beacon
health options

PARTICIPATING FACILITY AGREEMENT

This **Participating Facility Agreement** ("Agreement") is made and entered as of this **First Day of May 2018** ("the Effective Date"), by and between **Beacon Health Strategies, LLC** ("Beacon Health Strategies") and **Broward County, a political subdivision of the State of Florida** ("Facility"). Facility shall comply with all of the terms and conditions of this Agreement and all subsequent CMS or AHCA-mandated addendums, and will be a participating facility in Beacon Health Strategies' network throughout the Term of this Agreement.

WHEREAS, Beacon Health Strategies has entered into, and may consider entering into, written agreements with Payors which obligate Beacon Health Strategies to arrange for the provision of specified Covered Services to Members enrolled through health plans, whose Behavioral Health Services are managed by Beacon Health Strategies; and

WHEREAS, the arrangements between such Payors and Beacon Health Strategies require the participation of certain health care facilities, Beacon Health Strategies desires to enter into this Agreement with Facility, in order to engage Facility to provide Behavioral Health Services to Members, and Facility desires to enter into this Agreement to provide such services, according to the provisions set forth in this Agreement.

NOW, THEREFORE, in consideration of the promises, the mutual covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, Beacon Health Strategies and Facility agree as follows:

Non-Medicare Facility Disclosure

Medicare language in this agreement is not applicable. Parties understand that Facility is not a Medicare Facility and will not perform Medicare services. In the event that Facility should become Medicare certified, both parties shall negotiate an amendment.

Definitions

For purposes of this Agreement, **Exhibits A-1, Definitions and A-2, Florida Medicaid Core Contract Definitions** list and define terms which, if listed, are capitalized but not defined in this Agreement, and the meanings ascribed to such terms shall be incorporated herein.

I. FACILITY OBLIGATIONS

1.1 Facility Services. Facility shall provide and monitor Behavioral Health Services to Members in accordance with this Agreement, with **Schedule 1.1**, and in accordance with all applicable local, state and federal legal requirements, including CMS and AHCA, as well as all applicable standards of professional ethics and practice. In the event of any conflict between the provisions of this Agreement and any provisions otherwise set by CMS or AHCA, the provisions of CMS or AHCA shall govern and control.

1.2 Licensing, Medicare Certification, as applicable, and Accreditation. Facility shall be duly-licensed in accordance with its State requirements and shall maintain and remain currently certified under Title XVIII (Medicare as applicable) of the Social Security Act of 1965. Facility's services in **Schedule 1.1** provided to Members and locations in **Exhibit B** where services are rendered under the terms of this Agreement shall be included in the Facility's accreditation status achieved through The Joint Commission, CARF, or COA. Further, Facility understands that Practitioner(s) providing services via this Agreement are not now, nor have they ever been excluded from Medicare, Medicaid, or any federal health program.

1.3 Staffing. Facility shall meet all state and federal regulatory requirements for staffing, relative to the delivery of Behavioral Health Services provided under this Agreement.

1.4 Access to Care. Facility shall abide by all access to care standards as required by applicable laws and guidelines, including but not limited to standards established by CMS, AHCA, NCQA, and The Joint Commission, CARF, or COA.

1.5 Non-Discrimination. Facility agrees to provide all Behavioral Health Services to Beacon Health Strategies Members in the same manner as such services are provided to Facility's other patients. Nothing in this Agreement restricts Facility from providing information to a Member regarding such Member's medical care or treatment options when Facility deems the Member's knowledge of such information to be in the best interest of Member, regardless of benefit coverage limitations. Facility shall also comply, to the extent applicable, with requirements of Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 C.F.R., Part 84; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975, as implemented by regulations at 45 C.F.R., Part 91, and with the Americans with Disabilities Act.

1.6 Facility's Compliance with Rules and Regulations. Facility shall cooperate with Beacon Health Strategies, Payor, NCQA, state, and The Joint Commission's credentialing processes, risk management processes, quality improvement program and activities and utilization management processes. As per Beacon Health Strategies' Member complaint and quality review processes, any and all requests for written responses regarding either Member complaints and/or potential quality of care issues, must be received by Beacon Health Strategies' Quality Management Department within five (5) business days of Facility's receipt of the Member complaint or quality review notification. Facility shall comply with any and all applicable AHCA and CMS laws and regulations, as well as applicable state laws, rules and regulations including, without limitation, the requirements set forth in Chapter 641.17-641.3923, F.S., Health Maintenance Organizations. Facility shall supply Beacon Health Strategies with applicable National Provider Identifier (NPI) numbers prior to execution of the contract. Should NPI numbers be added, modified or deleted to the Facility, Facility will notify Beacon Health Strategies within fifteen (15) days of the addition, modification or deletion. Facility will comply with Beacon Health Strategies' cultural competency plans.

II. Beacon Health Strategies OBLIGATIONS

2.1 Non-Intervention. Beacon Health Strategies will not intervene in any way or manner with the provision of services by Facility, it being understood and agreed that the traditional relationship between Facility and Member, as well as physician and Member, and physician and Facility, will be maintained. Nothing contained within this **Section II.2.1** shall be construed to limit Facility's compliance with rules and regulations, as noted in **Section I.1.6.**

2.2 Beacon Health Strategies' Compliance with Rules and Regulations. Beacon Health Strategies shall comply with any and all applicable AHCA and CMS laws and regulations, as well as applicable state laws, rules and regulations including, without limitation, the requirements set forth in Chapter 641.17-641.3923, F.S., Health Maintenance Organizations and by Section 6032 of the federal Deficit Reduction Act of 2005, and, as applicable to maintain compliance with health plan delegation agreements, the requirements set forth in 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106.

III. UTILIZATION MANAGEMENT

3.1 Facility's Authorization Procedure and Verification of Coverage and Eligibility. Except for Emergency Services, Facility shall only provide Behavioral Health Services to a Member upon receipt of a prior authorization from Beacon Health Strategies to provide such services. The ability for Facility to obtain an

authorization from Beacon Health Strategies shall be made available by Beacon Health Strategies twenty-four (24) hours per day, seven (7) days per week, each day of the calendar year. Except in the case of Emergency Services, Beacon Health Strategies shall have no liability whatsoever for the payment of services which were not pre-authorized in accordance with Beacon Health Strategies' treatment authorization procedures. Facility shall be solely liable for bearing the cost of such unauthorized treatment rendered by Facility, whether inpatient or outpatient Behavioral Health Services, and shall not require Member or Payor to pay any such costs. In the case of Emergency Services, Facility shall notify Beacon Health Strategies of the necessity for Emergency Behavioral Health Services or Emergency Services for Medicare or Commercial Members, as soon as possible, but no later than twenty-four (24) hours after providing Behavioral Health Services to such Member.

