**SERVICE AGREEMENT**

THIS SERVICE AGREEMENT (hereinafter referred to as the "AGREEMENT") is entered into this ____th day of _____ 2009, between the San Mateo Health Commission, hereinafter referred to as "HPSM", and the County of San Mateo Health System, Behavioral Health and Recovery Services, hereinafter referred to as "BHRS."

WHEREAS, HPSM has entered into and will maintain a contract with the Centers for Medicare and Medicaid Services (CMS), pursuant to which qualifying individuals who are dually eligible for Medicare and Medi-Cal and who have subscribed and enrolled under HPSM's CareAdvantage Program will receive, through HPSM, health services hereinafter defined as "Medicare Services".

WHEREAS, HPSM has entered into and will maintain a contract with the California Department of Health Care Services (DHCS), pursuant to which individuals who subscribe and are enrolled under HPSM's CareAdvantage Program will receive, through HPSM, Medi-Cal services provided as wraparound benefits to the Medicare Covered Services noted above, hereinafter defined as "Medi-Cal Wraparound Health Services".

WHEREAS, Medicare Services and Medi-Cal Wraparound Services together shall hereinafter be referred to as "Covered Services."

WHEREAS, BHRS has entered into and will maintain a contract with the California Department of Health Care Services (DHCS), pursuant to which individuals who are dually eligible for Medicare and Medi-Cal will receive, through BHRS, Medi-Cal-covered mental health and substance abuse recovery services provided as wraparound benefits to the Medicare Covered Services noted above, hereinafter defined as "Medi-Cal Wraparound Mental Health and Substance Abuse Recovery Services".

WHEREAS, BHRS has developed expertise in arranging for and managing delivery of mental health and substance abuse recovery services to Medi-Cal beneficiaries.

WHEREAS, HPSM seeks a delegated mental health and substance abuse recovery service benefit administrator to arrange for and manage the delivery of mental health and substance abuse recovery services to its CareAdvantage Program members.

NOW THEREFORE, in consideration of the mutual promises and agreement herein contained, HPSM and BHRS hereby agree as follows:

**ARTICLE 1**
**DEFINITIONS**

1.1 Benefit Plans. The term "Benefit Plan" shall mean the scope of benefits indicated in the CareAdvantage Evidence of Coverage (Attachment A) as it is updated on an annual basis and which includes Claims processing parameters and other information specifying healthcare coverage for CareAdvantage members, as those parameters currently exist or may be amended in the future. HPSM will provide BHRS with certain information relating to such Benefit Plan ("Benefit Plan Information") including, but not limited to the names of the CareAdvantage Members entitled to services and other parameters of the Benefit Plan as BHRS may reasonably request from time-to-time.

1.2 Case Management. The term “Case Management” shall mean the coordination and follow up by the Primary Care Physician of all services deemed necessary to provide the Member medically necessary and appropriate health care.

1.3 Commission. The term “Commission” shall mean the San Mateo Health Commission.

1.4 Contracted Hospital. The term "Contracted Hospital” shall mean a licensed hospital which has entered into an agreement with HPSM to provide Covered Services to Members.

1.5 Contracted Medical Group. The term "Contracted Medical Group” shall mean a medical group or independent practice association which has entered into an agreement with HPSM to provide Covered Services to Members.

1.6 Contracted Physician. The term "Contracted Physician” shall mean a physician who is duly licensed to practice medicine or osteopathy under California law and who has contracted with HPSM or is employed by or contracts with a Contracted Medical Group to provide Covered Services to Members.

1.7 Contracted Provider. The term "Contracted Provider” shall mean a Contracted Physician, Contracted Hospital, Contracted Medical Group or other licensed health facility or health professional which has entered into an agreement with HPSM to provide Covered Services to Members.

1.8 Copayment and Deductible. The term “Copayment and Deductible” shall mean cost sharing charges for Covered Services. CareAdvantage members shall not be subject to any Copayments or Deductibles for any services provided under the terms of this contract.

1.9 Covered Services. The term "Covered Services" shall mean those health care services, equipment and supplies, inclusive of Medicare Services and Medi-Cal Wraparound Services, which a Member is entitled to receive under the CareAdvantage program and which are set forth in the CareAdvantage Evidence of Coverage (Attachment A).

1.10 Delegated Entity. The term “Delegated Entity” shall mean a First Tier Entity with whom HPSM has contracted to perform specified delegated functions on HPSM’s behalf in accordance with state, local, and federal laws, rules, and guidelines, as well as in accordance with HPSM policies and procedures.

1.11 Downstream Entity. The term “Downstream Entity” shall mean any party that enters into an acceptable written arrangement below the level of the arrangement between HPSM and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.

1.12 Emergency. The term "Emergency” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in 1) serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her

unborn child; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

1.13 Evidence of Coverage. The term "Evidence of Coverage" shall mean the document issued by HPSM to a Member that sets forth the HPSM's Covered Services.

1.14 First Tier Entity. The term "First Tier Entity" shall mean any party that enters into a written arrangement with HPSM to provide administrative services or health care services for a Medicare eligible individual.

1.15 Formulary. The term "Formulary" shall mean the list of prescription drugs and medications that are recommended by HPSM for routine use and which will be dispensed through Contracted Pharmacies.

1.16 Identification Cards. The term "Identification Cards" ("ID Cards") shall mean printed identification cards containing information about the benefits to which the Members are entitled.

1.17 Medi-Cal Wraparound Services. "Medi-Cal Wraparound Services" shall mean those Medi-Cal services that HPSM provides to eligible Medi-Cal beneficiaries who are enrolled in HPSM under HPSM's Medi-Cal contract with the California Department of Health Care Services and that are provided secondary to services, including Medicare Services, covered by other payers or programs that have primary payment responsibility.

1.18 Medically Appropriate. The term "Medically Appropriate" means services and medical supplies which are required for prevention, diagnosis, or treatment of sickness or injury, and which are:

1.18.1 Consistent with the symptoms of a medical condition or treatment of a medical condition;
1.18.2 Appropriate with regard to standards of good medical practice and generally recognized by the medical scientific community as effective;
1.18.3 Not solely for the convenience of the Member or provider of the service or medical supplies; and
1.18.4 The most cost effective of the alternative levels of service or medical supplies which can be safely provided to the Member in HPSM's judgment.

