison person.
- 10.8 Assignment. Neither this Agreement nor any right, interest or obligation hereunder may be assigned (by operation of law or otherwise) by any party without the prior written consent of the other party and any attempt to do so will be void; provided, however, that: (a) the parties may, upon notice to the other but without being obligated to obtain the other's consent, assign this Agreement or any of its rights, interests or obligations hereunder to a wholly owned affiliate or subsidiary or parent company of the party; and (b) no such written consent will be required in connection with a change of control, merger or reorganization of a party, or a sale of all, or substantially all, of such party's assets. Subject to the preceding sentence, this Agreement is binding upon, inures to the benefit of and is enforceable by the parties hereto and their respective successors and assigns.
- 10.9 Amendments. All amendments or modifications to this Agreement shall be effective only upon mutual written agreement of the parties.
- 10.10 Waiver. Waiver, whether express or implied, of any breach of any provision of this Agreement shall not be deemed to be a waiver of any other provision or a waiver of any subsequent or continuing breach of the same provision. In addition, waiver of one of the remedies available to either party in the event of a default or breach of this Agreement by the other party shall not at any time be deemed a waiver of a party's right to elect such remedy(ies) at any subsequent time if a condition of default continues or recurs.
- 10.11 Marketing. Except as otherwise specifically provided for herein, neither party will advertise or utilize any marketing materials, logos, trade names, service marks, or other materials created or owned by the other without their prior written consent. Neither party will acquire any right or title in or to the marketing materials, logos, trade names, service marks or other materials of the other.
- 10.12 News Release & Use of Name. Upon the execution of this Agreement by both parties, Administrator may use PIHP's name in a representative client listing for marketing and proposal purposes. Any notices, communications and/or other written, verbal or electronic document or information proposed for distribution to the media and the general public and/or a news release in any format announcing the Agreement between PIHP and Administrator must be reviewed and approved in advance by both parties.
- 10.13 Force Majeure. Neither party nor their subcontractor(s) or affiliate(s) hereto shall be held responsible for delay or failure to perform hereunder when such delay or failure is due to fire, flood, epidemic, strikes, acts of God or the public enemy, acts of terrorism, acts of war, unusually severe weather, legal acts of public authorities, or delays or defaults caused by public carriers, or other circumstances which cannot reasonably be forecast or provided against.
- 10.14 Disaster Recovery. Both parties have in place disaster recovery programs to preserve and protect data in the event a party's electronic information is damaged, destroyed or compromised by a malfunction/dysfunction of a mainframe or other high-end platform at the party's primary data center. The parties will make all commercially reasonable efforts to implement their disaster recovery program to restore the continuity of their business operations and reinstate the provision of services as soon as possible. A disaster as used in this section is an event as described in Section 10.13 above.

- 10.15 Severability. Any term or provision of this Agreement that is invalid, illegal or unenforceable in any situation in any jurisdiction shall not affect the validity, legality or enforceability of the offending term or provision in any other situation or in any other jurisdiction. If such invalidity, illegality or unenforceability is caused by length of time or size of area, or both, the otherwise invalid provision shall be, without further action by the parties, automatically amended to such reduced period or area as would cure such invalidity, illegality or unenforceability; provided, however, that such amendment shall apply only with respect to the operation of such provision in the particular jurisdiction in which such determinations is made.
- 10.16 Ancillary Agreements. The parties agree to execute or cause to be executed such ancillary agreements as are appropriate and necessary to enable the services described in this Agreement to be performed as mutually agreed upon by the parties.
- 10.17 Interpretation. The parties hereto agree that this Agreement is the product of negotiation between sophisticated parties and individuals, all of whom were represented by, or had an opportunity to be represented by legal counsel, and each of whom had an opportunity to participate in, the drafting of each provision hereof. Accordingly, ambiguities in this Agreement, if any, shall not be construed strictly or in favor of or against any party hereto but rather shall be given a fair and reasonable construction.
- 10.18 Attachments & Exhibits. Incorporated into this Agreement by reference are the following attachments and exhibits:
- Exhibit A: PIHP Description of Services
 - o Appendix A-1: PIHP Medicaid and Waiver Services
 - Exhibit B: Compensation
 - Exhibit C: Utilization Review Services
 - Exhibit D: Claims Processing and Encounter Submission
 - Exhibit E: Credentialing & Re-Credentialing Services
 - Exhibit F: Customer Service
 - Exhibit G: Provider Network
 - Exhibit H: Reports
 - Exhibit I: Delegation Grid
 - Exhibit J: Service Level Agreement / Performance Guarantees
 - Exhibit K: Medical Risk and Incentive
- 10.19 Counterparts; Facsimile Execution & Captions. This Agreement may be executed and delivered: (a) in any number of counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument; and/or (b) by facsimile, in which case the instruments so executed and delivered shall be binding and effective for all purposes. The captions in this Agreement are for reference purposes only and shall not affect the meaning of terms and provisions herein.
- 10.20 Exclusivity. The parties understand and agree that through this Agreement, PIHP will use Administrator exclusively as the administrator of Behavioral Health Services and Intellectual/Developmental Disability Services for those services delegated to the Administrator and not delegated to other parties such as the CMHSP Members for the Managed Care Plans.
- 10.21 Entire Agreement. This Agreement, including all exhibits, attachments, schedules, addenda and amendments hereto, contains all the terms and conditions agreed upon by the parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations of or between the parties, either oral or written, relating to the subject matter of this Agreement, which are not expressly set forth in this Agreement are null and void and of no further force or effect.

ARTICLE 11: COMPLIANCE

Laws: This Agreement shall be construed according to the laws of the United States and the laws of the State of Michigan as to the interpretation, construction and performance. Pursuant to MDHHS/PIHP Master Contract, Sections 13.0 and 18.0, the Member, its principals, officers, employees, servants, and agents shall perform all their respective duties and obligations under this Agreement in compliance with all applicable: Federal, State, and local laws, ordinances, rules and regulations, including but not limited to the following:

11.1. Michigan's State Plan under Title XIX of the Social Security Act and Michigan's Medicaid Member Manual and Medicaid Policies and Guidelines;

11.2. 45 CFR Part 76 and 42 CFR Part 455 (subpart B): The Member certifies to the best of its knowledge and belief that it, including its employees, Board members, contractors, subcontracted providers and providers' employees, managers and Board members:

- (a) Are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transactions by any federal department or agency.
- (b) Have not within a three (3)-year period preceding this Agreement 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 antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property.
- (c) c. Are not presently indicted or otherwise criminally or civilly charged by a government entity (Federal, State or local) with commission of any of the offenses enumerated in subsection b.
- (d) d. Have not within a three (3)-year period preceding this Agreement had one or more public transactions (Federal, State or local) terminated for cause or default.
- (e) e. Are not excluded from participation in any Federal or State Health Care Program.

11.3. 42 CFR 100.1001(a)(1) Member will;

- (a) Promptly notify the PIHP of any disclosures made by providers with regard to the ownership or control by a person that has been convicted of a criminal offense described under sections 1128(a) and 1128(b)(1), (2), or (3) of the Act or that have had civil money penalties or assessments imposed under section 1128A of the Act.
- (b) Ensure that it has, and its contractors have, a list of the criminal offenses described under sections 1128(a) and 1128(b)(1), (2), and (3) of the Act as well as the civil money penalties or assessments described under section 1128A of the Act—reference 42 CFR 1001.1001(a)(1)—so that credentialing and contract specialists conducting background checks understand what must be reported.

11.4. The Anti-Lobbying Act, 31 USC 1352 as revised by the Lobbying Disclosure Act of 1995, 2 USC 1601 et seq., and Section 503 of the Departments of Labor, Health and Human Services and Education. Further, the Member shall require that the language of this assurance be included in the award documents of all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly; (Part I, Section 18.1.1)

11.5. The Balanced Budget Act of 1997 ("BBA"), as amended, and final Rule 42 CFR Part 438;

11.6. The Member agrees to adhere to the **Office of Civil Rights Policy Guidance on Title VI Prohibition Against Discrimination** as it affects persons with Limited English Proficiency; (**Part I, Section 18.1.6**)

11.7. In accordance with 42 CFR 438.3(d) Member will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability.

11.8. In accordance with 42 CFR 422.128 and 42 CFR 438.6, the Payor shall maintain and the Member shall adhere to written policies and procedures for Advance Directives. The Member shall provide adult beneficiaries with written information on Advance Directive policies and a description of applicable State law and their rights under applicable laws. This information must be continuously updated to reflect any changes in State law as soon as possible but no later than ninety (90) days after it becomes effective. The Member must inform individuals that grievances concerning noncompliance with the Advance Directive requirements may be filed with Customer Services.

11.9. The Payor's policies and procedures governing subcontracted provider grievances, disputes and appeals, including without limitation any grievance, dispute or appeal of changes in the subcontracted provider's status as a subcontracted provider in the Payor's subcontract provider Network.