3.2 Inpatient Pre-Service and Concurrent Reviews. Beacon Health Strategies processes all inpatient pre-service and concurrent reviews as Urgent Care Reviews due to the acute level of care. Beacon Health Strategies adheres to pre- service and concurrent inpatient urgent care review processes in accordance with the Department of Labor (DoL) Claims Regulations, 29 C.F.R, Part 2560.503-1; Appeals and Grievance Procedures, 42 C.F.R., Parts 422 and 489; and national accrediting bodies' standards. As per Appeals and Grievance Procedures, 42 C.F.R., Parts 422 and 489, if applicable, the Facility is responsible for issuing an "Important Message from Medicare" notice to all Medicare Members according to the terms and timeframes as stated in the regulations.

3.3 Post-Service Reviews. Beacon Health Strategies adheres to post-service review processes in accordance with the Department of Labor (DoL) Claims Regulations, 29 C.F.R., Part 2560.503-1; Title 42, C.F.R. 422, Section 424.44; the Florida State Medicaid Contract, and national accrediting bodies' standards. A Participating Provider may submit a written request and the clinical information necessary to determine Medical Necessity for a post- service review within one hundred and eighty (180) calendar days from the completion of treatment that Beacon Health Strategies neither authorized nor denied. The Member is not held financially liable for the services provided.

3.4 Medicaid Members Only – Request for Payment for Behavioral Health Emergency Services. In the event Beacon Health Strategies' Claims Department receives a claim from a network and/or out-of-network practitioner/ provider requesting payment for Behavioral Health Emergency Services previously rendered, the treatment record documentation justifying the behavioral health emergency must accompany the claim to determine the Medical Necessity of the services as per the Florida Medicaid Contract's definition of Emergency Behavioral Health Services. If there is insufficient information to make a post-service medical necessity determination for payment of the claim, the claim is initially denied and the practitioner/provider is sent a letter by the Claims Department, which specifies the request for the clinical documentation, in order to proceed with the post-service review request to determine the medical necessity of the services rendered.

IV. REIMBURSEMENT

4.1 Prompt Payment of Claims. For all Behavioral Health Services for Covered Services provided by Facility under this Agreement, all factors related to electronic or hard copy claims, including the timeliness of claim submission, the establishment of the date a claim is considered received, the data required on a UB-04 or CMS-1500 form, the timeliness of payment of claims, the procedures and timeframes for notification of denial of claims, the procedures and timeframes for contesting claims, the procedures and timeframes for overpayment of claims, and the permissible error ratios for violation of terms related to payment of claims, shall be in accordance with Chapter 641.3155, F.S., Prompt Payment of Claims, as well as Chapter 627.6131, F.S., Payment of Claims. Facility shall not balance-bill Members. Facility agrees to submit timely, complete and accurate encounter data if requested by Payor in accordance with state and federal laws and regulations.

4.2 Non-Covered Services. For non-Covered Services provided to any Members, Facility may bill such Member directly for such non-Covered Services, provided that prior to providing such non-Covered Services, Facility advised such Member: (i) that the services being provided by Facility are non-Covered Services; (ii) the applicable fees associated with any such service, and (iii) that the Member is financially responsible to pay for such services.

4.3 Provider Service Networks. Beacon Health Strategies, has entered into Aagreements with Payors that are classified by ~~the State of Florida, Agency for Health Care Administration, (~~AHCA~~)~~, as "Provider Service Networks," or "PSN's." These PSN's have contracts with the State of Florida to provide services to Medicaid Members on a fee-for-service basis. As such, Facility will receive authorization from Beacon Health Strategies to provide behavioral health services to PSN members. Facility billing for PSN members will be sent through Beacon Health Strategies. Beacon Health Strategies, will forward Facility's claims for payment to AHCA. Facility will be paid directly by AHCA.

4.4 Actions to Collect Amounts Owed if applicable. Facility agrees that in the event of the following, including (i) breach of this Agreement, (ii) non-payment by Beacon Health Strategies or Payor, or (iii) of Payor or Beacon Health Strategies' insolvency, Facility shall not bill, charge, or attempt to collect from, seek compensation, remuneration or reimbursement for Behavioral Health Services, or have any legal recourse against AHCA, or CMS, or a Member enrolled under an HMO health plan. Facility shall not maintain any action at law or equity against any Member enrolled under an HMO health plan to collect any sum owed to Facility by Beacon Health Strategies or by the Payor for Covered Services rendered, pursuant to this Agreement. The foregoing shall not in any way affect Facility's rights to collect directly from a Member any copayments, deductibles or fees for non-Covered Services owed by a Member to Facility. The terms of this Section shall survive the termination of this Agreement for any reason.

4.5 Financial Audits and Offsets. Nothing contained in this Agreement shall in any way be construed to provide Beacon Health Strategies, Payor or Facility the right to offset any amount believed to be due from the other party against other outstanding accounts or claims. Further, it is agreed that in the event one party selects to seek recovery of any over- or under-payment associated with Covered Services for eligible, covered Members rendered to any specific Bbeneficiary, then the other party shall have the right to seek recovery of an over- or under-payment associated with Covered Services rendered to that same Beneficiary or any other Beneficiary(s). In all circumstances relating to such recovery proceedings, the party seeking the adjustment shall provide justification for the recovery to the reasonable satisfaction of the other party.

V. MEDICAL RECORDS

5.1 Medical Record Maintenance. Facility shall establish and maintain an accurate medical record for all Members in accordance with all applicable federal, state, and regulatory agency requirements, as well as Beacon Health Strategies requirements.

5.2 Medical Record Release of Information. In accordance with applicable laws and regulations, including but not limited to 42 C.F.R., Chapter 1, Subchapter A, Part 2, and Chapter 394.4615 F.S., Clinical Records; Confidentiality, the Florida Mental Health Act, Facility shall obtain from each Member that Facility provides Behavioral Health Services to, specific written authorization from that Member to release specified information contained within the medical record to Beacon Health Strategies or Payor for Behavioral Health Services managed by Beacon Health Strategies.

5.3 **Medical Record Access.** Facility shall ensure that a Member has timely access to Member's medical records, in accordance with state and federal laws, including but not limited to parameters stated in Chapter 394.4615 F.S., Clinical Records; Confidentiality, the Florida Mental Health Act. Upon forty- eight hours (48-hours) prior notice and during customary business hours, Beacon Health Strategies and any duly-designated third party, including but not limited to the Department of Health and Human Services (HHS) Master Participation Index (MPI) and Medicaid Fraud Control Units (MFCU), shall be provided access to Member medical records, including data related to claims and payments that are maintained by Facility during the term of this Agreement, thereafter for a period in conformance with state and federal law, and at any time thereafter that such access is required in connection with a Member's medical care, and as related to utilization management, quality improvement, or claims.