1.19 Medicare Services. The term "Medicare Services" means those health care services that are covered under the Original Medicare program in accordance with Medicare coverage guidelines and offered through HPSM CareAdvantage, as well as supplemental Medicare benefits offered through HSPM CareAdvantage in accordance with the Centers for Medicare and Medicaid Services approval of PLAN's annual Medicare Advantage-Prescription Drug Plan bid.

1.20 Members. The term "Members" shall mean those individuals who are enrolled in CareAdvantage who are entitled to receive Covered Services.

1.21 Non-Covered Services. The term "Non-Covered Services" means those services and supplies that HPSM is not required to provide to Members pursuant to the CareAdvantage Evidence of Coverage.

1.22 Non-Participating Provider. The term “Non-Participating Provider” means a provider of health care services or equipment that does not have a contract with HPSM to provide such services or equipment to Members.

1.23 Participating Providers. The term “Participating Providers” shall mean those individuals or organizations which contract directly with HPSM or BHRS to provide health care services or equipment for CareAdvantage Members.

1.24 Primary Care Provider (PCP). The term “Primary Care Provider” or “PCP” means a Participating Provider selected by a Member to render first contact medical care and certain Covered Services.

1.25 PCP Assignment. The term “PCP Assignment” refers to the process by which an Member is assigned by HPSM to a PCP for provision of certain Covered Services, or to the PCP assigned for a particular Member.

1.26 RBRVS. The term "RBRVS" (Resource-Based Relative Value Scale) means the current year's physician compensation schedules published by the United States Centers for Medicare and Medicaid Services (“CMS”), which are used by CMS to reimburse those physicians Contracted in the Federal Medicare Program (“Medicare”).

1.27 Referral. The term "Referral” shall mean the process by which a Contracted Physician directs a Member to a Non-Contracted Provider.

1.28 Referral Provider. The term "Referral Provider” shall mean a Contracted Physician who is professionally qualified to practice his/her designated specialty and whose agreement with HPSM includes responsibility for providing Covered Services in his/her designated specialty.

**ARTICLE 2**
**DUTIES TO BE PERFORMED BY HPSM**

2.1 Member Eligibility. HPSM shall provide up-to-date information on the eligibility status of CareAdvantage members via its HPSM Web Claims system. Eligibility information provided shall be in accordance with HPSM’s best available information. However, if retroactive changes are made to individual members’ eligibility, final eligibility status information shall be honored by BHRS.

2.2 Benefit Plan Information. HPSM will deliver to BHRS detailed Benefit Plan Information. Such information shall contain all of the elements required by BHRS so that BHRS may verify, price, and pay the Claims submitted by Participating Providers, as well as prepare the various reports as described in Exhibit A. In addition, HPSM shall provide any Benefit Plan Information changes to BHRS within thirty (30) days of the date such changes shall become effective (the “change date”).

2.3 Notification Requirements. HPSM will review all reports, statements, and invoices provided by BHRS and shall notify BHRS in writing of any errors or objections within ninety (90) days of receipt. Specifically, this shall also apply to all service requests,

benefit change requests, and any operation change requests. Until HPSM notifies BHRS in writing of any errors or objections, BHRS will be entitled to rely on the information contained in the reports, statements, and invoices. If HPSM does not notify BHRS in writing of any errors or objections within the ninety (90) day period, the information contained therein will be deemed accurate, complete, and acceptable to HPSM, and thereafter BHRS shall have no liability related thereto. This does not apply with respect to any undercharges or underpayments of HPSM. BHRS shall document and retain supporting documentation for audit purposes. If HPSM notifies BHRS within the ninety (90) day period of any errors or objections, BHRS shall compensate HPSM for any verifiable errors or objections. Nothing in this article will absolve BHRS of any liability of errors, discrepancies, objections, or omissions identified under Section 5.3 of this contract.

**ARTICLE 3**
**DUTIES TO BE PERFORMED BY BHRS**

3.1 Provision of Services to HPSM. BHRS shall provide to HPSM the services listed in Exhibit A, attached hereto and incorporated herein as referenced. These services shall be provided at the agreed upon rates listed in Exhibit B, attached hereto and incorporated herein as referenced.

3.2 Compliance with Laws and Regulations. BHRS shall comply with all applicable Federal laws, regulations, reporting requirements, and CMS instructions, and with HPSM's policies and procedures and contractual obligations with the California Department of Health Care Services, including, but not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Federal criminal law, the False Claims Act (31 U.S.C. §3729 et.seq.) and the Anti-Kickback statute (section 1128B(b) of the Act), HIPAA, and the HIPAA administrative simplification rules at 45 CFR Part 160, 162, and 164. BHRS agrees to include the requirements of this section in its contracts with any Downstream Entity, and to require any Downstream Entity to comply accordingly.

3.3 Capacity to Contract. BHRS acknowledges that HPSM is prohibited by CMS and the California Department of Health Care Services from contracting with any entity that itself, its employees, managers, or Downstream Entities are excluded from participating in the Medicare or Medi-Cal programs. BHRS warrants that it shall review the Office of the Inspector General, General Services Administration, and Medi-Cal exclusions, debarment, licensure or sanctions lists at the time of entering into this Agreement and annually thereafter to ensure that neither itself, nor any employee, manager, Downstream Entity, or subcontractor responsible for administering or delivering benefits under any federal or state health care program is listed. If BHRS finds any employee, manager, or Downstream Entity is on an exclusion list, that person or entity will immediately be removed from any work related directly or indirectly to all federal or state health care programs.

**ARTICLE 4**
**PAYMENT DUE BHRS AND TO HEALTH CARE PROVIDERS**

4.1 Monthly Statement for Payment Administrative Services. As set forth in Exhibit B of this Agreement, HPSM shall remit payment to BHRS within thirty (30) calendar days of the close of each month payment of a monthly administration fee. HPSM will prepare a statement using current month's CareAdvantage member counts plus/minus adjustments for the previous month. If BHRS questions the amount of the monthly administrative services statement, BHRS shall notify HPSM of its questions regarding said amount. If HPSM receives such a notice, both BHRS and HPSM shall make a reasonable effort to resolve such questions within thirty (30) calendar days. Upon and in accordance with such resolution, HPSM will remit to BHRS any outstanding amount due, if applicable, to BHRS within thirty (30) calendar days of the resolution.

4.2 Payment to Health Care Providers. BHRS shall process and issue payments to health care providers based on approved claims for Covered Services provided to Members. As a delegated entity, BHRS shall follow all applicable CMS policies and guidelines regarding timely and appropriate processing of claims, member notification of claims denial, and appropriate payment levels to contracted and non-contracted providers.