11.10. The Member 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.); **(Part I, Section 18.1.12)**. (Contracts in excess of \$100,000). Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.), as amended -- Contracts and sub-grants of amounts in excess of \$100,000 shall contain a provision that requires the recipient to agree to 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.). Violations shall be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

11.11. The Hatch Political Activity Act, 5 U.S.C.1501-1508, and Intergovernmental Personnel Act of 1970, as amended by Title VI of the Civil Service Reform Act, P.L. 95-454, 42 U.S.C. 4728. Federal funds cannot be used for partisan political purposes of any kind by any person or organization involved in the administration of federally assisted programs. **(Part I, Section 18.1.15)**

11.12. 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. The Member also assures that this language will be included in any sub-awards that contain provisions for children's services. **(Part I, Section 18.1.14)**

11.13. The Member also assures, in addition to compliance with Public Law 103-227, any service or activity funded in whole or in part through this 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 the Member. If activities or services are delivered in residential facilities or in facilities or areas that are not under the control of the Member (e.g., a mall, residential facilities or private residence, restaurant or private work site), the activities or services shall be smoke free

14. Confidentiality: (Part I, Section 18.1.7) To the extent that Payor and Member 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 this Agreement. To the extent that Member determines that it is a HIPAA Business Associate of Payor and/or a Qualified Service Organization of Payor, then Payor and Member

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 Payor and Member.

Payor and the Member 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 Member Health Code (PA 368 of 1978 as amended), and 42 CFR Part 2. **(Part I, Section 17.0)**

MDHSS Standard Consent Form: The Member will promote the use and acceptance of the standard release form that was created by MDHHS under Public Act 129 of 2014. The Member may provide comments to the Payor regarding challenges and successes with the standard consent form (DCH-3927). The Payor will take Member comments and concerns and communicate these during the annual review process of MDHHS. There are remaining issues to be addressed before the form can be used to support electronic health Information Exchange. However, for all non-Health Information Exchange the Member will utilize and accept DCH-3927 as a standard release form.

11.15. 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 of 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. **(Part I, Section 18.1.8)**

11.16. Davis-Bacon Act: (All contracts in excess of \$2,000). (40 U.S.C. 276a to a-7) -- When required by Federal program legislation, all construction contracts awarded by the recipients and sub-recipients of more than \$2,000 shall include a provision for compliance with the Davis-Bacon Act (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". Under this act, contractors shall be required to pay wages to laborers and mechanics at a rate not less than the minimum 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. **(Part I, Section 18.1.9)**

11.17. Contract Work Hours and Safety Standard: (All contracts in excess of \$2,000 for construction and \$2,500 employing mechanics or laborers). (40 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). Under Section 102 of the Act, each contractor shall be required to compute the wages of every mechanic and laborer on the basis of a standard workweek of 40 hours. Work in excess of the standard workweek is permissible provided that the worker is compensated at a rate of not less than 1 and 1/2 times the basic rate of pay for all hours worked in excess of 40 hours in the workweek. Section 107 of the Act is applicable to construction work and provides that no laborer or mechanic shall be required to work in surroundings or under working conditions that are unsanitary, hazardous or dangerous. These requirements do not apply to the purchases of supplies or materials or articles ordinarily available on the open market, or contracts for transportation or transmission of intelligence. **(Part I, Section 18.1.10)**

11.18. 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. **(Part I, Section 18.1.11)**

11.19. Special Waiver Provisions for MSSSP:

- (a) Michigan's Specialty Services and Supports Waiver Program is authorized under 1915(b)(1), (3) and (4) of the Social Security Act;
- (b) The 1915(b) Waiver is concurrent with a five-year 1915(c) Waiver, referred to as the Home and Community-Based Habilitation Supports Waiver, serving people with a developmental disability.

Under these waivers, beneficiaries are entitled to specified medically necessary specialty supports and services from the Member. **(Part I, Section 18.2)**

11.20. Conflict of Interest: (Part I, Section 30.0) The Member and Payor are subject to the Federal and State conflict of interest statutes and regulations including Section 1902(a)(4)(C) and (D) of the Social Security Act: 41 U.S.C. Chapter 21 (formerly Section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. §423): 18 U.S.C. §207): 18 U.S.C. §208: 42 CFR §438.58: 45 CFR Part 92: 45 CFR Part 74: 1978 PA 566: and MCL 330.1222, as well as the conflict of interest policies of the parties.

11.21. Human Subject Research: (Part I, Section 31.0) Protection of Human Subjects Act, 45 CFR, Part 46, Subpart A, Sections 46.101-124 and HIPAA. The Member agrees that prior to the initiation of the research, the Member will submit institutional Review Board (IRB) application material for all research involving human subjects, which is conducted in programs sponsored by the Department or in programs which receive funding from or through the State of Michigan, to the Department's IRB for review and approval, or the IRB application and approval materials for acceptance of the review of another IRB. All such research must be approved by a Federally assured IRB, but the Department's IRB can only accept the review and approval of another institution's IRB under a formally-approved interdepartmental agreement. The manner of the review will be agreed upon between the Department's IRB Chairperson and the Contractor's IRB Chairperson or Chief Executive Officer(s).

11.22. SUD Administrative Rules:

- (a) Program Match Requirements, R 325.4151 - 325.4156
- (b) Substance Use Disorders Service Program, R 325.14101 - 325.14125
- (c) Licensing of Substance Use Disorder Programs, R 325.14201 - 325.14214
- (d) Recipient Rights, R 325.14301 - 325.14306
- (e) Methadone Treatment and Other Chemotherapy, R **325.14401 - 325.14423**
- (f) Prevention, R 325.14501 - 325.14530
- (g) Case-finding, R 325.14601 - 325.14623
- (h) Outpatient Programs, R 325.14701 - 325.14712
- (i) Inpatient Programs, R 325.14801 - 325.14807
- (j) Residential Program, R 325.14901 - 325.14928

11.23. Michigan Public Health Code and Administrative Rules

11.24. Approved Medicaid Waivers and corresponding CMS conditions, including 1915(b), (c) and 1115 Demonstration Waivers.

11.25. MDHHS Appropriations Acts in effect during the contract period.

11.26. All final Payor guidelines, and final technical requirements, as referenced in the contract. Additional guidelines and technical requirements must be added as provided for in **(Part 1, Section 11.0)**.

11.27. Michigan Medicaid Provider Manual: Behavioral Health and Intellectual/Developmental Disabilities Supports and Services Section

11.28. MSA Policy Bulletin Number: MSA 13-09

11.29. Member's Substance Use Disorder service delivery system shall comply with:

- (a) The **Drug Abuse Office and Treatment Act** of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse.
- (b) b. The **Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act** of 1970 (P.L. 91-616) as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism.
- (c) §§523 and 527 of the **Public Health Service Act** of 1912 (42 U.S.C. §§290 dd-3 and 290 ee 3), as amended, relating to confidentiality of alcohol and drug abuse patient records.
- (d) Any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made and,
- (e) The requirements of any other nondiscrimination statute(s) which may apply to the application. **(Part I, Section 18.1)**

11.30. 1978 PA 368, Public Health Code, health reporting requirements. The Member agrees to ensure compliance with all such reporting requirements through its subcontracted provider contracts.

11.31. For purposes of this Agreement, **OMB Circular 2 CFR 200 Subpart E** is applicable to Member as a local government entity.

11.32. If any laws or administrative rules or regulations that become effective after the date of the execution of this Agreement substantially change the nature and conditions of this Agreement, they shall be binding to the parties hereto, but the parties hereto retain the right to exercise any remedies available to them by law or by any other provisions of this Agreement.

11.33. Any breach of this section shall be regarded as a material breach of this Agreement and may be a cause for termination thereof by the non-breaching party.

Breach: Any breach of this section shall be regarded as a material breach of this Agreement and may be a cause for termination thereof by the non-breaching party.

ARTICLE 12: NONDISCRIMINATION (Part I, Section 18.1.2)

Law: In performing their duties and responsibilities under this Agreement, the parties hereto shall comply with all applicable Federal and State laws, rules and regulations prohibiting discrimination.

12.1. The parties hereto shall not discriminate against any employee or applicant for employment with respect to hire, tenure, terms, conditions, or privileges of employment or a matter directly or indirectly related to employment because of race, color, religion, national origin, age, sex, height, weight, marital status, physical or mental disability unrelated to the individual's ability to perform the duties of the particular job or position, as required pursuant to the Elliott Larsen Civil Rights Act of 1976 PA 453, as amended and Section 504 of the Federal Rehabilitation Act 1973, PL 93-112, 87 Stat. 394.

12.2. The parties hereto shall 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.

12.3. The Member 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.

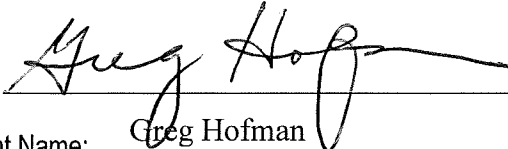
12.4. For purposes of this Section XXI, Employee shall be defined as an individual classified or unclassified, of the executive branch of this State. For the purpose of section 2b of MCL 15.341, employee shall include an employee of this State or a political subdivision of this State. Public Officer shall be defined as a person appointed by the governor or another executive department 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.