5.4 **Medical Record – Requests for Copies.** Members' physical medical records shall remain the property of Facility. Information contained within the medical records belongs to the Member, within the confines of state and federal laws. Copies of specified information contained within a Member's medical record will be furnished to Beacon Health Strategies within five (5) calendar days of a request by Beacon Health Strategies or Payor, based on the signed release of information obtained by Facility, as stated in **Section V.5.2**, and as related to services provided by Facility to Member. Copies will also be furnished, when necessary, based on 42 C.F.R., Chapter 1, Subchapter A, Part 2, and Chapter 394.4615 F.S., Clinical Records; Confidentiality, the Florida Mental Health Act.

5.5 **Medical Record Retention Policy.** Facility shall maintain all medical records for the longer of: (i) the maximum applicable statute of limitations period; (ii) the period of time as is otherwise required by state or federal law with respect to the retention of medical records. This obligation of Facility is not terminated upon termination of this Agreement.

VI.CONFIDENTIALITY

6.1 **Confidentiality.** Facility agrees to maintain in strict confidence Member information, including, without limitation, the information contained in 42 C.F.R., Chapter 1, Subchapter A, Part 2, as well as in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191. Facility also agrees to abide by The Department of Health and Human Services (HHS) rules, known as the HIPAA Administrative Simplification Rules, located at 45 C.F.R. Parts 160, 162, and 164, and which include both (1) the HIPAA Privacy Rule, created to set national standards for the protection of individually identifiable health information (PHI) [See Section 6.2] by three types of covered entities: health plans, health care clearinghouses, and health care providers who conduct health care transactions electronically and (2) the HIPAA Security Rule, which sets national standards for the security of electronic protected health information. Both rules are administered and enforced by the Office of the Civil Rights (OCR). Facility's compliance is also required in additional HIPAA Administrative Simplification Rules, known as (1) the Transactions and Code Sets Standards, (2) the Employer Identification Standards, and (3) the National Provider Identifier Standards, which are administered and enforced by the Centers for Medicare & Medicaid Services (CMS). In 45 C.F.R. Part 160, the Enforcement Rule provides standards for the enforcement of the HIPAA Administrative Simplification Rules. The Facility also agrees to comply with the American Recovery and Reinvestment Act of 2009 (ARRA), as well as Title XIII of ARRA, known as the Health Information Technology for Economic and Clinical Health Act (HITECH Act), including, but not limited to the Breach Notification Rule, which requires notification following a breach of unsecured protected health information. Facility will maintain confidentiality on all financial information, statistical data, reports, standards, and membership listings, and agrees not to disclose any information contained within this Agreement to any third party, except as may be required by law or pursuant to a written consent executed by Beacon Health Strategies. Facility understands and agrees with Beacon Health Strategies' policy not to disclose rates of reimbursement to any third party who submits a request for same, unless as required by law. When a third-party request for the disclosure of rates is submitted in writing or

is requested verbally, Beacon Health Strategies shall contact and advise the requestor of Beacon Health Strategies' non-disclosure policy. Unless as required by law, at no time should any information be disclosed to a third party regarding the rate of reimbursement to be paid to any provider or practitioner in Beacon Health Strategies' network. The terms of this section shall survive the termination of this Agreement for any reason.

6.2 Protected Health Information and Mutual Compliance with Adherence. Protected health information, as defined in 45 C.F.R., Subtitle A, Subchapter C, Part 160, Subpart A, Section 160.103, shall be used solely to perform the contractual obligations between the Facility and Beacon Health Strategies. Facility and Beacon Health Strategies will not use or further disclose any protected health information, except as specifically authorized in the terms of this Agreement, including without limitation, any use or disclosure which would violate the provisions of the protected health information.

VII. INSURANCE, MUTUAL INDEMNIFICATION, and MUTUAL MANDATORY NOTIFICATION

7.1 Governmental Immunity/Insurance. Facility is a self-insured governmental entity subject to the limitations set forth in Section 768.28, F.S., as may be amended from time to time. FACILITY has instituted and shall maintain a fiscally sound and prudent risk management program with regard to its obligations under this Agreement in accordance with the provisions of Section 768.28 F.S. as amended. Nothing herein is intended to serve as a waiver of Facility's sovereign immunity. Facility~~FACILITY~~ shall provide BEACON HEALTH STRATEGIES with written verification of liability protection upon request.

7.2 Mutual Indemnification. To the extent permitted by Florida law,~~;~~ ~~Each~~ each party shall be liable for the negligent acts or omissions of its own employees or agents which result in, or are attributable to, any claims, damages, causes of action, costs and expenses, including~~,~~ court costs and reasonable attorneys' fees.~~"~~

7.3 Mutual Mandatory Notification. Facility shall notify Beacon Health Strategies in writing, within one (1) business day, of any of the following: (i) Facility's license(s), Medicare certification, or The Joint Commission, CARF, or COA accreditation is under investigation, disciplined, reduced, suspended, surrendered, revoked, terminated or subject to terms of probation or other restrictions; (ii) Facility's exclusion from participation under the Medicare or Medicaid program or any other governmental program for any reason; (iii) Facility's professional liability/malpractice coverage no longer meets the requirements as required in Section VII.7.1; or (iv) notification to Facility regarding a determination of any malpractice case(s) previously pending against Facility; (v) any material change in the nature or extent of services rendered by Facility; and/or (vi) any other act, event, occurrence or the like which materially affects Facility's ability to carry out Facility's duties and obligations under this Agreement. To the extent permitted by State law, Facility shall indemnify Beacon Health Strategies from and against any loss or damage incurred as a result of Facility's failure to notify Beacon Health Strategies of any of the above events. Facility consents to Beacon Health Strategies disclosing any of the events described above to the affected Payors. Beacon Health Strategies shall notify Facility in writing, within one (1) business day, of any of the following: (i) any material change in the nature or extent of services rendered by Beacon Health Strategies; (ii) any other act, event, occurrence or the like which materially affects Beacon Health Strategies' ability to carry out Beacon Health Strategies' duties and obligations under this Agreement. Beacon Health Strategies shall indemnify Facility from and against any loss or damage incurred as a result of Beacon Health Strategies' failure to notify Facility of any of the above events. Beacon Health Strategies consents to Facility disclosing any of the events described above to the affected Payors.

VIII. TERM AND TERMINATION

8.1 Term. This Agreement shall commence as of the Effective Date as defined on the first and signature pages of this Agreement and shall continue in full force for an initial term of two (2) years, whereupon

this Agreement shall thereafter automatically renew for additional two (2) year periods, unless earlier terminated according to the provisions of this Agreement.

8.2 Termination – Non-Quality Service or Care. Either party may terminate this Agreement, upon ninety (90) calendar days' notice via certified mail to the other party, for any non-quality service or care reason. Such termination shall be effective as of the first (1st) day of the month following the ninetyieth (90th) calendar day fromafter receipt of the notice.