4.3 Payment of Health Care Costs. BHRS shall electronically submit claims to HPSM for reimbursement of health care costs paid under this Agreement. HPSM shall issue payment according to Exhibit B for adjudicated claims to BHRS within thirty (30) calendar days from the date of submission.

4.4 No Member Liability. BHRS agrees that neither BHRS nor any of its Downstream Entities, in any circumstances, including, but not limited to nonpayment by HPSM shall bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any HPSM member for services performed under this Agreement. This provision shall survive the termination of this Agreement for any reason and shall be construed to be for the benefit of HPSM members.

## ARTICLE 5
## RECORDS

5.1 Maintenance of Records. BHRS shall maintain, and require any of its Downstream Entities, contractors, or subcontractors, to maintain, documentation of all activity conducted under this Agreement, including Claims processed, for a minimum of ten (10) years. Such documentation, including books and records, shall be in a format and media deemed appropriate by BHRS and HPSM and sufficient to accommodate periodic auditing of the records to evaluate the quality, appropriateness and timeliness of services performed by BHRS under this Agreement. The records shall be accessible to HPSM upon thirty (30) days prior written notice for annual audits, or sooner if required by the circumstances or state or local oversight agencies.

5.2 Use of Information. BHRS and HPSM may use, reproduce, or adapt information obtained in connection with this Agreement, including Claims data information and eligibility information, in any manner they deem appropriate, except that each party and its agents, employees, and contractors shall maintain the confidentiality of this information to the extent required by applicable Law, including the provisions of the Health Insurance Portability and Accountability Act of 1996, Subtitle F – Administrative Simplification, (referred to in this Agreement as "HIPAA"), and may not use the

information in any way prohibited by Law. Each party shall be solely responsible for its own use of the information, and shall indemnify and hold the other party harmless for, from and against any and all costs, losses, and damages incurred by such other party as a result of such use.

5.3 Right to Audit Claims and Business Records. BHRS agrees to permit access to, inspection, and audit by HPSM, the California Department of Managed Health Care, the California Department of Health Services, the United States Department of Health and Human Services, the Centers for Medicare and Medicaid Services, the Comptroller General of the United States, and or their designees, at all reasonable times of all facilities, books, records and documents maintained or utilized by BHRS in the performance of this Agreement.

HPSM and representatives of a regulatory or accreditation agency may each inspect and audit, at least once annually, BHRS's business records that directly relate to billings made to HPSM for Claims. BHRS may inspect and audit, or cause to be inspected and audited, once annually, the books and records of HPSM directly relating to this Agreement, including the existence and number of Members. HPSM and BHRS shall fully cooperate with and assist and provide information to representatives of each other, independent accountants hired by either party, and representatives of any regulatory or accreditation agency, to conduct any such inspection or audit. To the extent that HPSM and/or BHRS have control of the following, such audits shall be at the auditing party's sole expense and shall only be made during normal business hours, following thirty (30) days written notice, without undue interference to the audited party's business activity, and in accordance with reasonable audit practices. Where a regulatory or accreditation agency imposes demands that do not meet the above standards for conducting an audit, HPSM and BHRS will cooperate with the requirements of the auditing agency to the extent possible. An audit of BHRS's records may be conducted at BHRS's office where such records are located and shall be limited to transactions over the ten (10) year period preceding such audit unless the document retention period is extended according to applicable law. If a completed audit reveals a discrepancy in the results and the previous calculations of the audited party, then the auditing party shall deliver written notice setting forth in reasonable detail the basis of such discrepancy. The parties shall use reasonable efforts to resolve the discrepancy within thirty (30) days following delivery of the notice, and such resolution shall be final, binding, and conclusive upon the parties. Upon a final and conclusive determination of a discrepancy revealed by an audit procedure under this Agreement, the party that owes money shall pay such sums to the other party within thirty (30) days of the delivery of the conclusive audit findings.

## ARTICLE 6
## INDEMNIFICATION

6.1 Mutual Indemnification. HPSM and BHRS shall indemnify and hold harmless each other from and against all third party claims, demands, losses, damages and reasonable expenses arising from or in connection with the performance of the terms of this Agreement, except to the extent that such claims, demands, losses, damages and expenses result from the negligence of the other.

6.2 Concurrent Negligence. In the event of concurrent negligence of HPSM, its officers and/or employees, and BHRS, its officers and/or employees, then the liability for any and all claims for injuries or damage to persons and/or property which arise out of terms and conditions of this Agreement shall be apportioned according to the California theory of comparative negligence.

**ARTICLE 7**
**NON-DISCRIMINATION**

7.1 Non-Discrimination.

7.1.1 BHRS shall comply with § 504 of the Rehabilitation Act of 1973, which provides that no otherwise qualified handicapped individual shall, solely by reason of a disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination in the performance of this Agreement.

7.1.2 *General non-discrimination*. No person shall, on the grounds of race, color, ethnicity, religion, ancestry, gender, age (over 40), national origin, medical condition (cancer), physical or mental disability, sexual orientation, pregnancy, childbirth or related medical condition, marital status, claims experience, medical history, evidence of insurability, genetic information, source of payment, or political affiliation be denied any benefits or subject to discrimination under this Agreement. BHRS shall implement procedures to ensure that Members are not discriminated against in the delivery of health care services consistent with the benefits covered under CareAdvantage based on any of these factors.

7.1.3 *Equal employment opportunity.* BHRS shall ensure equal employment opportunity based on objective standards of recruitment, classification, selection, promotion, compensation, performance evaluation, and management relations for all employees under this Agreement. BHRS's equal employment policies shall be made available to HPSM upon request.

7.1.4 *Violation of Non-discrimination provisions.* Violation of the non-discrimination provisions of this Agreement shall be considered a breach of this Agreement and subject BHRS to penalties, to be determined by the HPSM Executive Director, including but not limited to:

7.1.4.1 termination of this Agreement;
7.1.4.2 disqualification of BHRS from bidding on or being awarded a contract with HPSM for a period of up to 3 years;
7.1.4.3 liquidated damages of $2,500 per violation;
7.1.4.4 imposition of other appropriate contractual and civil remedies and sanctions, as determined by the Executive Director.

To effectuate the provisions of this section, the Executive Director or his/her designee shall have the authority to examine BHRS's employment records with respect to compliance with this paragraph and/or to set off all or any portion of the amount described in this paragraph against amounts due to BHRS under the Service Agreement or any other Service Agreement between BHRS and HPSM.