12.5. Each of the parties hereto shall not refuse to treat nor will they discriminate in the treatment of any beneficiary 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, or involuntary patient status.

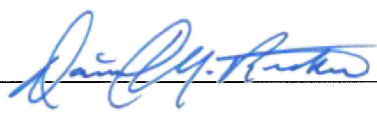
Breach: Any breach of this section shall be regarded as a material breach of this Agreement and may be a cause for termination thereof by the non-breaching party.

The authorized representatives of the parties hereto have executed this Agreement to be effective as of the Commencement Date identified above.

PIHP: Lakeshore Regional Entity

By: 
Print Name: Greg Hofman
Title: Interim CEO
Date: 10/30/18

Beacon Health Options, Inc.

By: 
Print Name: Daniel M. Risku
Title: EVP & General Counsel
Date: 11/8/2018

Address for Notice:

5000 Hakes Drive
Suite 500
Norton Shores, MI 49441

Attn: _____

Copy to:

Address for Notice:

200 State Street, Suite 302
Boston, MA 02109

Attn: _____

Copy to:

I: PIHP DESCRIPTIONS

The following is the name and a description of the benefit plan options of PIHP covered under this Agreement, the name used in coverage documents and Member handbooks describing the benefit plan, and a description of the service area.

II: BEHAVIORAL HEALTH SERVICES AND INTELLECTUAL/DEVELOPMENTAL DISABILITY SERVICES

Covered Services include without limitation the following Behavioral Health Services and Intellectual/Developmental Disability Services. Services are defined based on funding stream and defined in the MDHHS, PIHP contract and summarized in Appendix A-1 Medicaid and Waiver services and Appendix A-2 Block Grant and Non-Medicaid services.

*All services must be Medically Necessary and otherwise covered under the applicable Managed Care Plan to be considered Covered Services.

Only those Services that qualify as Covered Services under the applicable Member Managed Care Plan shall be administered by Administrator. All other services for members shall be considered outside of the scope of service of this agreement and this may include Medical services, low to moderate acuity Behavioral Health services managed by Medicaid Health Plans or supplemental Behavioral Health services managed by CMHSP Members and not defined in Covered Services Appendix A-1, the MDHHS Medicaid Provider Manual's Behavioral Health and Intellectual/Development Disability Supports and Services section and County-based Block-Grant and Non-Medicaid Services.

**APPENDIX A-1
PIHP MEDICAID AND WAIVER SERVICES**

Service Reference Guide (Scope)	Billing Units (1 unit = X)	Individual Plan of Service Description	Medicaid Provider Manual page numbers			
			State Plan	HCW (HAB) Waiver	Children's Waiver	Additional (B3)
ACT	15 minute	# of face to face contacts or visits / week	28-35			
Applied Behavior Analysis/Behavioral Health Treatment Services	15 minute		148-156			
Assessments	Encounter	# of Assessments / year	15-16			
Assistive Technology	Item	# of Items / year				127-128
Behavior Treatment Review	Encounter	# of Encounters / year	16			
Child Therapy	Encounter		16			
Clubhouse PSR	15 minute	# of 15- minute units / week	36-44			
Community Living Supports (unlicensed setting)	15 minute	# of face to face time spent w/consumer / day or week		103-104	92	128-129
Community Living Supports (Specialized Residential)	Day	# of days / year				128-129
Crisis Intervention	15 minute	# of face to face time spent w/consumer	17			
Crisis Residential	Day	# of Days	44-47			
Crisis Stabilization (Intensive)	Hour	# of Hours	65-67			
Enhanced Equipment & Supplies	Item	# of Items / year		104-105		
Drop-In Centers	Day					136
Enhanced Pharmacy	Item	# of Items / month		105-106		130
Enhanced Transportation	Service	Refer to CWP section			93	
Environmental Accessibility Adaptations (EAA's)	Item	Refer to CWP section			93-94	
Environmental Modifications	Service	# of Service/ year		106-108		130-132
Family Therapy	Encounter	# of Encounters	17			
Family Training/Support	Encounter	# of face to face contact / week		108	94	132-133
Fencing	See MPM	See MPM			94	
Fiscal Intermediary Services	1 Unit	1 Unit / month			95	
Goods and Services	Item	# of Items / month		109		
Health Services	15 minute/ Encounter	# of face to face time spent w/ consumer/month	17-18			
Home Based Services	15 minute	# of time spent w/ consumer / week	47-54			
Housing Assistance	Service	1 Month				133-134
Individual/Group Therapy	Encounter	# of Encounter	18			
ICF/IDD	Day	# of Days	18			
Inpatient Psychiatric	Day	# of Days	55-64			
Medication Administration	Encounter	# of face to face contacts / month	19			
Medication Review	Encounter	# of face to face visits / year	19			
Non-Family Training	Encounter	See MPM			94	
Nursing Facility MH Monitoring	15 minute	# of face to face visits / month	19			
Occupational Therapy	15 minute/ Encounter	# of face to face contacts/ month or Q	19-20			

Service Reference Guide (Scope)	Billing Units (1 unit = X)	Individual Plan of Service Description	Medicaid Provider Manual page numbers			
			State Plan	HCW (HAB) Waiver	Children's Waiver	Additional (B3)
Out of Home Nonvocational Habilitation	15 minute	# of 15 minute units / day or week		109		
Outpatient Partial Hospital	Day	# of Days	68-73			
Peer-Delivered or Operated Support Services	15 minute/ Encounter	# of 15-minute units / month				134-136
Personal Care in Specialized Residential	Day	# of Days / year	74-75			
Personal Emergency Response System	Month	See MPM		109		
Physical Therapy	15 minute/ Encounter	# of face to face contacts/ month or Q	20-21			
Prevention Services	Encounter/ 15 minute	# of face to face visits / month				138-140
Prevocational Services	Hour	# of Hours/ week		110-111		
Private Duty Nursing	Hour	# of Hours/ week		111-117		
Respite Care	15 minute	# of face to face time spent w/ consumer / month		117-118	96	140-142
SED Waiver						
Skill Building	15 minute	# of 15 minute units / day or week				142-143
Specialized Medical Equipment and Supplies					96-100	
Specialty Services					100	
Speech, Hearing & Language Therapy	Encounter	# of face to face contacts/ month or Q	21-22			
Supports Coordination	15 minute	# of face to face contacts/month		118-121		143-145
Supported Employment	15 minute	# of 15-minute units / month		121		145-146
Targeted Case Management	15 minute	# of Face to face contacts/month	88-90			
Telemedicine	XXXXXXX	Refer to Practitioner section	22			
Transportation	See cost coding	Misc.	22			
Youth Peer Support Services	Encounter					136-137
Peer Mentoring						137-138
Treatment Planning			23			
Wraparound Services	Encounter	1 Encounter/year	23			
Substance Abuse Services	15 minute	# of face to face contact /week	23-27			
Assessment/Referral						
Outpatient Treatment	Encounter	1 Encounter/year	77			
IOP Treatment	Encounter	# of Sessions/month	76-79			
DPT/CSAT	Day	# of Days/ week	70-73			
Sub-Acute Detoxification	Encounter	# of Visits/week	79-85			
Residential Treatment	Day	# Days	85-86			

Page numbers are directly from the Michigan Medicaid Provider Manual, Behavioral Health and Intellectual/Developmental Disability Supports and Services chapter.

EXHIBIT B
COMPENSATION

1. Administrative Fees.

- (a) Commencing on January 1st, 2019, and on the first (1st) day of each calendar month (“**Due Date**”) thereafter during the term of this Agreement, PIHP shall pay Administrator the amount set out in Table 1 below for all Members enrolled in the PIHP’s Managed Care Plans covered under this Agreement for such month as compensation for providing the administrative services in that calendar month, and based on the number of Members identified on the fifteenth (15th) day of the prior month, and as evidenced by a written communication provided by PIHP.
- (b) Notwithstanding anything to the contrary above and during the term of this Agreement, PIHP shall pay Administrator the PMPM administrative fees identified in Table 1 below based on the greater of a minimum of 150,000 Members or the actual number of Members.
- (c) A grace period of thirty calendar (30) days from the Due Date for the current month’s payment is allowed. In the event payment is not made by the end of the thirty (30) day grace period, Administrator may charge a late fee of 1% per month, or portion of a month, for which payment is late.
- (d) Initial Term, Program Year 1, Month 1 (January 1, 2019 – January 31, 2019 shall be dedicated to the completion of implementation activities such as but not limited to; staff training, testing, business function transitions and activation of new systems or interfaces).