8.3 Termination With Cause. Either party may terminate this Agreement, with cause, upon fifteen (15) calendar days' prior written notice, via certified mail, if the other party breaches any material provision of this Agreement, and such breach is not cured to the satisfaction of the non-breaching party within such fifteen (15) day period. Such termination shall be effective as of midnight beginning the sixteenth (16th) day following the receipt of the letter advising of the termination.

8.4 Termination by Payor. Facility agrees that subject to 42 C.F.R. §422.204, if applicable, a Payor may, with cause or for any non-quality service or care reason, terminate or obligate Beacon Health Strategies to terminate Facility's participation with Payor notwithstanding the continuation of this Agreement.

8.5 Automatic Termination. Beacon Health Strategies may terminate this Agreement immediately upon notice to Facility if (i) Facility becomes insolvent, files a petition for protection from its creditors, enters into any general arrangement or assignment for the benefit of its creditors, or suffers or consents to the appointment of a trustee or a receiver to take possession of substantially all of Facility's assets, or in the event of the attachment, execution or other judicial seizure of substantially all of Facility's assets; or (ii) Beacon Health Strategies determines, in good faith, that: (a) the actions or inactions of Facility are causing or will cause imminent danger to the health, safety or welfare of any Member; (b) Facility fails to maintain any license(s) or bond(s) required by state or federal law, or Facility becomes uninsured for professional liability/malpractice or general liability insurance, or Facility becomes uninsured for error and omissions liability, or Facility otherwise no longer meets the requirements set forth in **Section 1.2** or **Section 7.1** of this Agreement.

8.6 Notification of Members and Payors. Facility understands that Beacon Health Strategies will notify Members and Payors of the termination of this Agreement prior to effective date of termination.

8.7 Continuity and Coordination of Care Upon Termination or Transition. Upon termination of this Agreement, the rights of each party hereunder shall terminate, except as otherwise provided herein, and as mandated by CMS or AHCA. Facility shall continue to provide Behavioral Health Services to Members who were receiving inpatient Behavioral Health Services from Facility prior to such termination, in accordance with the terms and conditions of this Agreement, until the Member's discharge from Facility or transfer to another facility. Commercial and Medicare Members who were receiving outpatient services prior to termination, will have access to their discontinued provider for ninety (90) days, or until the completion of treatment, whichever comes first, and Medicaid Members will have access to their discontinued provider for six (6) months, or until the completion of treatment, whichever comes first. Facility shall cooperate with Beacon Health Strategies in the coordination and continuity of care for Members affected by such termination. Notwithstanding anything herein to the contrary, if Beacon Health Strategies or Payor becomes insolvent, (i) Facility shall continue to provide Behavioral Health Services to Members as mandated by CMS or AHCA. In the event, Member's benefits are transitioned to another Payor, Behavioral Health Services will be provided by facilities of that Payor, and Facility agrees to cooperate with said facility and the transition process to assure maximum health outcomes for enrollees. The terms of this section shall survive termination of this Agreement for any reason.

8.8 Appeal. If Facility's participation is terminated pursuant to this Agreement, for any reason, Facility

shall contact Beacon Health Strategies, under the terms of Section 9.1 Notice, of this Agreement, within five (5) business days of the date of the confirmed receipt of the notice of termination to request an appeal. No additional or separate right of appeal to AHCA or the health plan is created as a result of Payor or Beacon Health Strategies' act of terminating, or decision to terminate Facility under this Agreement.

IX. GENERAL PROVISIONS

9.1 Notice. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be sent by certified mail, return receipt requested, to the address listed below, or such other address as may be later designated by either party hereto.

Facility:
Broward Addiction Recovery Division (BARC)
900 NW 31st Ave, Suite 2000
Fort Lauderdale, FL 33311
Attention: William Card, Acting Director

and

Elderly and Veteran's Services Division
2995 North Dixie Highway
Oakland Park, FL 33334
Attention: Andrea Busada, Director

Beacon Health Strategies, LLC
10200 Sunset Drive
Miami, FL 33173
Attention: Ray Coleman, Assistant Vice President, Provider Relations & Network Development
Fax: 800-370-1116

9.2 Non-Exclusivity Provisions. Facility shall not enter into an agreement, directly or indirectly, to provide services to Members of a Payor with which Beacon Health Strategies has entered into a Payor ~~Agreement~~ agreement and which is included as a health plan for the product lines managed by Beacon Health Strategies to which Facility is providing services during the Term of this Agreement. Notwithstanding anything herein to the contrary, nothing shall prohibit Facility from negotiating or contracting with any other Payor, before, during, or subsequent to this Agreement.

9.3 Disputes. The parties agree to meet at a mutually-agreed upon location and confer in good faith to resolve any problems or disputes that may arise under this Agreement.

9.4 Unforeseeable Events. In the event that operations of either party are substantially interrupted by an act of war, fire, insurrection, strike, riots, hurricanes, earthquakes or other acts of nature of any cause that is not the fault of either party or is beyond the reasonable control of either party, that party shall be relieved of its obligations, only as to those affected organizations and only as to those affected portions of this Agreement for the duration of such interruption.

9.5 Independent Contractors. The parties hereto are independent contractors and are not in joint

ventures with or employees of each other.

9.6 No Third-Party Beneficiaries. Neither Members nor any other third parties are intended by the parties to this Agreement to be third-party beneficiaries under this Agreement, and no action may be brought to enforce the terms of this Agreement against either party of this Agreement by any person who is not a party to this Agreement.

9.7 Assignment. Neither party to this Agreement may assign its rights or obligations under this Agreement without the prior consent of the other party. Any attempted assignment by one party which is not approved by the other party shall result in the immediate termination of this Agreement.

9.8 Governing Law. This Agreement shall be governed in all respects by the State of Florida and federal laws. Any provision requiring inclusion in this Agreement by said regulations shall bind Facility and Beacon Health Strategies, whether or not expressly provided in this Agreement.

9.9 Severability. If any part of any provision of this Agreement shall be invalid or unenforceable under present or future applicable laws during the term of this Agreement, said part shall be ineffective to the extent of such invalidity or unenforceability only and without affecting, in any way, the remaining parts of said provision or the remaining provisions of this Agreement. If any provision or part of any provision conflicts with Medicaid, Medicare or any other governmental program's laws and regulations, then such provision or part of such provision shall be void, and the parties will use their best efforts to renegotiate the applicable provision so as to equal the original intent of such provision as closely as possible without being in conflict with such laws and regulations.

9.10 Waiver. The waiver by either party to this Agreement of any one (1) or more breaches or defaults, if any, on the part of the other, shall not be construed to operate as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder shall not operate as a waiver of such right. All rights and remedies provided herein are cumulative.