BHRS shall report to HPSM the filing by any person in any court of any complaint of discrimination or the filing by any person of any and all charges with the Equal Employment Opportunity Commission, the Fair Employment and Housing Commission or any other entity charged with the investigation of allegations within 30 days of such filing, provided that within such 30 days such entity has not notified BHRS that such charges are dismissed or otherwise unfounded. Such notification shall include the name of the complainant, a copy of such complaint, and a description of the circumstance. BHRS shall provide HPSM with a copy of their response to the Complaint when filed.

7.1.5 *Compliance with Equal Benefits Ordinance*. With respect to the provision of employee benefits, BHRS shall comply with the San Mateo County Ordinance which prohibits contractors from discriminating in the provision of employee benefits between an employee with a domestic partner and an employee with a spouse.

7.1.6 Where applicable, BHRS shall comply fully with the non-discrimination requirements required by 41 CFR 60-741.5(a), which is incorporated herein as if fully set forth.

7.1.7 *Jury Service.* BHRS shall comply with the San Mateo County Ordinance with respect to provision of jury duty pay to employees and have and adhere to a written policy that provides that its employees shall receive from BHRS, on an annual basis, no less than five days of regular pay for actual jury service in San Mateo County. The policy may provide that employees deposit any fees received for such jury service with BHRS or that BHRS deduct from the employees' regular pay the fees received for jury service.

**ARTICLE 8**
**CONFIDENTIALITY**

8.1 Confidential Information. The term "Confidential Information" means information of a confidential or proprietary nature relating to the subject matter described in this Agreement which is taken from or disclosed by one party (the "Disclosing Party") to the other (the "Receiving Party"). Confidential Information includes, but is not limited to, matters of a technical nature such as trade secrets, methods, compositions, data and know-how, designs, systems, processes, computer programs, files and documentation, similar items or research projects, and any information derived therefrom; matters of a business nature, such as the terms of this Agreement (including any pricing terms and contract terms which must be subject to a protective order), marketing, sales, strategies, proposals, and lists of actual or potential Members, Participating Providers as well as any other information that is designated by either party as confidential.

8.2 Treatment of Confidential Information. Subject to the California Public Records Act and related state and federal legislation, the Receiving party agrees: (i) to hold the Disclosing Party's Confidential Information in strict confidence and to take reasonable precautions to protect such Confidential Information (including, without limitation, all precautions Receiving Party employs with respect to its own confidential materials);

(ii) not to divulge any such Confidential Information or any information derived therefrom to any third party unless required in the performance of the Receiving Party's duties under this Agreement or pursuant to controlling law; (iii) not to make any use whatsoever at any time of such Confidential Information except for the purpose of this Agreement and will not use it for its own or any third party's benefit; and (iv) not to copy, analyze, transcribe, transmit, decompile, disassemble or reverse engineer any such Confidential Information, and not use such Confidential Information in any patent application. The confidentiality obligations of this Section 8.2 shall not apply to information which, as evidenced in writing:

8.2.1 is or becomes publicly known by Receiving Party through no breach of this Agreement;
8.2.2 is learned by the Receiving Party from a third party entitled to disclose it;
8.2.3 is rightfully obtained by the Receiving Party prior to this Agreement; or
8.2.4 is required by law to be disclosed.

The confidential obligations contained in the foregoing clauses (i), (ii), (iii) and (iv) shall be perpetual. Receiving Party may make disclosures required by law or court order provided Receiving Party uses diligent, reasonable efforts to afford the Disclosing Party the opportunity to limit disclosure and to obtain confidential treatment or a protective order.

8.3 No Transfer Or Right Or Title. Receiving Party acknowledges that it shall not acquire any rights or title to any Confidential Information merely by virtue of its use or access to such Confidential Information hereunder. Neither the execution of this Agreement nor the furnishing of any Confidential Information hereunder shall be construed as granting, either expressly or by implication, or otherwise, the Receiving Party any license under any invention or patent now or hereafter owned by or controlled by the Disclosing Party. Each party agrees that it may not be adequately compensated for damages arising from a breach or threatened breach of any of the covenants contained in this Article 8 by the other party, and each party shall be entitled to injunctive relief and specific performance in addition to all other remedies. None of the information that may be submitted or exchanged by the parties shall constitute any representation, warranty, assurance, guarantee, or inducement by a party to the other with respect to the infringement of patents, copyrights, trademarks, trade secrets, or any other rights of third persons.

## ARTICLE 9
## EXCLUSIVITY

9.1 Exclusivity. HPSM agrees that BHRS shall be the sole and exclusive agent providing administration services for behavioral health and recovery services provided to CareAdvantage members during the term of this Agreement.

## ARTICLE 10
## TERM AND TERMINATION

10.1 Term. This Agreement shall have an Effective Date of January 1, 2009 and shall be for a term of three (3) years, ending December 31, 2011. Termination shall have no effect

upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination. This agreement supercedes the current agreement for these services.

10.2 Termination With Cause. This Agreement may be terminated at anytime by either party based on a material breach of any terms or conditions herein stated provided that thirty (30) days' advance written notice of such material breach shall be given to the other party and such party shall have the opportunity to cure such material breach during such thirty (30) day notice period.

10.3 Effect of Termination. If this Agreement is terminated pursuant to this Article 10: (i) all further obligations of the parties under this Agreement shall terminate (but not such party's obligation to make payments arising prior to the termination of this Agreement or any obligation surviving the termination hereof); (ii) all Confidential Information provided by either party shall, except for Confidential Information required by law to be retained by a party, be immediately returned by a Receiving Party (as defined in Section 8.1), or such Receiving Party shall certify to the Disclosing Party that such materials have been destroyed; (iii) neither party shall be relieved of any obligation or liability arising from any prior breach of such party or any provision of this Agreement; and (iv) the parties shall, in all events, remain bound by and continue to be subject to the provisions set forth in Sections 5.1, 5.2, 5.3, 6.1, 6.2, 8.1, 8.2, 8.3, 11.1, 11.7, 11.9, 11.10, 11.12, 11.13, 11.17, 11.18, 11.19, 12.1, 12.2, and 12.4.

