Concordia
BEHAVIORAL HEALTH

June 20, 2017

Letter of Agreement by and between Concordia Care, Inc. d/b/a Concordia Behavioral Health, a managed behavioral health organization ("MBHO Network") and Broward County, a political subdivision of the State of Florida operating under Federal Tax Identification Number 59-6000531 ("MHSA Provider" or "Provider) to be effective as of February 1, 2016.

The purpose of this Letter of Agreement is to memorialize the mutual understanding and agreement between Network and Provider regarding the provision of certain specialty services by Provider to those individuals who are members of a health care benefit plan offered or sponsored by Network ("Network Members") in accordance with the terms and conditions set forth in this Letter of Agreement. This Letter of Agreement is intended to be an interim agreement which shall be effective until the execution of a provider agreement between Network and Provider.

A. Engagement; Compensation Arrangement.

1. Engagement. Provider will cooperate with Network to be available to all eligible Network Members in order to provide such Network Members with the highest quality specialty services. During the term of this Letter of Agreement, Provider will provide to Network Members the behavioral health care services listed in Attachments A and B.

2. Contracted Rate. For services rendered by Provider on behalf of Network Members during the term of this Letter of Agreement, the parties acknowledge and agree that Provider shall be entitled to compensation from Network as listed in Attachment B.

3. Limitation on Reimbursement. The Contracted Rate is the full amount of compensation to which Provider shall be entitled in connection with the provision of services to Network Members. Provider will not seek any payment in excess of the Contracted Rate in connection with the provision of services to Network Members from Network.

4. No Assurances. Nothing described in this Letter of Agreement shall be construed to require Network to assign or refer any minimum number of Network Members to Provider. Provider hereby acknowledges and agrees that Network has not made and will not make any express or implied warranties or representations that the arrangement set forth in this Letter of Agreement will result in any particular amount or level of business or revenue, or any cost savings, to Provider.

5. Provider Agreement. Provider agrees to use its best efforts to execute a complete provider agreement with Network within the next thirty five (35) business days that complies with all applicable regulatory requirements and provides for compensation consistent with the Contracted Rate.

6. Term and Termination. The parties may terminate this Letter of Agreement upon twenty (20) business days written notice; provided that either party may terminate this Letter of Agreement, by written notice to the other party, upon a material breach of the terms of this Letter of Agreement by the other party.

7. Referrals and Authorization. Provider shall comply and shall cause its MHSA (Mental Health/Substance Abuse) Provider Practitioners to comply with the protocols established by MBHO Network as they pertain to the referral, admission, or transfer of a Member for Covered Services not rendered by MHSA Provider through its MHSA Provider Practitioners and the process for obtaining authorization for such services. Except in the case of an Emergency, if a Benefit Plan design so requires, MHSA Provider shall refer, admit, or transfer a Member only to other Participating Providers.

8. Verification of Eligibility. Provider is responsible for verifying eligibility of Members before rendering services as appropriate, except in the case of an Emergency or Urgent Care needed services. Notwithstanding the foregoing, if following the verification of eligibility, the MBHO Network determines that a Member was not

eligible for Behavioral Health Care Services rendered or the Behavioral Health Care Services rendered were not Medically Necessary, Provider shall not be entitled to payment under this Letter of Agreement and MBHO Network shall be entitled to recover all payments made retroactive to the date of the prospective Member's ineligibility. In such event, Provider shall be entitled to recover all such payments owed for services rendered directly from the prospective Member or successor insurance coverage.

9. Covered Services. "Covered Services" means those mental health and substance abuse health care services identified in Attachment B.

B. Compliance; Miscellaneous.

1. Compliance with Network Policies and Procedures and Applicable Law. Provider shall comply with all applicable Network policies and procedures found in the Provider Portal at www.concordiabh.com ,as well as all applicable laws, rules and regulationsgoverning the rendering of care to Network Members by contracted professionals, including all Medicareand Medicaid laws and regulations that are applicable to Network or to those health plans sponsored byNetwork, to the same extent as if such regulations and requirements were set forth in this Letter of Agreement.

2. Counterparts. This Letter of Agreement may be executed in any number of counterparts and by the different parties hereto on separate counterparts, each of which when so executed and delivered shall be an original, but all of which shall together constitute one and the same instrument. A facsimile or scanned copy of an executed counterpart shall be valid and have the same force and effect as an original.

3. Governing Law. This Letter of Agreement is governed by, construed and interpreted in accordance with the laws of the State of Florida without regard to its conflicts of laws provisions.