9.11 Amendment. This Agreement, or any part of the Agreement, may be amended at any time during the term of the Agreement, only by mutual written consent of duly-authorized representatives of both parties to this Agreement; provided, however, that any modification, including additions or deletions, to any provision or provisions of this Agreement required by duly-enacted state or federal legislation, or by regulation or rule finally issued by a regulatory agency pursuant to such legislation, rule or regulation, will be deemed part of this Agreement, without further action required to be taken by either party to amend this Agreement to effect such change or changes, for as long as such legislation or regulation or rule is in effect.

9.12 Mutual Consent to Use of Either Party's Name and Demographic Information. During the term of this Agreement, Facility consents to the use of Facility's name, address and telephone number in any provider listing generated by Beacon Health Strategies. Further, upon consent by Facility, Beacon Health Strategies may use the Facility's name, address and telephone number for marketing or advertising or other specified purpose. During the term of this Agreement, Beacon Health Strategies consents to the use of Beacon Health Strategies' name, address and telephone number to publish Facility as being a facility in Beacon Health Strategies' network. Further, upon consent by Beacon Health Strategies, Facility may use Beacon Health Strategies' name, address and telephone number for marketing or advertising or other specified purpose.

9.13 Incorporation of Attachments. All schedules and exhibits to this Agreement are considered part of this Agreement and are fully incorporated in this Agreement with the same effect as if such schedules and exhibits were restated in their entirety in the body of this Agreement.

9.14 **Cooperation with Federal and State Agencies.** Facility shall comply fully with any federal or state agency investigation including but not limited to CMS, AHCA, MPI and MFCU and in any subsequent legal action that may result from such an investigation involving this Agreement.

9.15 **Financial Incentives.** The parties hereto agree that none of the compensation terms provided in this Agreement: (i) provide any incentives, monetary or otherwise, for withholding any Medically Necessary Services; nor (ii) violate any provision of applicable federal and state laws or regulations, including without limitation, any provisions of 42 USCA 1395 (1997), 42 C.F.R. 417 *et seq.*, 42 C.F.R. § 422.208, or any of the other laws or regulations relevant to physician incentive plans.

9.16. **Federal and State Law Regulations.** This Agreement and/or the Florida Medicaid Addendum, and the performance thereof, is subject to the requirements and regulations promulgated by the Florida Office of Insurance Regulation ("OIR"), AHCA, CMS, Occupational Safety and Health Administration ("OSHA") and HHS, and all provisions required thereby to be in this Agreement shall be incorporated by this reference and shall bind the parties to this Agreement whether or not specifically provided herein. This Agreement may be amended by Beacon Health Strategies in order to comply with federal and state requirements by giving written notice to Facility of such amendment and its effective date. Such amendment shall not require the signature of Facility unless specifically required by federal or state authorities.

9.17 **Entire Agreement.** This Agreement, in its entirety, including any schedules and exhibits between the parties, supersedes all prior written or verbal Agreements or negotiations between the parties relating to the subject matter herein.

9.18 **Acknowledgment.** By signing this Agreement, Facility represents that Facility has read and agreed to this Agreement and the terms contained therein, as well as applicable behavioral health service provisions of CMS and AHCA.

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PARTICIPATING FACILITY AGREEMENT

SIGNATURE PAGE
FOR COMPLETION BY BOTH PARTIES TO THIS AGREEMENT

IN WITNESS WHEREOF, the parties have duly executed this Agreement with the **Effective Date** noted on **Page 1** of this Agreement and below:

Beacon Health Strategies, LLC

By: _____

Print Name: Ray Coleman

Title: Assistant Vice President, Provider Relations & Network Development

Date: _____

Broward County

By: _____

Print Name: _____

Title: _____

Date: _____

Tax ID: _____

Effective Date: 05/01/2018

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

By _____
Jeffrey S. Siniawsky
Assistant County Attorney

Insurance requirements approved by
Broward County Risk Management Division

By _____ 05/21/18
Signature (Date)

Colleen Pannell Risk Analyst
Print Name and Title above

Schedule 1.1 REIMBURSEMENT SCHEDULE

Facility agrees to submit claims and accept as payment in full, except for applicable copayments and deductibles, from Beacon Health Strategies, the reimbursement rates as set forth below for Behavioral Health Services provided by Facility to a Member, in accordance with the terms of this Agreement.

The inclusion of Behavioral Health Services in the Reimbursement Schedule indicates the full spectrum of services the Facility is eligible to contractually receive an authorization to perform; however, inclusion of services in the Reimbursement Schedule does not ensure that said services will be authorized. Authorizations are based on Member eligibility, clinical necessity, and utilization management processes.

Any and all claims submitted per this Agreement will be paid solely to the Facility named on **Page 1** and on the **Signature Page**, with claims paid to the **Tax ID#** noted on the **Signature Page**.

REIMBURSEMENT SCHEDULE: MEDICAID AND COMMERCIAL (if applicable)

Revenue Code	Service Description	Reimbursement Rate
116, 126, 136, 146, 156	Inpatient Detoxification, all-inclusive including physician fees	$650.00 Per Diem

REIMBURSEMENT SCHEDULE: MEDICAID AND COMMERCIAL (if applicable)

Revenue Code	Service Description	Reimbursement Rate
1002, 1001	Residential Treatment Substance Abuse, all inclusive, including physician fees	$450.00 Per Diem

REIMBURSEMENT SCHEDULE: MEDICAID

One hundred percent (100%) of the Medicaid fee schedule for covered Medicaid services as delineated in the applicable Agency for Health Care Administration's Medicaid Handbook.

REIMBURSEMENT SCHEDULE: COMMERCIAL

CPT Code by Discipline	Service Health Service(s)	Licensure Level (See Exhibit C)	Reimbursement Rate
Psychiatrist		**Psychiatrist**	
90792	Psychiatric Diagnostic Interview (w/Med. Servs.)	Psychiatrist (MD, DO)	$110.00
90785	Complex inter(90785) Mh Md	Psychiatrist (MD, DO)	$5.00
90833	Eval. Mgmt. and Psychotherapy–30 Min Add On	Psychiatrist (MD, DO)	$20.00
90836	Eval. Mgmt. and Psychotherapy–45 Min Add On	Psychiatrist (MD, DO)	$40.00
90870	Electroconvulsive Therapy (ECT), Single Seizure	Psychiatrist (MD, DO)	$100.00
99201	E&M - new patient - straightforward; 10 min.	Psychiatrist (MD, DO)	$48.80
99202	E&M - new patient - straightforward; 20 min.	Psychiatrist (MD, DO)	$74.50
99203	E&M - new patient - low; 30 min.	Psychiatrist (MD, DO)	$110.00
99204	E&M - new patient - Moderate; 45 min.	Psychiatrist (MD, DO)	$155.00