**ARTICLE 11**
**GENERAL PROVISIONS**

11.1 Use of BHRS Software. HPSM acknowledges that BHRS owns, or possesses license rights (including off-the-shelf vendor agreements) from certain third parties to the entire software system used by BHRS in processing Claims and preparing reports including computer programs, system and program documentation, and other documentation relating thereto (collectively, including certain license rights, the "BHRS Software System"), and that BHRS Software System is the exclusive and sole property of BHRS. HPSM disclaims any rights to BHRS Software System as described above (including access to any applicable source codes), any procedures or forms developed by BHRS, as well as development or modification of BHRS Software System as a result of any customization performed by any party.

11.2 Insurance. Each party shall obtain (to the extent not already possessed) and maintain, with respect to the activities in which such party engages pursuant to this Agreement, professional liability (errors and omissions) insurance in amounts reasonable and customary for the nature and scope of business engaged in by such party and comprehensive liability insurance. Upon request, either party shall promptly deliver to the other party evidence of such insurance. Each party agrees to notify the other party immediately upon such party's receipt of any notice canceling, suspending or reducing the coverage limits of its professional liability insurance or comprehensive liability insurance.

11.3 Successors and Assigns. Neither this Agreement nor any of the rights, interests or obligations hereunder shall be assigned by either party hereto (whether by operation of

law or otherwise) without the prior written consent of the other party hereto. Subject to the preceding sentence, this Agreement shall be binding upon, inure to the benefit of and be enforceable by the parties and their respective successors and permitted assigns. Notwithstanding anything to the contrary contained in this Agreement (including this Section11.3), no consent shall be required and this Agreement will apply to, be binding in all respects upon, and inure to the benefit of any successors of HPSM to this Agreement resulting from a Change of Control. A "Change of Control" shall occur if as a result of one or a series of related transactions: (i) all or substantially all the assets of SMMC are disposed of to any entity not wholly owned and controlled by HPSM, outside the ordinary course of business; (ii) SMMC effects a merger with one or more other entities in which HPSM is not the surviving entity; or (iii) HPSM engages in a transaction that results in any entity holding securities possessing a majority of the voting power that does not hold such voting power as of the time of this Agreement. HPSM shall provide BHRS with thirty (30) days' advance written notice in the event of any transaction(s) resulting in a Change of Control, as well as an Officer's Certificate from the successor entity, agreeing to be bound by the terms and conditions of this Agreement.

11.4 Waiver. Any term or condition of this Agreement may be waived at any time by the party that is entitled to the benefit thereof, but no such waiver shall be effective unless set forth in a written instrument duly executed by or on behalf of the party waiving such term or condition. No waiver by any party of any term or condition of this Agreement, in any one or more instances, shall be deemed to be or construed as a waiver of the same or other term or condition of this Agreement on any future occasion.

11.5 Severability. In the event that any provision of this Agreement shall be determined to be invalid, unlawful, void or unenforceable to any extent, the remainder of this Agreement, and the application of such provision other than those as to which it is determined to be invalid, unlawful, void or unenforceable, shall not be impaired or otherwise affected and shall continue to be valid and enforceable to the fullest extent permitted by law.

11.6 Further Assurances. Each party hereto shall execute and cause to be delivered to each other party hereto such instruments and other documents, and shall take such other actions, as such other party may reasonably request (at or after the date hereof) for the purpose of carrying out or evidencing any of the transactions contemplated by this Agreement.

11.7 Choice of Law. This Agreement shall be construed, interpreted, and governed according to the laws of the State of California without regard to its conflict of laws and rules.

11.8 Force Majeure. The performance obligations of BHRS and/or HPSM respectively hereunder shall be suspended to the extent that all or part of this Agreement cannot be performed due to causes which are outside the control of BHRS and/or HPSM, and could not be avoided by the exercise of due care, including but not limited to acts of God, acts of a public enemy, acts of a sovereign nation or any state or political subdivision or any department or regulatory agency thereof or entity created thereby, acts of any person engaged in a subversive or terrorist activity or sabotage, fires, floods, earthquakes, explosions, strikes, slow-downs, lockouts or labor stoppage, freight embargoes, or by any enforceable law, regulation or order. The foregoing shall not be considered to be a waiver of any continuing obligations under this Agreement, and as

soon as conditions cease, the party affected thereby shall fulfill its obligations as set forth under this Agreement. In order to benefit from the provisions of this Section 11.8, the party claiming force majeure must notify the other reasonably promptly in writing of the force majeure condition. If any event of force majeure, in the reasonable judgment of the parties, is of a severity or duration such that it materially reduces the value of this Agreement, then this Agreement may be terminated without liability or further obligation of either party (except for any obligation expressly intended to survive the termination of this Agreement and except for all amounts that have become or will become due and payable hereunder).

11.9 Entire Agreement; No Third Party Beneficiaries. This Agreement, including the Exhibits: (i) constitutes the entire agreement among the parties with respect to the subject matter hereof and supersedes all prior agreements and understandings, both written and oral, among the parties with respect to the subject matter hereof; and (ii) is intended solely for the benefit of each party hereto and their respective successors or permitted assigns, and it is not the intention of the parties to confer third party beneficiary rights, and this Agreement does not confer any such rights, upon any other third party.

11.10 Use of Name. Neither party shall use the other party's name, trade or service mark, logo, or the name of any affiliated company in any advertising or promotional material, presently existing or hereafter established, except in the manner and to the extent permitted by prior written consent of the other party.

11.11 Notice. Any notice required or permitted by this Agreement, unless otherwise specifically provided for in this Agreement, shall be in writing and shall be deemed given: (i) one (1) day following delivery to a nationally reputable overnight courier; (ii) one (1) day following receipt by facsimile during the receiving party's business hours with written confirmation thereof; or (iii) three (3) days after the date it is deposited in the United States mail, postage prepaid, registered or certified mail, or hand delivered addressed as follows:

To: Health System
Jean Fraser, Chief
San Mateo County Health System
225 37th Avenue
San Mateo, CA 94403

To: BHRS
Louise Rogers, Director
Behavioral Health and Recovery Services
225 West 37th Ave
San Mateo, CA 94403

To: HPSM
Maya Altman, Executive Director
Health BHRS of San Mateo
701 Gateway Blvd., Suite 400
South San Francisco, CA 94080

Any party may at any time change its address for notification purposes by mailing a notice stating the change and setting forth the new address.