4. Notices. Any notice, demand or other document required or permitted to be given or delivered hereunder shall be in writing and shall be deemed given or delivered if delivered in person, or sent by courier or expedited delivery service, or sent by registered or certified mail, postage prepaid, return receipt requested, or sent by facsimile (if confirmed), to the address set forth below or any other address that either party may specify by notice to the other party. Each party may change its address for purposes of this Letter of Agreement by written notice to the other party.

5. If to Network:
Concordia Care, Inc. d/b/a Concordia Behavioral Health
Attn: Provider Relations Department
10685 N. Kendall Drive
Miami, FL 33176-1510
Fax: 305-514-5331
E-mail: providers@concordiabh.com

If to Provider:
Broward County, a political subdivision of the State of Florida
2995 North Dixie Hwy.
Oakland Park, FL 33334

Please indicate your receipt and acceptance of the foregoing Letter of Agreement as described above.

Concordia Care, Inc.
d/b/a Concordia Behavioral Health

By:_____

_____
Print Name and Title

Broward County, a political subdivision of the State of Florida

By:_____

_____
Print Name and Title

Reviewed and approved as to form:
Andrew J. Meyers, County Attorney

By_____ 12/5/17
Karen S. Gordon, Assistant County Attorney

By_____
Sharon V. Thorsen, Senior Assistant County Attorney

Attachment A

Please submit the information below:

- **W-9 form,**
- **Proof of current medical malpractice insurance,**
- **Copy of state license.**

Locations:

1000 SW 2nd Street, Fort Lauderdale, FL 33312
Phone: 954-357-4879 Fax: 953-357-4859
Medicaid No.:060455101

900 NW 31st Street, Fort Lauderdale, FL 33311
Phone: 954-357-5080 Fax: 953-357-5058 Medicaid No.:060455103

4733 SW 18th Street, Hollywood, FL 33023

NPI No.:	1326171034
Telephone No.:	954-357-4851
Fax No.:	954-357-5695
Medicaid No.:	
Hours of Operation:	

3275 NW 99th Way, Coral Springs, FL 33065

NPI No.:	1326171034
Telephone No.:	954-357-7940
Fax No.:	954-357-3925
Medicaid No.:	
Hours of Operation:	

2995 North Dixie Hwy Oakland Park, FL 33334

NPI No.:	1255346813 954-357-6622
Telephone No.:	954-357-8815
Fax No.:	099082501
Medicaid No.:	
Hours of Operation:	

Billing address:	900 NW 31 Avenue, Suite 2000, Fort Lauderdale, FL 33311 59-
Tax ID:	6000531
Master NPI number:	1326171034
Medicaid number:	060455103
Medicare Number:	NA
Accreditation information, if any:	
Email (primary contact):	scarr@broward.org
Contact Name:	Sherjuana Carr

Please attach a roster of all Mental Health/Substance Abuse rendering practitioners interested in joining our Provider Network including their full name, service location, NPI, License, Medicare, and Medicaid numbers (if Applicable).

Facility Services Provided:

__ Statewide Inpatient Psychiatric Program (SIPP)

__ Crisis Stabilization Unit (CSU)

__ Applied Behavioral Analysis (ABA)

_X_ Targeted Case Management (TCM)

X Residential Mental Health

___Federally Qualified Health Center (FQHC)

_X__ Community Mental Health Center (CMHC)

___Inpatient Mental Health

_X_ Detox Program

Attachment B
Covered Services

"Covered Services" means those mental health and substance abuse health care services identified in the Reimbursement Rate schedule below.

Please indicate the lines of business you are contracting for:

__ Medicare

X Commercial

X Medicaid (Medicaid number is required)

__ Children's Medical Services Title XIX

__ Children's Medical Services Title XXI

Reimbursement Rates

Commercial Lines of Business

Service Description	Population	Line of Business	Rate
Substance Abuse Inpatient Treatment - Detox Revenue Codes: 0116, 0126, 0136, 0146, 0156 Inclusive of professional fees: Initial hospital care E & M: 99221, 99222, & 99223. Subsequent hospital care E & M: 99231, 99232, & 99233. Hospital discharge: 99238 & 99239.	• Adults	• Commercial	$450 per diem
Residential Mental Health Treatment Revenue Codes: 0100, 1001 Inclusive of all services	• Adults	• Commercial	$375 per diem
Residential Chemical Dependency Treatment Revenue Codes: 0129,1002 Inclusive of all services	• Adults	• Commercial	$375 per diem

Medicaid: All covered Medicaid claims shall be reimburse at the prevailing allowable Medicaid rate listed in Appendix *A of the* Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook, Mental Health Targeted Case Management Services Coverage and Limitations Handbook, Behavioral Health Overlay Services Coverage and Limitations Handbook, and Specialized Therapeutic Services Coverage and Limitations Handbook.