PARTICIPATING FACILITY AGREEMENT

CPT Code by Discipline	Service Health Service(s)	Licensure Level (See Exhibit C)	Reimbursement Rate
99205	E&M - new patient - High; 60 min.	Psychiatrist (MD, DO)	$160.00
99211	E&M - Existing Patient - straightforward; 5 min	Psychiatrist (MD, DO)	$12.15
99212	E&M - Existing Patient - straightforward; 10 min	Psychiatrist (MD, DO)	$27.00
99213	E&M - Existing Patient -low; 15 min	Psychiatrist (MD, DO)	$45.00
99214	E&M - Existing Patient – moderate; 25 min	Psychiatrist (MD, DO)	$66.15
99215	E&M - Existing Patient – high; 40 min	Psychiatrist (MD, DO)	$89.10
Psychologist		Psychologist	
90791	Psychiatric Diagnostic Interview	Doctorate Level	$60.00
90832	Individual Psychotherapy, 30 minutes	Doctorate Level	$45.00
90834	Individual Psychotherapy, 45 minutes	Doctorate Level	$60.00
90837	Individual Psychotherapy, 60 minutes	Doctorate Level	$65.00
90847	Family Therapy, Member Present	Doctorate Level	$60.00
90853	Group Therapy	Doctorate Level	$40.00
90785	Complex inter(90785)	Doctorate Level	$5.00
96101	Psychological testing	Doctorate Level	$65.00
96118	NeuroPsych Testing	Doctorate Level	$65.00
Therapist		Master's Licensed Therapist	
90791	Psychiatric Diagnostic Interview	Licensed Master's Level	$55.00
90832	Individual Psychotherapy, 30 minutes	Licensed Master's Level	$40.00
90834	Individual Psychotherapy, 45 minutes	Licensed Master's Level	$55.00
90837	Individual Psychotherapy, 60 minutes	Licensed Master's Level	$60.00
90847	Family Therapy, Member Present	Licensed Master's Level	$55.00
90853	Group Therapy	Licensed Master's Level	$35.00
90785	Complex inter (90785)	Licensed Master's Level	$5.00
Nurse		ARNP	
90785	Complex inter (90785)	Master's Level (ARNP)	$5.00
90792	Psychiatric Diagnostic Interview	Master's Level (ARNP)	$75.00
99201	E&M - new patient - straightforward; 10 min.	Master's Level (ARNP)	$30.00
99202	E&M - new patient - straightforward; 20 min.	Master's Level (ARNP)	$45.00
99203	E&M - new patient - low; 30 min.	Master's Level (ARNP)	$60.00
99204	E&M - new patient - Moderate; 45 min.	Master's Level (ARNP)	$93.00
99205	E&M - new patient - High; 60 min.	Master's Level (ARNP)	$96.00
99211	E&M - Existing Patient - straightforward; 5 min	Master's Level (ARNP)	$7.50
99212	E&M - Existing Patient - straightforward; 10 min	Master's Level (ARNP)	$16.50
99213	E&M - Existing Patient -low; 15 min	Master's Level (ARNP)	$35.00
99214	E&M - Existing Patient – moderate; 25 min	Master's Level (ARNP)	$40.00
99215	E&M - Existing Patient – high; 40 min	Master's Level (ARNP)	$50.00

Exhibit A-1

DEFINITIONS

AHCA - the Agency for Health Care Administration ("AHCA"), an agency of the State of Florida. An AHCA Agreement is a prepaid Medicaid risk contract between Payor and AHCA under which Payor is reimbursed on a per capita basis for each Medicaid Member enrolled with Payor.

CARF – Commission on Accreditation of Rehabilitation Facilities, an accreditation organization.

Claim – according to Chapter 641.3155, F.S., a claim for an institutional provider means a paper or electronic billing instrument that consists of the UB-92 data set or its successor with entries stated as mandatory by the National Uniform Billing Committee, and a claim for a non-institutional provider means a paper or electronic billing instrument submitted that consists of the HCFA 1500 data set, or its successor.

CMS – the Centers for Medicare & Medicaid Services is a Federal agency within the U.S. Department of Health and Human Services. A CMS Agreement is the Medicare Advantage Health Plan contract between a Payor and CMS, under which a Payor is reimbursed on a per capita basis for each Medicare beneficiary enrolled as a Member with a Payor.

COA – Commission on Accreditation, an accreditation organization.

Commercial Member – an individual or eligible dependent of such individual, who is enrolled in a health plan and who is entitled to receive Behavioral Health Services.

Covered Services - those Medically Necessary Services for which Payor provides, or otherwise arranges for, coverage on behalf of Members.

Emergency Services/Emergency Behavioral Health Services – coverage of Emergency Services to screen and stabilize the Member without prior approval is issued where a prudent layperson, acting reasonably, would have believed that an emergency behavioral health condition existed, or a practitioner or other authorized representative acting through the organization has authorized the provision of Emergency Services. With respect to Medicaid, Emergency Behavioral Health Services are defined as those services that are required to meet the needs of an individual who is experiencing an acute crisis, resulting from mental illness, which is at the level of severity that would meet the requirements for involuntary hospitalization pursuant to Section 394.463, F.S., and who, in the absence of a suitable alternative or psychiatric medication, would require hospitalization.

The Joint Commission - Joint Commission on Accreditation of Healthcare Facilities, an accreditation organization.

Medicaid Member - an individual who is eligible to receive Medicaid benefits and who is enrolled as a Member in a Medicaid health plan sponsored or purchased on behalf of a Member, or otherwise provided to a Member by a Payor, also referred to herein as enrollee.

Medically Necessary Services/Medical Necessity - Beacon Health Strategies' definition of medical necessity is adapted from AHCA. Medically Necessary Services must contain the five (5) following elements: (1) necessary to protect life, and prevent significant illness or significant disability; (2) specific and consistent with symptoms and a Confirmed DSM-V diagnosis, and not in excess of the Member's needs; (3) consistent with the generally accepted community standards as determined by Beacon Health Strategies, and not experimental or investigational; (4)Reflective of the level of service that can be effectively furnished, and for which no equally effective and more

conservative treatment is available, and (5) furnished in a manner not intended for the convenience of the recipient, the recipient's caretaker or the practitioner/provider.

Medicare - Part A, Hospital Insurance Benefits for the Aged and Disabled, Part B, Supplemental Medical Insurance Benefits for the Aged and Disabled, and the Medicare Advantage Health Plan, provided under Title XVII of the Social Security Act, as amended.

Medicare Member – an individual who is identified on CMS records as eligible to receive Medicare benefits and who is enrolled as a Member in a Medicare Advantage Health Plan, sponsored or purchased on behalf of a Member, or otherwise provided to a Member by a Payor.

Member - any individual or eligible dependent of such individual, who is enrolled in a health plan and who is entitled to receive Behavioral Health Services from Participating Provider via Commercial, Medicare, or Medicaid plans.