11.12 Counterparts; Facsimile. This Agreement may be executed in one or more counterparts, all of which shall be considered one and the same agreement and shall become effective when one or more counterparts have been signed by each of the parties and delivered to the other parties, it being understood that all parties need not sign the same counterpart. This Agreement may be executed and delivered by facsimile and upon such delivery the facsimile signature will be deemed to have the same effect as if the original signature had been delivered to the other party. The original signature copy shall be delivered to the other party by express overnight delivery. The failure to deliver the original signature copy and/or the nonreceipt of the original signature copy shall have no effect upon the binding and enforceable nature of this Agreement.

11.13 Independent Contractors. HPSM and BHRS are independent entities and nothing in this Agreement shall be construed or be deemed to create a relationship of employer and employee or principal and agent or franchiser and franchisee or any relationship, fiduciary or otherwise, other than that of independent parties contracting with each other solely for the purpose of carrying out the provisions of this Agreement. Nothing in this Agreement is intended to be construed, or be deemed to create, any rights or remedies in any third party, including but not limited to a Member. Nothing in this Agreement shall be construed or deemed to confer upon BHRS any responsibility for or control over the terms or validity of the Covered Services. BHRS shall have no final discretionary authority over or responsibility for HPSM's administration. Further, because BHRS is not an insurer or HPSM sponsor, BHRS shall have no responsibility for: (i) any funding of HPSM or CareAdvantage benefits; or (ii) any insurance coverage relating to HPSM or any BHRS contract of HPSM or Members, except as described in Exhibit A.

11.14 Consent to Amend. This Agreement or any part or section of it may be amended at any time during the term of this Agreement only by mutual written consent of duly authorized representatives of BHRS and HPSM.

11.15 Headings. The headings of Articles, Sections and Exhibits contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

11.16 Compliance with Laws and Regulations. This Agreement will be in compliance with all pertinent federal and state statutes and regulations. If this Agreement, or any part hereof, is found not to be in compliance with any pertinent federal or state statute or regulation, then the parties shall renegotiate the Agreement for the sole purpose of correcting the non-compliance.

11.17 Construction.

11.17.1 For purposes of this Agreement, whenever the context requires: the singular number shall include the plural, and vice versa; the masculine gender shall include the feminine and neuter genders; the feminine gender shall include the masculine and neuter genders; and the neuter gender shall include the masculine and feminine genders.

11.17.2 The parties hereto agree that any rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not be applied in the construction or interpretation of this Agreement.

11.17.3 As used in this Agreement, the words "include" and "including," and variations thereof, shall not be deemed to be terms of limitation, but rather shall be deemed to be followed by the words "without limitation."

11.17.4 Except as otherwise indicated, all references in this Agreement to "Articles," "Sections" and "Exhibits" are intended to refer to Articles of this Agreement, Sections of this Agreement and Exhibits to this Agreement.

11.18 Remedies Cumulative; Specific Performance. The rights and remedies of the parties hereto shall be cumulative (and not alternative). The parties to this Agreement agree that to the extent permitted by applicable law, in the event of any breach or threatened breach by any party to this Agreement of any covenant, obligation or other provision set forth in this Agreement for the benefit of any other party to this Agreement, such other party shall be entitled (in addition to any other remedy that may be available to it) to: (i) a decree or order of specific performance to enforce the observance and performance of such covenant, obligation or other provision; and (ii) an injunction restraining such breach or threatened breach. Neither party shall be required to provide any bond or other security in connection with any such decree, order or injunction or in connection with any related action or legal proceeding.

11.19 HIPAA Compliance. For the purposes of this Agreement, BHRS is deemed to be a "Business Associate" of HPSM as such term is defined in the Privacy Standard of the Federal Register, published on December 28, 2000 (Business Associate Requirements, Exhibit C, attached hereto and incorporated herein as referenced). The parties will endeavor to comply with all applicable regulations published pursuant to HIPAA, as of the effective enforcement date of each standard. In addition, without limiting any other provision of this Agreement:

11.19.1 all services provided by BHRS under this Agreement will be provided in such a manner as to enable HPSM to remain at all times in compliance with all HIPAA regulations applicable to HPSM, to the extent that HPSM's compliance depends upon the manner in which such services are performed by BHRS;

11.19.2 all software, application programs and other products licensed or supplied by BHRS under this Agreement will contain such characteristics and functionality (including as applicable, but not limited to, the ability to accept and securely transmit data using the standard HIPAA transaction sets) as necessary to ensure that HPSM's use of such software, application programs and other products and associate documentation from BHRS, when utilized by HPSM in the manner as directed by BHRS, will fully comply with the HIPAA regulations applicable to HPSM. In the event any amendment to this Agreement is necessary for HPSM to comply with the HIPAA regulations as they relate to this Agreement or its subject matter, including, but not limited to, requirements pertaining to Business Associate agreements, HPSM and BHRS will negotiate in good faith and amend this Agreement accordingly, with such amendment to be effective prior to the date compliance is required under each standard of the HIPAA regulations; and

11.19.3 all software, application programs, eligibility lists or other member-specific information and other products licensed or supplied by HPSM under this Agreement will contain such characteristics and functionality (including as

applicable, but not limited to, the ability to accept and securely transmit data using the standard HIPAA transaction sets) as necessary to ensure that BHRS's use of such software, application programs and other products and associate documentation from HPSM, when utilized by BHRS in the manner as directed by HPSM, will fully comply with the HIPAA regulations applicable to BHRS. In the event any amendment to this Agreement is necessary for BHRS to comply with the HIPAA regulations as they relate to this Agreement or its subject matter, including, but not limited to, requirements pertaining to Business Associate agreements, BHRS and HPSM will negotiate in good faith and amend this Agreement accordingly, with such amendment to be effective prior to the date compliance is required under each standard of the HIPAA regulations.

11.20 Cultural Competence. BHRS shall ensure that all services, both clinical and non-clinical, are accessible to all CareAdvantage members and are provided in a culturally competent manner, including those with limited English proficiency or reading skills and those with diverse cultural backgrounds.

**ARTICLE 12**
**COMPLIANCE WITH CAREADVANTAGE LAWS AND REGULATIONS**

12.1 BHRS understands that HPSM oversees and is accountable to the Centers for Medicare and Medicaid Services (CMS) for any functions or responsibilities that are described in the laws or regulations applicable to Medicare Plans, and that HPSM may be held accountable by CMS if BHRS and/or its Downstream Entity violates the provisions of such law or regulations or HPSM's policies in the performance of this Agreement. In furtherance of the foregoing, BHRS shall comply with and ensure any of its Downstream Entities or related entities providing services under this Agreement also comply with applicable Medicare laws, regulations, reporting requirements, and CMS instructions, and will cooperate, assist, and provide information, as requested.