TABLE 1¹²

Operating Year	Membership Tier	DAB (PMPM)	TANF (PMPM)	HMP (PMPM)	HSW (PMPM)	Estimated Composite Rate	Estimated Annualized Fees
Initial Term, Program Year 1: (January 1, 2019 to September 30, 2019)	150,000 - 200,000 members	\$11.22	\$0.98	\$1.76	\$222.44	\$3.75	\$8,900,811 for 257,406 total, annualized members (consumers)
	200,001 - 250,000 members	\$9.04	\$0.99	\$1.42	\$179.05	\$3.13	
	250,001 - 300,000 members	\$8.31	\$0.91	\$1.31	\$164.65	\$2.88	
Renewal Year 1, Program Year 2: (October 1, 2019 to September 30, 2020)	150,000 - 200,000 members	\$12.56	\$1.10	\$1.97	\$248.70	\$4.20	\$10,206,170 for 257,406 total, annualized members (consumers)
	200,001 - 250,000 members	\$10.28	\$1.12	\$1.62	\$203.47	\$3.56	
	250,001 - 300,000 members	\$9.53	\$1.04	\$1.51	\$188.70	\$3.30	

¹ Per Member per month payment rates or “PMPMs” are subject to adjustment pursuant to the terms of the Agreement.

Operating Year	Membership Tier	DAB (PMPM)	TANF (PMPM)	HMP (PMPM)	HSW (PMPM)	Estimated Composite Rate	Estimated Annualized Fees
Renewal Year 2, Program Year 3: October 1, 2020 - September 30, 2021)	150,000 - 200,000 members	\$12.88	\$1.13	\$2.02	\$254.92	\$4.31	\$10,470,969 for 257,406 total, annualized members (consumers)
	200,001 – 250,000 members	\$10.54	\$1.15	\$1.67	\$208.56	\$3.65	
	250,001 – 300,000 members	\$9.77	\$1.07	\$1.55	\$193.42	\$3.39	

Pricing Notes and Assumptions

- (1) Estimated Annual Fees above assumes: 257,406 total members (consumers)
- (2) Total membership determines the membership tier and rate cells used to calculate composite rate
- (3) Monthly invoicing will use total members and membership blends to determine actual fees
- (4) Membership blend used for above Estimated Composite Rate and Estimated Annual Fees are: DAB: 20.2435%, TANF: 55.6005%, HMP: 23.9252%, HSW: 0.2308% - of total members
- (5) The following formula shall be used to calculate monthly invoicing and was used to generate Estimated Composite Rate and Estimated Annual Fees in this table is defined below. Example based on Program Year 1 rates for 257,406 members:
 - a. Membership tier of 250,001 – 300,000 selected based on total membership of 257,406
 - b. $DAB: 20.2435\% * 257,406 = 52,108 * \text{Rate of } \$8.31 \text{ PMPM} * 12 \text{ months} = \text{DAB annual Total of } \$5,196,210$
 - c. $TANF: 55.6005\% * 257,406 = 143,119 * \text{Rate of } \$0.91 \text{ PMPM} * 12 \text{ months} = \text{TANF annual Total of } \$1,562,859$
 - d. $HMP: 23.9252\% * 257,406 = 61,585 * \text{Rate of } \$1.31 \text{ PMPM} * 12 \text{ months} = \text{HMP annual Total of } \$968,116$
 - e. $HSW: 0.2308\% * 257,406 = 594 * \text{Rate of } \$164.65 \text{ PMPM} * 12 \text{ months} = \text{HSW annual Total of } \$1,173,625$
 - f. $DAB \text{ Total} + TANF \text{ Total} + HMP \text{ Total} + HSW \text{ Total} = \$8,900,811 \text{ Total Estimated Annual Fees}$
 - g. $\$8,900,811 \text{ Total Estimated Annual Fees} / \text{Total Members } (257,406) / 12 \text{ months} = \text{Composite Rate of } \2.88 PMPM
- (6) The above pricing assumes Beacon will provide all functions as defined in this Agreement, its Exhibits (A, C, D, E, F, G, H, I, J, K) and Appendix A-1.

- (e) PIHP and Administrator agree that the PMPM rate set out above may be adjusted by mutual agreement of the parties to account for any implementation, administrative and/or programming costs as a result of the following:
 - i. The initial membership provided by PIHP and upon which Administrator based its proposal for administrative fees varies from the actual membership on the Commencement Date of this Agreement resulting in a material impact, directly related to the membership change, to the underlying financial assumptions used to base the payment rates under this Agreement;
 - ii. A change in the membership used to determine the PMPM amount of 10% or more (A party may make a request for renegotiation on the basis of such change in the underwriting assumptions, only once per year.);
 - iii. Change in Managed Care Plan requirements and/or Behavioral Health Services and Intellectual/Developmental Disability Services covered thereunder or to the process for identification of Members, including without limitation changes made to address state and/or federal law, rules and/or regulations at any time subsequent to the parties' agreement to the administrative fees identified in Table 1 above and/or after the initial implementation of this Agreement;
 - iv. Additions or revisions to PIHP policies and/or procedures after the initial implementation of this Agreement and which additions or revisions may have an adverse financial or administrative impact to Administrator;

- v. To account for systems changes resulting changes made by PIHP to its systems and/or data fees and/or requested electronic reporting and/or systems data interface requirements; and/or
- vi. To account for additional implementation and/or variation in administrative services and/or systems resulting from any future PIHP acquisition.

The parties agree to negotiate in good faith in the event that one party requests renegotiation of the fee(s) as provided for herein.

- (f) If this Agreement continues in effect after the last Operating Year of the Operating Years defined in Table 1, the monthly Administrator fee(s) of any additional Operating Year shall be equal to the Administrator fee(s) for the immediately preceding Operating Year, increased by the percentage increase in the Consumer Price Index, All Consumers, plus two percentage points unless either party requests renegotiation of fee(s) by providing written notice to Administrator no later than sixty (60) days prior to the expiration of the current term of this Agreement. The parties agree to negotiate in good faith in the event that one party requests renegotiation of the fee(s).

EXHIBIT C
UTILIZATION REVIEW SERVICES

1. Delegation. PIHP hereby delegates to Administrator certain of the PIHP's Case Management and Utilization Review activities and functions identified herein ("**UR Functions**"), and Administrator hereby agrees to perform such UR Functions solely as they relate to Behavioral Health Services and Intellectual/Developmental Disability Services.
 - (a) Prior to the Commencement Date, PIHP shall have performed an initial evaluation of the ability of Administrator to perform UR Functions identified hereunder through evaluation of the Utilization Review processes and procedures used by Administrator and additional documentation and/or information as may be reasonably requested by PIHP.
 - (b) Capitalized terms not otherwise defined in this Exhibit are ascribed the meaning given in the Agreement.
2. UR Functions. Administrator agrees to perform the UR Functions described herein.
 - (a) Administrator will make Utilization Review decisions in a timely manner, taking into account the clinical urgency of the situation. Administrator will monitor compliance with standards and take appropriate action to improve performance as necessary;
 - (b) Administrator shall conduct and manage Behavioral Health and Intellectual/Developmental Disability Service Utilization Review decisions in accordance with the Utilization Management level of care scope specified in Exhibit I Delegation Grid;
 - (c) Administrator will maintain and make available to Members and Providers a toll-free "800" number seven (7) days per week, twenty-four (24) hours per day for the purposes of making referrals and determining the Medical Necessity of Behavioral Health Services and Intellectual/Developmental Disability Services;
 - (d) Administrator will respond to Member and Provider requests for referrals and determinations of the Medical Necessity of Behavioral Health Services and Intellectual/Developmental Disability Services received through to the Administrator toll-free customer service line and transfers from CMHSPs and/or received from the established PIHP IVR systems;
 - (e) Administrator shall use its own clinical standards, which have been reviewed and approved by PIHP, acknowledging that Administrator's clinical standards and review criteria may not mirror Member CMHSP's in all instances. Administrator shall provide PIHP with updates to its clinical review standards and criteria;
 - (f) The parties acknowledge that Administrator will not provide treatment to Members, and that the final responsibility for all decisions concerning the provision of treatment will rest with the treating Provider and the Member;
 - (g) Administrator shall provide appropriate care management resources, through a mutually agreed upon combination of on-site and telephonic support, to facilitate: (i) participation in regularly scheduled clinical rounds; (ii) scheduled clinical case review; (iii) ongoing collaborative care management; and (iv) ad-hoc review for collaborative management when necessary;
 - (h) Administrator will obtain relevant clinical information and consult with treating practitioners, primary care physicians, the Member and Administrator staff in determining Medical Necessity;
 - (i) Administrator shall ensure that licensed and experienced behavioral health clinicians will assess the clinical information used to support Utilization Review decisions. Non-licensed staff may also support the UM process through intake coordination activities. A psychiatrist or doctoral level clinical psychologist will review any denial based on Medical Necessity;
 - (j) Administrator will document and communicate reasons for denial of Behavioral Health Services and Intellectual/Developmental Disability Services in accordance with applicable Michigan state and/or federal laws and regulations pursuant to processes established by Administrator;

- (k) Administrator will administer: (i) all first and second level Behavioral Health and Intellectual/Development Disability Service appeals for those authorizations in which Administrator makes decisions and in accordance with the Utilization Management level of care scope specified in Exhibit I Delegation Grid, and Administrator, pursuant to the provisions of subsection 'A' below shall be responsible for administration of external reviews available under the PIHP.
- (l) Administrator shall conduct and manage all available Behavioral Health Service Utilization Review decisions and appeals submitted by a Provider on Provider's own behalf;
- (m) Subject to any legal restrictions, the parties agree to work cooperatively with respect to any Member appeals, including providing access to necessary documentation, and/or active participation by an authorized representative of PIHP or Administrator, respectively and as requested by the other party, to the extent such actions or activities are not unduly burdensome;
- (n) Regardless of any provision to the contrary, should PIHP fail to provide enrollment, eligibility, coordination of benefits and/or other information necessary for Administrator to conduct first level and/or second level Member appeals, Administrator will not be held responsible for any delay, lack of performance or deficiencies regarding such first level and/or second level appeal activities; and
- (o) Should Administrator fail to comply with the provisions of this Exhibit and/or fail to perform UR Functions as represented hereunder, PIHP may, in its sole discretion: (i) require Administrator to implement a correction action plan or plans; and/or (ii) revoke any one or all of the delegated UR Functions hereunder upon advance written notice to Administrator.