Behavioral Health Services - the inpatient or outpatient Behavioral Health Services listed in **Schedule 1.1**, attached hereto, that are Medically Necessary Services required to be provided by Participating Providers to Members eligible to receive such services as Covered Services pursuant to the Members' health plan.

NCQA - the National Committee for Quality Assurance, an accreditation organization.

Participating Provider - an entity that is a duly-licensed hospital or behavioral health provider which is accredited by The Joint Commission, CARF, or COA, or an entity who holds an unrestricted license to practice independently within the scope of Beacon Health Strategies' network, to include psychiatrists, licensed psychologists, and LCSWs, LMFTs, and LMHCs; these independently-licensed practitioners have been credentialed by Beacon Health Strategies. Each of the above entities has entered into a written agreement with Beacon Health Strategies to participate in its network by providing for or arranging specified Behavioral Health Services to Members.

Payor - a prepaid health plan, health maintenance organization, insurer or other entity that enters into agreements with members, pursuant to which the health plan's Members receive coverage for health care services, and has entered into a Payor Agreement with Beacon Health Strategies to provide Covered Services to Members.

Payor Agreement - an Agreement entered into between a Beacon Health Strategies and a health plan to provide Covered Services to the health plan's Members.

Practitioner – an individual, who for purposes of this Agreement, refers to persons who are duly-licensed to practice independently with an unrestricted license within the scope of Beacon Health Strategies' provider network and who have applied to join the network for a specified Provider and were subsequently credentialed and approved by Beacon Health Strategies for inclusion in this Agreement.

Term - the duration of time in which this Agreement is in effect, except for specified sections in this Agreement which shall survive termination of this Agreement for any reason.

Urgent Care Review - A pre-service or concurrent urgent care review is conducted when the application of time period for a non-urgent review a) could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or b) in the opinion of a physician with knowledge of the Member's condition would subject the Member to severe pain that cannot be adequately managed without the care or treatment of the services requested.

Exhibit A-2
FLORIDA MEDICAID CORE CONTRACT DEFINITIONS

Advance Directive — A written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.

Baker Act — The Florida Mental Health Act, pursuant to Sections 394.451-394.4789, F.S.

Behavioral Health Care Provider — A licensed or certified behavioral health professional, such as a clinical psychologist under Chapter 490, F.S., clinical social worker, mental health professional under Chapter 491, F.S., or registered nurse qualified due to training or competency in behavioral health care, who is responsible for the provision of behavioral health care to patients, or a physician licensed under Chapters 458 or 459, F.S., who is under contract to provide behavioral health services to enrollees.

Behavioral Health Services — Services listed in the Community Behavioral Health Services Coverage & Limitations Handbook and the Mental Health Targeted Case Management Coverage & Limitations Handbook as specified in Attachment II, Section VI, Behavioral Health Care, Item A., General Provisions.

Care Coordination/Case Management — A process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an enrollee's health needs using communication and all available resources to promote quality cost-effective outcomes. Proper case management occurs across a continuum of care, addressing the ongoing individual needs of an enrollee rather than being restricted to a single practice setting. For purposes of this Agreement, "care coordination" and "case management" are the same.

Centers for Medicare & Medicaid Services (CMS) — The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the State Children's Health Insurance Program under Title XXI of the Social Security Act.

Children/Adolescents — Enrollees under the age of 21. For purposes of the provision of Behavioral Health Services, excluding inpatient psychiatric services, adults are persons age 18 and older, and children/adolescents are persons under age 18, as defined by the Department of Children and Families.

Community Living Support Plan — A written document prepared by a behavioral health resident of an assisted living facility with a limited mental health license and the resident's behavioral health case manager in consultation with the administrator of the facility or the administrator's designee. A copy must be provided to the administrator. The plan must include information about the supports, services, and special needs that enable the resident to live in the assisted living facility and a method by which facility staff can recognize and respond to the signs and symptoms particular to that resident that indicate the need for professional services.

Coverage & Limitations Handbook and/or Provider General Handbook (Handbook) — A Florida Medicaid document that provides information to a Medicaid provider about enrollee eligibility; claims submission and processing; provider participation; covered care, goods and services; limitations; procedure codes and fees; and other matters related to participation in the Medicaid program.

Crisis Support — Services for persons initially perceived to need emergency behavioral health services, but

upon assessment, do not meet the criteria for such emergency care. These are acute care services available twenty-four hours a day, seven days a week (24/7) for intervention. Examples include: mobile crisis, crisis/emergency screening, crisis hot line and emergency walk-in.

Direct Service Behavioral Health Care Provider — An individual qualified by training or experience to provide direct behavioral health services.

Emergency Behavioral Health Services — Those services required to meet the needs of an individual who is experiencing an acute crisis, resulting from a mental illness, which is a level of severity that would meet the requirements for an involuntary examination (See Section 394.463, F.S.), and in the absence of a suitable alternative or psychiatric medication, would require hospitalization.

Emergency Medical Condition — (a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in any of the following: (1) serious jeopardy to the health of a patient, including a pregnant woman or fetus; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part. (b) With respect to a pregnant woman: (1) that there is inadequate time to effect safe transfer to another hospital prior to delivery; (2) that a transfer may pose a threat to the health and safety of the patient or fetus; (3) that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes (see Section 395.002.F.S.).

Florida Mental Health Act — Includes the Baker Act that covers admissions for persons who are considered to have an emergency mental health condition (a threat to themselves or others) as specified in Sections 394.451 through 394.4789, F.S.

Fraud — An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to that person or another person. The term includes any act that constitutes fraud under applicable federal or state law.

Grievance — An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or Health Plan employee or failure to respect the enrollee's rights.

Health Care Professional — A physician or any of the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech- language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), a licensed clinical social worker, registered respiratory therapist and certified respiratory therapy technician.

Licensed Practitioner of the Healing Arts — A psychiatric nurse, registered nurse, advanced registered nurse practitioner, physician assistant, clinical social worker, mental health counselor, marriage and family therapist, or psychologist.

Medically Necessary or Medical Necessity — Services that include medical or allied care, goods or services furnished or ordered to:

1. Meet the following conditions:

a. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
b. Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs;
c. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational;
d. Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
e. Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee's caretaker or the provider.

2. For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate Medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
3. The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

Mental Health Targeted Case Manager — An individual who provides mental health targeted case management services directly to or on behalf of an enrollee on an individual basis in accordance with the Medicaid Mental Health Targeted Case Management Handbook.

Post-Stabilization Care Services — Covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain, improve or resolve the enrollee's condition pursuant to 42 CFR 422.113.

Protected Health Information (PHI) — For purposes of this Attachment, protected health information shall have the same meaning and effect as defined in 45 CFR 160 and 164, limited to the information created, received, maintained or transmitted by the Health Plan from, or on behalf of, the AHCA

Telebehavioral Health — The use of telemedicine to provide behavioral health individual and family therapy.