12.2 BHRS shall comply with the reporting requirements in 42 CFR §422.516 and the requirements in 42 CFR §422.310 for submitting data to CMS for the purposes of reporting costs, utilization, quality, enrollee health status, and fiscal soundness to CMS, as well as of enabling CMS to characterize the context and purpose of each item and service provided to a Medicare enrollee for accurate application of CMS's risk adjustment payment model. BHRS also agrees to furnish medical records and/or ensure that Participating Providers furnish medical records that may be required to obtain any additional information or corroborate the encounter data.

12.3 BHRS understands and agrees that HPSM is responsible for the monitoring and oversight of all duties of BHRS under this Agreement, and that HPSM has the authority and responsibility to: (i) implement, maintain and enforce HPSM's policies governing BHRS's duties under this Agreement; (ii) conduct audits, inspections and/or investigations in order to oversee BHRS's performance of duties described in this Agreement; (iii) require BHRS to take corrective action if HPSM or an applicable federal or state regulator determines that corrective action is needed with regard to any duty under this Agreement; and/or (iv) revoke the delegation of any duty, if BHRS fails to meet HPSM standards in the performance of that duty. BHRS shall cooperate with

HPSM in its oversight efforts and shall take corrective action as HPSM determines necessary to comply with the laws, accreditation agency standards, HPSM policies governing the duties of BHRS or the oversight of those duties.

12.4 If BHRS gives Confidential Information including Protected Health Information, as defined in 45 CFR §164.501, received from HPSM, or created or received by BHRS on behalf of HPSM, to any of its Downstream Entities, including agents or subcontractors, BHRS shall require the Downstream Entity to agree to the same restrictions and conditions that apply to BHRS under this Agreement. BHRS shall be fully liable to HPSM for any acts, failures or omissions of the Downstream Entity in providing the services as if they were BHRS's own acts, failures or omissions, to the extent permitted by law. BHRS further expressly warrants that its agents will be specifically advised of, and will comply in all respects with the terms of this Agreement.

12.5 BHRS shall comply with CMS instructions regarding responsibilities of delegated entities as outlined in Attachment B.

The provisions of this Agreement shall bind and inure to the benefit of the parties hereto and their heirs, legal representatives, successors and assignees. This Agreement constitutes the entire understanding between the parties hereto.

| | |
|---|---|
| SAN MATEO HEALTH COMMISSION<br>d.b.a. HEALTH PLAN OF SAN MATEO | COUNTY OF SAN MATEO |
| BY<br>**MAYA ALTMAN**<br>**EXECUTIVE DIRECTOR** | BY<br>**MARK CHURCH**<br>**PRESIDENT, BOARD OF SUPERVISORS** |
| DATE | DATE |

**EXHIBIT "A"**
**SCOPE OF SERVICES**

In consideration of the payments set forth in Exhibit "B", BHRS shall provide the services as set forth in the corresponding Appendix referenced below. Services shall be provided in accordance with Medicare guidelines, as detailed in Attachment B as relevant.

Appendix 1-A: Claims Processing and Data Management
Appendix 1-B: Outpatient Behavioral Health and Recovery Services Benefit
Appendix 1-C: Provider Relations
Appendix 1-D: Utilization and Medical Management
Appendix 1-E: Customer Service
Appendix 1-F: Grievances and Appeals
Appendix 1-G: Quality Assessment and Improvement
Appendix 1-H: Reporting

**APPENDIX 1-A**
**CLAIMS PROCESSING AND DATA MANAGEMENT**

1. Claims Processing. BHRS shall process claims for payment from Participating Providers, and Non-Participating Providers as needed, for authorized Covered Behavioral Health and Recovery Services on behalf of HPSM. Claims shall be processed at least twice per month.

2. Payment to Participating Providers. BHRS shall make payments to Participating Providers, and Non-Participating Providers as needed, for Covered Services to Members. BHRS shall not be obligated to pay Participating Providers (i) for services that are not Covered Services; or (ii) if Participating Providers fail to verify an individual's eligibility for Covered Services.

3. Encounter Data. BHRS shall submit encounter data in the form of claims to HPSM in electronic form. BHRS shall supply encounter data at least monthly, by the 10th of the month following the month of claim processing. BHRS will employ appropriate data security procedures to ensure rapid recovery and transmittal of all encounter data.

4. Certification of Data. BHRS agrees that by submitting any data to HPSM BHRS is certifying that the information is based on its best knowledge, information and belief available, and such information is accurate, complete and truthful.

## APPENDIX 1-B
## OUTPATIENT BEHAVIORAL HEALTH AND RECOVERY SERVICES BENEFIT

BHRS shall provide Medicare-covered outpatient behavioral health and recovery services benefit to Members under this contract, as well as Marriage and Family Therapy (MFT) services for each calendar year that the MFT benefit is available to CareAdvantage members as a Medicare supplemental benefit. The outpatient behavioral health and recovery services benefit shall be provided in accordance with Medicare rules and guidelines and HPSM policies and procedures.

In providing such services, BHRS shall ensure that CareAdvantage members are held harmless for payment of fees that are the legal obligation of HPSM or BHRS.

**APPENDIX 1-C**
**PROVIDER SERVICES**

BHRS shall be responsible for maintaining and monitoring a network of behavioral health and recovery services providers that is sufficient to provide adequate access to and availability of covered behavioral health and recovery services. BHRS shall be responsible for credentialing and executing contracts with Participating Providers, as designated by HPSM, to provide behavioral health and recovery services to Members under the CareAdvantage Program. Credentialing requirements will be waived if BHRS already has on file an up-to-date credentialing record. However, BHRS will re-credential the provider in accordance with the Participating Provider's existing credentialing schedule. BHRS's credentialing and re-credentialing process shall adhere to federal laws, rules, and guidelines under the Medicare program. HPSM shall at all times monitor the performance of BHRS and the network of behavioral health and recovery services providers and retains the right to approve, suspend, or terminate any arrangement set up by BHRS that in the opinion of HPSM does not contribute to the provision of good quality care to Members.

In contracting with Providers, BHRS shall ensure that each provider contract contain the following provisions.