EXHIBIT D
CLAIMS PROCESSING AND ENCOUNTER SUBMISSION

1. Claims and Encounter Data to Administrator. In Program Year 1 and until such a time that Administrator is responsible for claims processing and encounter submission, PIHP will supply Administrator with comprehensive and accurate claims and encounter data on at a minimum interval of monthly submissions so that Administrator can conduct financial management, quality management and analytics activities for the Plan. PIHP, Member CMHSPs and Administrator agree to work collaboratively to increase encounter submission rate, with a target goal of 99% of submission rate to help improve accuracy of financial reporting and rate setting.

2. After Commencement date, PIHP and Administrator may mutually agree that Administrator provide Claims Processing and Encounter Submission services to the PIHP for the Member CMHSPs. Administrator will not provide any Claims Functions (including Encounter processing, cleansing, assembly or submission to MDHHS) to the PIHP at time of Commencement Date, however, it is the expectation that the LRE shall transition encounter processing and submission functions to Administrator for Program Year 2 with an operational start date of October 1, 2019 and the CMHSP Members shall transition claims processing and payment functions to Administrator for Program Year 2 with an operational start date of October 1, 2019. Should the aforementioned transitions not occur so that Administrator is providing a single claims and encounter process for all providers in the Lakeshore Region, then Administrator reserves the right to renegotiate its risk position as defined in Exhibit K. Financial Management, Medical Risk and Incentive. During Program Year 1, Administrator, LRE and CMHSP Members will participate in discovery and implementation activities relating to the transition and subsequent execution of claims and encounter functions (see also: Exhibit I DELEGATION GRID, Claims).

EXHIBIT E
CREDENTIALING & RE-CREDENTIALING

1. Delegation. PIHP hereby delegates to Administrator certain of the PIHP's credentialing and re-credentialing functions related to Behavioral Health and Intellectual/Developmental Disability providers and identified herein ("**Credentialing Functions**"), including, without limitation, verification and decision making, and Administrator hereby agrees to perform such Credentialing Functions.
 - (a) Prior to the Commencement Date, PIHP shall have performed an initial evaluation of the ability of Administrator to perform credentialing/re-credentialing functions and activities identified hereunder through evaluation of the credentialing/re-credentialing processes and procedures used by Administrator and additional documentation and/or information as may be reasonably requested by PIHP.
 - (b) Capitalized terms not otherwise defined in this Exhibit are ascribed the meaning given in the Agreement.
 - (c) Regardless of any provision of this Agreement to the contrary, PIHP and Administrator agree that Providers are not the agents of PIHP or Administrator, and in no event shall PIHP or Administrator be obligated to indemnify or hold the other harmless against any acts or omissions of Providers or other providers rendering Behavioral Health Services and Intellectual/Developmental Disability Services to Members.
2. Credentialing Functions. Administrator agrees to perform the Credentialing Functions regarding Providers in the Provider Network:
 - (a) Documentation at the time of Credentialing Functions for Providers in the Provider Network to include verification of the following:
 - i. Current unrestricted professional license or certification;
 - ii. Education and training;
 - iii. Work history;
 - iv. Current general and professional liability insurance coverage consistent with limits required under Administrator's credentialing/re-credentialing policies and procedures;
 - v. Professional liability claims history;
 - vi. Current Medicare and Medicaid certification for participation;
 - vii. Clean record from the Office of Inspector General Medicare and Medicaid sanctions, exclusions and reinstatement report or the Excluded Parties Listing System (EPLS);
 - viii. Office of Foreign Assets Control (OFAC);
 - ix. Other malpractice or sanction activity, including Michigan state license sanctions or limitations; and
 - x. Medicare opt-out status.

Administrator shall ensure primary verification on all of the above (with the exception of education and work history) at the time of re-credentialing. Administrator shall conduct primary verification within the 180 days preceding the credentialing/re-credentialing decision. Administrator shall document all primary verification in the practitioner and organization provider files.
 - (b) Review of the Office of Inspector General's EPLS report on Medicaid/Medicare Sanctions.
 - (c) Re-credentialing of Providers in the Provider Network at least every three (3) years, including without limitation confirmation that Providers in the Provider Network continue in good standing with Michigan state and federal regulatory bodies.
 - (d) Ongoing monitoring of Behavioral Health Services and Intellectual/Developmental Disability Services provided. Such ongoing monitoring shall include without limitation Medicare/Medicaid sanctions, OIG actions, review of Michigan state license actions, Member complaints and quality concerns.
 - (e) Maintenance of a database to manage the credentialing and re-credentialing processes and that include documentation of all of the above criteria.

(f) To the extent necessary to meet regulatory requirements and subject to any legal restrictions, Administrator will provide PIHP with copies of individual Provider credential/re-credential files.

(g) Obtain an attestation from each applicant stating:

- i. Reasons for any inability to perform the essential functions of the position, with or without accommodation;
- ii. Lack of present illegal drug use;
- iii. History of loss of license and/or felony convictions; and
- iv. History of loss or limitation of privileges or disciplinary activity and attestation by the applicant of the correctness and completion of the application.

(h) The parties acknowledge that PIHP is responsible for assuring Members that the same standards for participation are maintained throughout its network of Participating Providers, and that PIHP retains the right to approve, suspend or terminate practitioners, organizational providers, and sites of care (including without limitation Providers in the Provider Network as to participation status in PIHP's network of Participating Providers), in its discretion.

(i) Should Administrator fail to comply with the provisions of this Exhibit, PIHP may, in its sole discretion:

- i. Require Administrator to implement a correction action plan or plans; and/or
- ii. Revoke any one or all of the delegated Credentialing Functions hereunder upon advance written notice to Administrator.

(j) Administrator shall conduct Provider audits with Member CMHSP and other Providers who deliver covered services in accordance with MDHHS requirements and scope specified in Exhibit I Delegation Grid,

CUSTOMER SERVICE

1. Delegation. PIHP hereby delegates to Administrator customer service functions identified herein for Members related to Behavioral Health Services and Intellectual/Developmental Disability Services (“**Customer Service Functions**”), and Administrator hereby agrees to perform such Customer Service Functions. Administrator shall perform Customer Service Functions in accordance with applicable Michigan state and federal law. Administrators Customer Service Functions shall not replace those Customer Service Functions provided by Member CMHSPs.
 - (a) Prior to the Commencement Date, PIHP shall have performed an initial evaluation of the ability of Administrator to perform Customer Service Functions identified hereunder through evaluation of the customer service processes and procedures used by Administrator and additional documentation and/or information as may be reasonably requested by PIHP.
 - (b) Capitalized terms not otherwise defined in this Exhibit are ascribed the meaning given in the Agreement.
2. Customer Service Functions. Administrator shall perform the following Customer Service Functions:
 - (a) Respond to Member and Provider Behavioral Health Services and Intellectual/Developmental Disability Services or Utilization Management related inquiries pertaining to Utilization Management decisions made by Administrator received through transfers from the CMHSP Members customer service teams during Administrator’s normal business hours.
 - (b) Administrator will respond to Member and Provider requests for referrals for Behavioral Health Services and Intellectual/Developmental Disability Services received through inbound calls to Administrator;
 - (c) Administrator will administer: (i) all first and second level (fair hearing) Behavioral Health Service and Intellectual/Developmental Disability appeals pertaining to Utilization Management decisions made by Administrator, and Administrator. All appeals must be performed by individual or individual(s) that are not directly responsible for Utilization Management decisions, Adverse Benefit Determinations or Finance.
 - (d) The parties agree to work cooperatively with respect to any Member grievances or appeals; this includes providing access to necessary documentation, and/or active participation by an authorized representative of PIHP or Administrator, respectively and as requested by the other party, to the extent such actions or activities are not unduly burdensome and taking into account any Member required consents or releases required by applicable laws.
 - (e) Handle and resolve Provider requests, inquiries, complaints, and appeals regarding Administrator’s services and/or Behavioral Health Services and Intellectual/Developmental Disability Services.
 - (f) Respond to any Michigan State Department of Insurance, Department of Health, Attorney General, or other authorized government agency complaints and inquiries received by Administrator. PIHP remains responsible for responding to government agency complaints and inquiries received by the PIHP.
 - (g) Should PIHP fail to provide enrollment, eligibility, coordination of benefits and/or other information necessary for Administrator to conduct first level Member administrative appeals and after receiving notice from Administrator, Administrator will not be held responsible for any delay, lack of performance or deficiencies regarding such first level and/or second level (fair hearing) appeal activities.
 - (i) Should Administrator fail to comply with the provisions of this Exhibit and/or fail to perform Customer Service Functions as represented hereunder, PIHP may, in its sole discretion: (i) require Administrator to implement a corrective action plan or plans; and/or (ii) revoke any one or all of the delegated Customer Service Functions hereunder upon advance written notice to Administrator.