CMS has contracted with MED3000, a division of McKesson, to serve as the Third Party Administrator to facilitate provider information, client information, service authorizations and claims payment. For CMS Title IXX and CMS Title XXI, please send your original HCFA 1500 and UB-04 claims forms to one of the below corresponding addresses:

CMSN MMA Specialty Plan Title XIX
P.O. Box 981648 El Paso, TX 79998-1648

For electronic claims submissions:
Availity Payor ID #M3FL0012 Emdeon
Payor ID #EM843

Med3000 CMS Title XXI
P.O. Box 981733 El Paso, TX 79998-1733

For electronic claims submissions:
Availity Payor ID #M3FL0014 Emdeon
Payor ID #EM2015

For all CMS lines of business, claims must be mailed or electronically submitted to Med3000 within 365 days (1 year) after the discharge for inpatient services or the date of service for outpatient services. If a claim is not made within the time frame specified above, the claim will be deemed automatically denied. Corrected claims must also abide by the same rule. Please refer to the Community Behavioral Health Services Coverage and Limitations Handbook for additional information - March 2014 edition.

Ped-I-Care and South Florida Community Care Network (SFCCN) providers must accept the payment made by MED3000 as payment in full and may not request payment or balance bill the CMSN Plan members or family members. Providers must not charge members co-payments for covered services. If your claim cannot be paid as submitted, MED3000 will give the reason for the denial on the Explanation of Benefits (EOB) that will accompany every payment to your office. Claims payments will be made in accordance with state and regulatory guidelines.

Electronically Submitted Claims

For all electronically submitted claims, the Managed Behavioral Health Organization (MBHO) Network shall (i) within twenty-four (24) hours after the beginning of the next business day after receipt of a claim, provide electronic acknowledgment of the receipt of the claim to MHSA Provider; and (ii) within twenty (20) days after receipt of the claim, pay the claim (if the claim received is a Clean Claim and is required to be approved for payment) or notify MHSA Provider if the claim is denied or contested. Notice of MBHO Network's action on the claim and payment of the claim will be considered to be made on the date the notice or payment was mailed or electronically transferred.

Notification of MBHO Network's determination of a contested claim shall be accompanied by an itemized list of additional information or documents necessary to process the claim. MHSA Provider must submit the additional information or documentation, as specified on the itemized list, within thirty-five (35) days after receipt of the notification. Additional information is considered submitted on the date it is electronically transferred or mailed.

MBHO Network shall pay or deny each claim within ninety (90) days after receipt of the Clean Claim. Failure on the part of MBHO Network to pay or deny a Clean Claim within one hundred twenty (120) days after receipt of the claim creates an uncontestable obligation on the part of MBHO Network to pay the claim.

Non-electronically Submitted Claims

For all non-electronically submitted claims, MBHO Network shall (i) within fifteen (15) days after receipt of the claim, provide MHSA Provider with an acknowledgment of receipt of the claim or electronic access to the status of the claim; and (ii) within forty (40) days after receipt of the claim, pay the claim (if the claim received is a Clean Claim and is required to be approved for payment) or notify MHSA Provider that the claim is denied or contested. Notice of MBHO Network's action on the claim and payment of the claim will be considered to be made on the date the notice or payment was mailed or electronically transferred.

Notification of MBHO Network's determination of a contested non-electronic claim shall be accompanied by an itemized list of additional information or documents necessary to process the claim. MHSA Provider must submit the additional information or documentation, as specified on the itemized list, within thirty-five (35) days after receipt of the notification. Additional information is considered submitted on the date it is electronically transferred or mailed.

MBHO Network shall pay or deny each non-electronic claim within one hundred twenty (120) days after receipt of the claim. Failure to pay or deny a claim within 140 days after receipt of claim creates an uncontestable obligation on the part of MBHO Network to pay the claim.

The parties consent to the terms of this Attachment B as described above.

Concordia Care, Inc. d/b/a Concordia Behavioral Health

By:_____

_____

Print Name and Title

Broward County, a political subdivision of the State of Florida

By:_____

_____

Print Name and Title

Reviewed and approved as to form:
Andrew J. Meyers, County Attorney

By 12/5/17
Karen S. Gordon, Assistant County Attorney

By 12/6/17
Sharon V. Thorsen, Senior Assistant County Attorney