Telecommunication Equipment — Electronic equipment that includes, at a minimum, audio and video equipment permitting two-way, real time, interactive communication between the enrollee and the provider for the provision of covered services through telemedicine.

Telemedicine — The practice of health care delivery using telecommunication equipment by the treating provider (at the spoke site) for the provision of approved covered services by the consulting provider (at the hub site) for the purpose of evaluation, diagnosis, or treatment.

Telepsychiatry — The use of telemedicine to provide behavioral health medication management.

Urgent Behavioral Health Care — Those situations that require immediate attention and assessment within twenty-three (23) hours even though the enrollee is not in immediate danger to self or others and is able to cooperate in treatment.

Exhibit B
SERVICE LOCATION(S), MAILING AND CLAIMS ADDRESSES

Service Locations
Broward Addiction Recovery Division (BARC):

900 NW 31 Ave, Suite 2000
Fort Lauderdale, FL 33311

1000 SW 2 Street
Fort Lauderdale, FL 33301
New address effective June 1, 2018
325 SW 28 Street
Fort Lauderdale, FL 33315

4733 SW 18 Street
Hollywood, FL 33023

3275 NW 99 Way
Coral Springs, FL 33065

Elderly and Veteran's Services Division (EVSD):
2995 North Dixie Highway
Oakland Park, FL 33334

Mailing Address

Broward Addiction Recovery Division (BARC):
900 NW 31 Ave, Suite 2000
Fort Lauderdale, FL 33311

Elderly and Veteran's Services Division (EVSD):
2995 North Dixie Highway
Oakland Park, FL 33334

Claims Address

Broward Addiction Recovery Division (BARC):
900 NW 31 Ave, Suite 2000
Fort Lauderdale, FL 33311

Elderly and Veteran's Services Division (EVSD):
2995 North Dixie Highway
Oakland Park, FL 33334

MEDICARE ADVANTAGE PROVISIONS ADDENDUM If Applicable

References to "Facility" in this Medicare Advantage Provisions Addendum ("Addendum") are to the provider of health care services contracted with Beacon Health Strategies under a participating facility agreement ("Agreement"). Beacon Health Strategies has entered into an agreement ("Payor Agreement") with one or more health care entities ("Payor") who have an agreement with the Centers for Medicare and Medicaid Services ("CMS") for the provision of medical and related health care services to Medicare Advantage beneficiaries ("Members"). The following provisions relate specifically to services provided by Facility to Payor and its Members. In the event of a conflict between the terms of this Addendum and the Agreement with respect to Medicare Advantage, the terms of this Addendum control.

a) Facility agrees to: (i) abide by all federal and state laws regarding confidentiality, privacy and disclosure of medical records or other health and enrollment information, (ii) ensure that medical information is released only in accordance with applicable state or federal law, or pursuant to court orders or subpoenas, (iii) maintain all Member records and information in an accurate and timely manner, and (iv) allow timely access by Members to the records and information that pertain to them.

b) Facility agrees in the event certain identified activity(ies) have been delegated to Facility under the Agreement, any sub-delegation of the noted activity(ies) by Facility requires the prior written approval of the Payor and Beacon Health Strategies. Facility shall adhere to the reporting responsibilities set forth by Beacon Health Strategies and Payor as required by CMS. Notwithstanding anything to the contrary in the Agreement, Payor and Beacon Health Strategies will monitor Facility's performance of any delegated activity(ies) on an ongoing basis and hereby retains the right to modify, suspend or revoke such delegated activity(ies) in the event Plan, Beacon Health Strategies and/or CMS determines, in their discretion, that Facility is not meeting or has failed to meet its obligations under the Agreement related to such delegated activity(ies). In the event that Plan has delegated all or any part of the claims payment process to Facility under the Agreement, Facility shall comply with all prompt payment requirements to which Plan and Beacon Health Strategies is subject. Plan and/or Beacon Health Strategies agrees that it shall review the credentials of Facility or, if Plan has delegated the credentialing process to Facility, Plan and Beacon Health Strategies shall review and approve Facility's credentialing process and audit it on an ongoing basis. Facility shall adhere to the reporting requirements required.

c) Facility agrees that in no event, including, but not limited to, nonpayment by the Payor, the Payor's insolvency or breach of the Agreement, shall Facility bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than the Payor (or the payor issuing the health benefits contract administered by the Payor) for Covered Services provided by Facility for which payment is the legal obligation of the Payor. This provision shall not prohibit collection by Facility from Member for any non-covered service and/or Copayments in accordance with the terms of the applicable Member health benefits contract. Facility further agrees that: (i) this provision shall survive the expiration or termination of the Agreement regardless of the cause giving rise to expiration or termination and shall be construed to be for the benefit of the Member; (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Facility and Member or persons acting on their behalf; and (iii) this provision shall apply to all employees and contractors of Facility, if any, who are providing services to Members.

d) Facility agrees that nothing in the Agreement shall be construed as relieving the Payor of its responsibility for performance of duties agreed to through its Medicare Advantage contracts existing now or entered into in the future with CMS.

e) Facility agrees to comply with and be subject to all applicable Medicare program laws, rules and regulations, reporting requirements, and CMS instructions as implemented and amended by CMS. This includes, without limitation, HHS', the Comptroller General's or their designees right to evaluate, inspect and audit Facility's operations, books, records, and other documentation and pertinent information related to Facility's obligations under the Agreement. As applicable, facility further agrees HHS', the Comptroller General's, or their designees right to inspect, evaluate and audit any pertinent information for any particular contract period will exist through ten (10) years from the final date of the contract period between the Payor and CMS or from the date of completion of any audit, whichever is later, and agrees to cooperate, assist and provide information as requested by such entities.

f) Facility agrees to retain all contracts, books, documents, papers and other records related to the provision of services to Medicare Advantage Members and/or as related to Facility's obligations under the Agreement for a period of not less than ten (10) years from: (i) the end of the contract period between the Payor and CMS; or (ii) from the date of completion of any audit, whichever is later.

Facility agrees to comply with the Payor's policies and procedures.

Facility agrees to immediately notify the Payor if he/she/it is excluded from participation in Medicare.

i) Facility agrees that in the event of the Payor's insolvency or termination of the Payor's contract with CMS, benefits to Members will continue through the period for which premium has been paid and benefits to Members confined in an inpatient facility will continue until their discharge.

j) In the event Facility is required to submit claims or other data to the Payor, the submission shall include a certification from Facility that such data is accurate, complete and truthful.

k) With respect to any Members who are eligible for both Medicare and Medicaid, Facility agrees that such Members will not be held liable for Medicare Part A and Medicare Part B cost sharing when the State is responsible for paying such amounts. Further, with respect to such Members, Facility agrees to: (i) accept the payment amount from the Payor as payment in full, or (ii) bill the appropriate State source.