EXHIBIT G
PROVIDER NETWORK

The actual contracts for the Provider Network shall remain between Providers and Member CMHSPs. Administrator will not recruit or contract providers directly in an Administrator network without consent of LRE and Member CMHSPs.

1. Delegation. PIHP hereby delegates to Administrator provide certain network functions identified herein related to Behavioral Health Services and Intellectual/Developmental Disability Services (“Provider Network Functions”), and Administrator hereby agrees to perform such Provider Network Functions. Administrator shall perform Provider Network Functions in accordance with applicable Michigan state and federal law.
 - (a) Prior to the Commencement Date, PIHP shall have performed an initial evaluation of the ability of Administrator to perform Provider Network Functions identified hereunder through evaluation of the provider network processes and procedures used by Administrator and additional documentation and/or information as may be reasonably requested by PIHP.
 - (b) Capitalized terms not otherwise defined in this Exhibit are ascribed the meaning given in the Agreement.
2. Provider Network Functions. Administrator shall perform the following Provider Network Functions:
 - (a) Administrator will also provide CMHSPs with a copy of its template Provider Agreement and will work with CMHSPs in a consultative manner to incorporate best practices as defined by Administrator into CMHSP contracts with providers. These best practices may include basic contract terms, value-based payment models or other terms.
 - (b) Administrator will provide Network functions in accordance with scope specified in Exhibit I Delegation Grid,

EXHIBIT H
REQUIRED REPORTS

1. Delegation. PIHP hereby delegates to Administrator reporting functions identified herein related to Administrator's Behavioral Health Services and Intellectual/Developmental Disability Services ("Reporting Functions"), and Administrator hereby agrees to perform such Reporting Functions. Administrator shall perform Reporting Functions in accordance with applicable Michigan state and federal law.
 - (a) Prior to the Commencement Date, PIHP shall have performed an initial evaluation of the ability of Administrator to perform Reporting Functions identified hereunder through evaluation of the reporting requirements used by Administrator to create the required reports and additional documentation and/or information as may be reasonably requested by PIHP.
2. Administrator Reporting Functions. Administrator shall create and distribute program reports to PIHP and/or, CMHSP Members for those functions in which the Administrator assumes delegated responsibility in accordance with scope specified in Exhibit I Delegation Grid. Administrator will not assume responsibility for MDHHS required program report assembly, creation or submission. Administrator will provide PIHP and Member CMHSPs with data in a timely manner and within required timeframes for the creation of required reports that must include information from the Administrator.
3. PIHP and Member CMHSP Reporting Functions. The PIHP and Member CMHSPs shall assemble, create and submit all required program reports to MDHHS such as but not limited BH-TED, MBPIS and SUD Program Reporting. The scope of reports that remain the responsibility of the PIHP and/or CMHSP Members includes all reports defined in the MDHHS, PIHP contract or PIHP, CMHSP contract.

EXHIBIT I
DELEGATION GRID

1. Managed Care Services Delegated to Administrator. Certain Managed Care functions for this program will be delegated to Administrator by PIHP. Other Managed Care functions will be retained by the PIHP and Member CMHSPs. This delegation grid defines the Managed Care responsibilities of the PIHP, Member CMHSPs and Administrator and is supplemental to the scope of work defined in all other Exhibits of this Contract.

Delegated Function	PIHP (LRE) Responsibility	Member CMHSP Responsibility	Administrator (Beacon) Responsibility
Governance / Leadership	<p>PIHP Retains fully public governance responsibility for oversight and strategic direction of the region. The PIHP will remain the primary points of contact with MDHHS and Member CMHSPs</p> <p>The PIHP maintains contracts with MDHHS and Member CMHSPs</p> <p>Implement financial management strategies such as Level of Care criteria, Provider contract amendments and new allocations to Member CMHSPs from PIHP</p> <p>Co-chair with Administrator Joint Operating Committee and oversee / manage operational and administrative services provided by Administrator (Beacon Health Options)</p> <p>PIHP will be responsible for managing the contract with Beacon</p> <p>PIHP will directly employ Executive Management positions</p>	<p>Appoints members to Governance Committees</p> <p>Participate in Joint Operating Committee and oversee / manage operational and administrative services provided by Administrator (Beacon Health Options)</p>	<p>Collectively work to establish relationship with board</p> <p>Collectively evaluate effectiveness of current operating agreement between the PIHP and Member CMHSPs and provide recommendations for enhancements</p> <p>Provide strategic support at the direction of PIHP and Member CMHSPs for financial (ex: rates setting), operational, clinical and strategic discussions with MDHHS and/or other parties in the interest of the program and public-system.</p> <p>Implement, operate and co-chair with PIHP Operational/Administrative Joint Operating Committee (JOC) consisting of Administrator, PIHP and Member CMHSPs to manage day-to-day operations and deliverables of the PIHP and Administrator's delegated duties</p>

Delegated Function	PIHP (LRE) Responsibility	Member CMHSP Responsibility	Administrator (Beacon) Responsibility
<p>Provider Network Management</p>	<p>PIHP to retain contracts for all Prevention providers. The PIHP will directly employ the SUD Director.</p> <p>Implement provider network strategy including value-based payment models (aka APMs) and quality measures</p> <p>Collaborative standardization of contracts including rates (where appropriate/applicable), payment models, credentialing process/schedule and quality expectations across counties for strategic providers mutually identified by Administrator, PIHP and Member CMHSPs.</p>	<p>Member CMHSPs to retain contracts for all service providers and most network management functions</p> <p>Management of funding model of providers.</p> <p>Implement provider network strategy including value-based payment models (aka APMs) and quality measures</p> <p>Collaborative standardization of contracts including rates (where appropriate/applicable), payment models, credentialing process/schedule and quality expectations across counties for strategic providers mutually identified by Administrator, PIHP and Member CMHSPs.</p>	<p>Look for collective efficiencies for areas that may be jointly implemented</p> <p>Collaborative standardization of contracts including rates (where appropriate/applicable), payment models, credentialing process/schedule and quality expectations across counties for strategic providers mutually identified by Administrator, PIHP and Member CMHSPs.</p> <p>Negotiation of Provider Rates/Development of APMs/Development of alternative funding model</p> <p>Facilitate standardization of process across Member CMHSPs</p> <p>Assistance to Member CMHSPs with provider quality and performance management against mutually agreed upon utilization and clinical quality measures including creation of provider scorecards/performance measures</p> <p>Singular regional credentialing process for all network providers (each provider will go through credentialing one-time for all Member CMHSPs' contracts in the region). Providers will be re-credentialled based on earliest re-credential date from any of the Member CMHSPs and that initial re-credentialing date will be used for subsequent re-credentialing (consider re-credentialing all providers by the end of the first full operating year).</p> <p>Retain a singular Provider Learning Management System, training content and training reciprocity. Manage access to system for providers and provide updates to content to reflect program changes as a result of this contract, changes to the MDHHS, PIHP contract or other requirements.</p> <p>Regional Provider Database</p> <ul style="list-style-type: none"> • Credentialing • Complaints • Bed Tracking • Performance ratings from score card and other critical performance measures • Recipient Rights issues— substantiated complaints of pre-established magnitude (e.g., abuse, neglect)

Delegated Function	PIHP (LRE) Responsibility	Member CMHSP Responsibility	Administrator (Beacon) Responsibility
Customer Services		<p>Customer services performed locally</p> <p>Complaints related to Member CMHSP or PIHP delegated functions are managed by Member CMHSPs during regular business hours</p>	<p>Coordinate CMHSP Member, Customer Service on behalf of CMHSP Members including:</p> <ul style="list-style-type: none"> • Member handbook content development and provision to PIHP/Member CMHSPs for printing and/or website publishing • 24-hour CS line (phone) support via paging to on-call team members • Local (first-level) appeals • Fair Hearing (aka second-level appeals) preparation and representation as necessary • Regional customer services database where customer service data is entered and available to PIHP and Member CMHSPs in standardized way • Quarterly reporting to CS ROAT, PIHP Board on regional and member CS Issues (vs. all tracking and trending occurring locally or only at PIHP) to support regional and local QI specific to customer services issues. <p>Assemble and distribute to PIHP, Member CMHSPs within required timeframe information required for Member CMHSP complaint response process.</p> <p>Complaints related to functions/activities delegated to Administrator will be managed by Administrator and reported to the PIHP.</p> <p>Grievances and Appeals related to activities delegated to Administrator.</p>

Delegated Function	PIHP (LRE) Responsibility	Member CMHSP Responsibility	Administrator (Beacon) Responsibility
Quality management	All state and regulatory quality reporting (PIHP and Member CMHSPs)	<p>Local QI Efforts</p> <p>Local compliance efforts</p> <p>All state and regulatory (PIHP and Member CMHSPs)</p> <p>Sentinel events reporting to Administrator</p> <p>Member CMHSP Medicaid Verification functions</p> <p>Corporate Compliance for Member CMHSPs</p>	<p>Coordinate regional Quality Management and manage the regional PIHP Quality Management Plan including creation of MDHHS deliverables including the QAPIP</p> <p>Member CMHSP audits against quality management plan initiatives and goals</p> <p>Impartial, third-party (Administrator) IPOS audits for appropriate person-centered and evidence-based Level of Care application across the entire region</p> <p>Medicaid Verification (Compliance for eligibility of services and full chain of service eligibility to plan of care and authorized services. See also Utilization Management Concurrent Reviews).</p> <p>Corporate Compliance for PIHP</p> <p>Fraud, Waste and Abuse investigation and reporting</p>
Utilization Management	<i>This cell Intentionally blank</i>	<p>Functions defined jointly by Administrator and Member CMHSP and executed locally by Member CMHSP staff</p> <ul style="list-style-type: none"> • Intake assessment (front-door access to program and services) • Authorizations and current medical necessity (eligibility for services) screening • IPOS creation and sign-off with consumer and family/caregiver, etc. • Care Coordination on behalf of consumers • Local implementation of ANSA, SIS, etc. <p>Implementation of Level of Care criteria in IPOS development process per industry standards</p>	<p>Administrator works with members to establish standardized criteria, and provide oversight to ensure consistency of benefit:</p> <ul style="list-style-type: none"> • Support for the rapid implementation of ANSA, SIS, CANs management in Member CMHSP EHRs • Assistance with development of standard forms • Support in outlier management and impartial, third-party (Administrator) reviews of IPOS for consumers with complex needs including Medicaid Verification Concurrent Reviews <p>Population management Support</p> <ul style="list-style-type: none"> • Data warehouse • Back end Analytics <p>Deploy a regional, UR-standard authorization, guideline-driven program with Level of Care Criteria. Administrator Utilization Management activity/reviews, etc. to focus on high-value non-Member CMHSP Providers (aka External Network Providers and Services) who provide high-volume/high-cost/high LOC services in one or more counties. Potential areas to explore include at a minimum: IOP, Inpatient Psych, SUD Residential, MH Residential and may be expanded to include other Levels of Care that</p>

Delegated Function	PIHP (LRE) Responsibility	Member CMHSP Responsibility	Administrator (Beacon) Responsibility
			<p>are <i>mutually agreed upon</i> between Administrator and Member CMHSP(s) and:</p> <ul style="list-style-type: none"> • Pre-Certification (Initial Authorizations) • Concurrent reviews/Continued Stay Reviews • Transitions of Care support from Inpatient to Community setting transitions • Retrospective reviews of IPOS against Level of Care criteria and clinical support and education to Member CMHSP Members and Providers specifically targeted high-cost external network services such as IOP, Inpatient Psych, Residential <p>Work directly with Member CMHSP assessor or in the case of Network180 who does not directly employ assessors Member CMHSP UR clinician, to agree upon and achieve final approval for all types of services on IPOS for consumers.</p> <p>Local (first-level) appeals and Fair hearings preparation and representation as necessary</p>
Financial Management	<p>PIHP completes Financial Reporting</p> <p>PIHP distributes funds to Member CMHSPs according to sub-capitation agreements, delegated services or other allocations and to Administrator for claims payments managed by Administrator according risk plan established</p> <p>Risk Reserves and Risk Planning in conjunction with Board and Beacon</p> <p>Funding analysis to support improved funding methodology along with the acquisition and management of impartial third-party actuarial expert for the development and maintenance of allocation agreement terms and rates including sub-capitation rates for Member CMHSPs</p>	<p>Local Analytics to support Member CMHSP Management</p> <p>Risk Reserves and Risk Planning in conjunction with PIHP (LRE) Board and Administrator</p>	<p>Data analytics to support PIHP management and Member CMHSPs</p> <p>Risk reserves and Risk Planning in conjunction with PIHP Board and Member CMHSPs</p> <p>Review and provide guidance to PIHP and Member CMHSPs on administrative cost reporting methodology and approach for the region</p> <p>Assist with management of sub-capitation agreements and payment models with select strategic (non-Member CMHSP) providers</p> <p>Development and ongoing maintenance of allocation agreement terms and rates including sub-capitation rates for Member CMHSPs and administrative cost allocations within the 6% administrative target.</p>

Delegated Function	PIHP (LRE) Responsibility	Member CMHSP Responsibility	Administrator (Beacon) Responsibility
Claims	<i>This cell Intentionally blank</i>	<p>Direct claims payment, reconciliation and Coordination of Benefits (COB) to providers for all services.</p> <p>Provision of claims and encounter data to Administrator for purposes of financial management, actuarial allocation agreement recommendations and program quality management.</p> <p>Submit claims and encounter data to MDHHS with enhanced accuracy and timeliness standards with a goal of achieving 99% timeliness and accuracy performance.</p> <p>Member CMHSPs to develop interfaces and programs to consume data from Administrator EDI program(s) into each Member CMHSP EHR.</p>	<p>Identification of opportunities for recoupments, coordination of benefits and third-party liability</p> <p>Use of claims payment data for financial management and quality functions such as rate setting, value-based payment (aka APM) design, FWA, trending and reporting</p> <p>Encounter and claims data analysis for internal and program management purposes. The PIHP and CMHSP Members will retain current systems.</p> <p>Monitoring of funds and availability of funding for expected claims payments based on analysis such as: IBNR, claims-triangles, etc.</p> <p>Administrator will develop and operate Electronic Data Interfaces (EDI) programs to consume data from Member CMHSP EHR systems (NetSmart Avatar, Core Solutions, PCE and Streamline) in support of Administrator functions and provide data to Member CMHSP EHR systems so that those systems can consume and utilize data from Administrator's delegated functions (such as delegated Utilization Management activity).</p> <p>LRE shall transition encounter processing and submission functions to Administrator for Program Year 2 with an operational start date of October 1, 2019 and the CMHSP Members shall transition claims processing and payment functions to Administrator for Program Year 2 with an operational start date of October 1, 2019. Should the aforementioned transitions not occur so that Administrator is providing a single claims and encounter process for all providers in the Lakeshore Region, then Administrator reserves the right to renegotiate its risk position as defined in Exhibit K. Financial Management, Medical Risk and Incentive. During Program Year 1, Administrator, LRE and CMHSP Members will participate in discovery and implementation activities relating to the transition and subsequent execution of claims and encounter functions.</p>
Information Management Services	<p>Reporting including BH-TEDS, MBPIS and SUD program reporting.</p> <p>Local analytics and warehouses supported by shared tools</p>	<p>Retain EHRs</p> <p>Reporting including BH-TEDS, MBPIS and SUD program reporting</p>	<p>Analytics, based on clean, normalized, comprehensive dataset from the Administrator's CONNECTS platform and Member CMHSP systems and claims/encounter data provided to Administrator:</p> <ul style="list-style-type: none"> • Cost

Delegated Function	PIHP (LRE) Responsibility	Member CMHSP Responsibility	Administrator (Beacon) Responsibility
	<p>PIHP contractually required program reporting including encounter submission to MDHHS.</p> <p>Collaboration with Administrator on data quality, integrity and data timeliness for required state reporting.</p>	<p>Retain necessary local IT to support reporting to PIHP</p> <p>Local analytics and warehouses supported by shared tools</p>	<ul style="list-style-type: none"> • Who we are serving • How we are serving • How we should be serving • Total healthcare • Cost vs what cost should be <p>Population management tools, ZTS software licensing and the data base that merges PIHP and CC360 data until replacement tools provided</p> <p>Data quality, validation, monitoring, correction tracking, and follow up on documentation required for PIHP submission of state required reports. Collaboration with the PIHP on how to use Administrator and Member CMHSP data in reports. Assist in implementing oversight related to data quality, validity and timeliness of data.</p> <p>At time of transition and after as defined in Claims section above, consume, normalize and store all claims/encounter data from each Member CMHSP in order to perform delegated financial management functions and assist the PIHP in performance of financial management.</p> <p>Provision of Managed Care Administrative Information Technology and MIS platform (CONNECTS platform) for Administrator's operations and in alignment with program delegation. Administrator will provide LRE and CMHSP Members with the option to access modules (such as those defined below) should delegation change in subsequent program changes and related contract amendments:</p> <ul style="list-style-type: none"> • Eligibility/enrollment processing • Claims processing and payment • Operational reporting on Administrator functions • Credentialing • Encounter tracking/processing • Member matching and braided-funding administration • Customer and provider service tracking • Utilization management workflow and batch authorizations from external systems • Care coordination workflow for aftercare support and Administrator case management • Transitions of care workflow • Referral management workflow

Delegated Function	PIHP (LRE) Responsibility	Member CMHSP Responsibility	Administrator (Beacon) Responsibility
			<ul style="list-style-type: none"> • Appeals, complaints and grievances support • Data warehousing • Data exchanges (EDI) • Analytics • Funding administration/management
Enrollee Rights / Grievance and Appeals	<p>Complaints related to PIHP delegated functions (including any complaints related to Utilization Management decision making and Appeals process)</p> <p>Oversight that Member CMHSPs' and Administrator's appeal process and representation is conflict-free and separate from Utilization Management Decisions and Finance.</p>	<p>Complaints related to Member CMHSP delegated functions</p> <p>Local appeals (must be performed by individual or individual(s) that are not directly responsible for Utilization Management decisions, Adverse Benefit Determinations or Finance).</p>	<p>First point of customer contact for Grievances</p> <p>Fair hearings (aka second-level appeals)</p> <p>Support of local (first-level) appeals for services authorized by Administrator and Fair hearings and will follow the process to prepare all clinical materials for any fair hearing requests timely and send representation (as required by contract - if applicable).</p> <p>Local appeals for those services authorized by Administrator (must be performed by individual or individual(s) that are not directly responsible for Utilization Management decisions, Adverse Benefit Determinations or Finance).</p> <p>Complaints related to Administrator delegated functions.</p>
Risk / Incentive	See Exhibit K. FINANCIAL MANAGEMENT, MEDICAL RISK AND INCENTIVE for details.		

EXHIBIT J
SERVICE LEVEL AGREEMENT / PERFORMANCE GUARANTEES

1. Administrator Service Level Agreements. Administrator will maintain (achieve) or report on the following service level standards. and provide PIHP with regular program reporting to track and manage the service levels standards listed below.

Delegated Function	Minimum membership of 150,000
Customer Service	Inbound calls to Administrator shall be answer by a human resource during normal business hours
Clinical	97% of all appeal acknowledgement letters will be sent within 5 calendar days for standard appeals – Measured Quarterly 97% of all standard appeals Administrator shall make a decision and provide notification to the member and provider within fifteen (15) calendar days – Measured Quarterly 97% of all retrospective appeals Administrator shall make a decision and provide notification to the member and provider within thirty (30) calendar days – Measured Quarterly
Credentialing	90% of initial credentialing applications processed within 60 days of receipt of a complete file 90% of providers re-credentialed within 36 months of their prior credentialing date
EDI / Eligibility	98% of received valid eligibility files processed within 2 business days.
Account Management	Account management will acknowledge within one business day all complaints expressed to them by the client's management staff
Implementation	Program will be delivered on time and satisfactorily. This is a first year standard only.
Reporting	Semi-annual reports will be delivered within 45 days from the end of the period. For a full report with Executive Summary 60 days from the end of the period for the semiannual. A year-end utilization and activity report, summarizing all services delivered and including onsite visits, shall be provided and submitted electronically within 60 days from the end of the period. For a full report with Executive Summary 90 days from the end of the period for the annual.
Quality	Quality of Care: when delegated, potential quality of care issues will be investigated with 30 business days or sooner if the member is at imminent risk 100% of the time.

2. Administrator Performance Guarantees. Administrator will meet or report on Service Level Agreement measures to track performance. Administrator's Risk to PIHP is defined in Exhibit K.

EXHIBIT K
MEDICAL RISK AND INCENTIVE

1. Medical Risk and Incentive. PIHP and Administrator agree to the following Medical Risk and Incentive arrangement whereby the Administrator will assume financial liability from the PIHP for the costs of services that exceed the planned Medical Loss Ratio or budgeted service cost allocation for the program and will also be eligible for receipt of payment for savings (reductions in costs) below the planned Medical Loss Ratio or budgeted service cost allocation in accordance with the methodology defined below:

- (a) The PIHP and Administrator will both assume Medical Risk in this program
- (b) The PIHP and Administrator will both be eligible for receipt of incentives
- (c) Risk payments and incentives will occur after true up process of 1 program year plus claims run-out
- (d) Risk and Incentive model design and delegation is defined below in Table K.1 Risk / Incentive Model

This Exhibit defines the Risk and Incentive relationship and delegated responsibilities between PIHP (LRE) Member CMHSP and Administrator (Beacon). This Exhibit does not change or modify the PIHPs contractual responsibilities with Michigan Department of Health and Human Services as defined in section 8.6.2 of the Lakeshore Regional Entity and MDHHS PIHP Contract (Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program).

Table K.1 Risk / Incentive Model

Delegated Function	PIHP (LRE) Responsibility	Member CMHSP Responsibility	Administrator (Beacon) Responsibility
Risk / Incentive	<p>If actual service costs (Medical Expense / MLR) exceed the total Budgeted Allocation, PIHP shall bear ½ of 5% program risk. PIHP's risk is capped at 2.5% of cost overrun to Budgeted Allocation.</p> <p>PIHP shall bear risk above the 5% shared risk total in a manner to be defined by PIHP and Member CMHSPs for any expenditures over 5%.</p> <p>If the program operates below the total Budgeted Allocation PIHP shall receive savings and utilization of such funds shall be subject to the terms of the PIHP/MDHHS contract.</p> <p>PIHP and Member CMHSPs will work together to align financial incentives so that PIHP, Member CHMSHPs and Administrator all bear some portion of risk within contract year 1 and all are similarly and jointly incentivized to implement clinical, operational and financial measures to improve care and serve consumers within the program budget and defined by MDHHS rates. If such measures are not implemented during program year 1, parties agree to revisit the terms of Administrator's risk.</p> <p><i>See Table K.2. PIHP and Administrator Risk and Incentive Example for additional details</i></p>	<p>Member CMHSPs will implement a new allocation model (Budgeted Allocation) that will be actuarially sound and defined by a third-party actuary to commence on February 1st, 2019. This budgeted allocation shall cover all costs outside of the PIHP and Administrator administrative fees for the services funded through this program.</p> <p>Member CMHSPs and PIHP will work together to align financial incentives so that PIHP, Member CHMSHPs and Administrator all bear some portion risk within contract year 1 and all are similarly and jointly incentivized to implement clinical, operational and financial measures to improve care and serve consumers within the program budget and defined by MDHHS rates. If such measures are not implemented during program year 1, parties agree to revisit the terms of Administrator's risk.</p> <p><i>See Table K.2. PIHP and Administrator Risk and Incentive Example for additional details</i></p>	<p>Administrator will provide advisory input and collaboration to PIHP and Member CMHSPs for the development and implementation of the Budgeted Allocation model.</p> <p>If actual service costs (Medical Expense / MLR) exceed the total Budgeted Allocation, Administrator shall bear ½ of 5% program risk. Administrator's risk is capped at 2.5% of cost overrun to Budgeted Allocation.</p> <p>If the program operates below the Budgeted Allocation, Administrator shall receive from the PIHP an incentive payment of up to a maximum of 2.5% of the total Budgeted Allocation.</p> <p>Administrator's Medical Risk and Incentive shall commence on February 1st, 2019 with the acceptance and implementation of new allocation model by PIHP and Member CMHSPs.</p> <p><i>See Table K.2. PIHP and Administrator Risk and Incentive Example for additional details</i></p>

Table K.2. PIHP and Administrator Risk and Incentive Example

PIHP and Administrator Risk and Incentive Example (Below example assumes \$270,063,040 of at-risk medical expense)					
Medical-Expense variance from MLR* Target	Total Risk \$	PIHP Risk \$	Administrator Risk \$	Medical-Expense variance from MLR* Target	Administrator Incentive
1% above target	\$(2,700,630)	\$(1,350,315)	\$(1,350,315)	1% below target	\$ 1,350,315
2% above target	\$(5,401,261)	\$(2,700,630)	\$(2,700,630)	2% below target	\$2,700,630
3% above target	\$(8,101,891)	\$(4,050,946)	\$(4,050,946)	3% below target	\$4,050,946
4% above target	\$(10,802,522)	\$(5,401,261)	\$(5,401,261)	4% below target	\$5,401,261
5% above target	\$(13,503,152)	\$(6,751,576)	\$(6,751,576)	5% below target	\$6,751,576
6% above target	\$(16,203,782)	\$(9,452,206)	Not applicable	6% below target	Not applicable
7% above target	\$(18,904,412)	\$(12,152,836)	Not applicable	7% below target	Not applicable
7.5% above target	\$(20,254,727)	\$(14,853,466)	Not applicable	7.5% below target	Not applicable

*MLR = Medical Loss Ratio