- Provider shall agree to safeguard Member privacy and confidentiality, consistent with all federal and state laws, and ensure accuracy of beneficiary medical, health, and enrollment information and records.
- Provider shall look only to BHRS for payment of Covered Services and shall at no time seek compensation from Members for Covered Services. Such payment by BHRS shall be considered payment in full. Provider shall not hold Members responsible for any Medicare or Medi-Cal cost sharing in accordance with the agreement that payment from PLAN for Covered Services shall be considered payment in full. In addition, the Provider shall not invoice or balance bill a Member for the difference between the provider's billed charges and the reimbursement paid by BHRS for Covered Services.
- Provider shall agree that neither the Provider or any of its Downstream Entities in any circumstances, including, but not limited to nonpayment by BHRS, insolvency of BHRS, or breach of this Agreement, shall bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than BHRS for services provided pursuant to this Agreement. At no time will Provider or any party with a claim against Provider for Covered Services provided to Members bill or otherwise seek compensation from Members for Covered Services except in the case when a third party payer is primarily responsible and has paid Member for a Covered Service.
- Provider shall agree that CareAdvantage Members' health services are being paid for, in whole or in part, with federal funds and, therefore, payments for such services are subject to laws applicable to individuals or entities receiving federal funds. Provider shall at all times during the term of this Agreement comply with, and require any of its Downstream Entities comply with, all applicable federal, state and municipal laws, regulations, reporting requirements, and CMS instructions (including applicable Medicare laws, regulations, and instructions), HPSM's contractual obligations to CMS, all HPSM policies and procedures related to health service delivery, and all applicable rules and regulations of the their applicable licensing

bodies. This includes compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Federal criminal law, the False Claims Act (31 U.S.C. §3729 et.seq.) and the Anti-Kickback statute (section 1128B(b) of the Act), and HIPAA administrative simplification rules at 45 CFR Part 160, 162, and 164. Provider shall also agree to audits and inspections by CMS and/or its designees and cooperate, assist, and provide information as requested. If at any time during the term of this Agreement, Provider shall have Provider's license to practice in the State of California suspended, conditioned or revoked, Provider's agreement with BHRS shall terminate immediately and become null and void without regard to whether or not such suspension, condition or revocation has been finally adjudicated. Provider agrees to include the requirements of this section in its contracts with any Downstream Entity.

- Provider shall agree: (1) not to differentiate or discriminate in his/her provision of Covered Services to Members because of race, color, national origin, ancestry, religion, sex, health status, marital status, sexual orientation, age, or other protected classes according to federal and state law; and (2) to render Covered Services to Members in the same manner, in accordance with the same standards and within the same time availability as offered to non-Members consistent with existing medical/ethical/legal requirements for providing continuity of care to any patient.
- Provider shall agree that Provider understands that BHRS has certain obligations including the credentialing of Provider, and that BHRS and HPSM will have the right to oversee and review the quality of care and services provided to Members by Provider. Provider shall agree to be accountable to cooperate and comply with BHRS and HPSM whenever BHRS, HPSM, and/or their Medical Directors impose such obligations on Provider. Obligations may include, but may not be limited to: on-site review, member transfer from or to referring facilities, cooperation with Healthcare Effectiveness Data Information Sets ("HEDIS") measurements and other internal and external quality review and improvement programs, and risk adjustment programs.
- Provider shall acknowledge that HPSM is prohibited by CMS and the California Department of Health Care Services from contracting with a provider who itself, its employees, managers, or Downstream Entities are excluded from participating in the Medicare or Medi-Cal programs. Provider shall warrant that it shall review the Office of the Inspector General, General Services Administration, and Medi-Cal exclusions, debarment, licensure or sanctions lists at the time of entering into this Agreement and annually thereafter to ensure that neither itself, nor any employee, manager, or subcontractor responsible for administering or delivering benefits under any federal or state health care program is listed. If Provider, any employee, manager, or Downstream Entity is on an exclusion list, that person or entity will immediately be removed from any work related directly or indirectly to all federal or state health care programs. Provider further understands that BHRS and HPSM are prohibited by CMS from including as a Contracted Provider, any provider that has entered into a private contract with a Medicare beneficiary for the provision of Covered Services. In such an event, BHRS reserves the right to terminate the Agreement with Provider immediately and require Provider to reimburse BHRS immediately for any direct or indirect payments to Provider and the amount of any sanctions imposed on BHRS or HPSM by CMS or Medi-Cal for violation of this prohibition.
- BHRS shall agree to promptly pay Provider for all clean claims within sixty (60) calendar days.

- Provider shall ensure that all services, both clinical and non-clinical, are accessible to all CareAdvantage members and are provided in a culturally competent manner, including those with limited English proficiency or reading skills and those with diverse cultural backgrounds.
- Provider shall maintain records related to any services provided to CareAdvantage members for a minimum of ten (10) years.

BHRS will also engage in standard provider services activities with Participating Providers, including maintaining a Claims department responsible for responding to inquiries related to claims processing, claims submission, and claims payment and maintaining a Utilization Review department responsible for responding to inquiries related to prior authorization for Covered Services. Departments will be available to respond to provider inquiries during regular business hours, from 8:00 a.m. to 5:00 p.m. Monday through Friday.

## APPENDIX 1-D
## UTILIZATION AND MEDICAL MANAGEMENT

1. Prior Authorization Review. BHRS shall perform initial review of prior authorization requests for Covered Services as determined by the Benefit Plan. BHRS agrees that in performance of prior authorization requests, BHRS shall comply with the prior authorization policies and procedures, and guidelines used and approved by HPSM, including policies and procedures and guidelines required under federal laws, rules, and guidance for the Medicare program. BHRS shall make authorization decisions based on relevant documentation received.

2. Timeframes. BHRS shall make authorization decisions on all emergent and urgent authorizations within 72 hours of receipt of the information reasonably necessary to make a decision. BHRS shall make authorization decisions on all non-urgent authorizations within fourteen (14) business days of receipt of the information reasonably necessary to make a decision.

3. Retroactive Authorizations. BHRS shall have a written process for reviewing retroactive authorizations for Covered Services and take action on all retroactive authorizations within thirty (30) calendar days of receipt of the information reasonably necessary to make a decision.

4. Notification of Decision. BHRS agrees that it shall notify the Member, Participating Provider, and/or Referring Provider of the specific benefits that were denied, modified, or deferred, in writing, by mail. BHRS agrees that such notification to Members shall be in English and Spanish and shall be provided within the same timeframes as those required for making the authorization decisions.

5. Utilization Management and Quality Review Programs. BHRS shall cooperate with, participate in, and comply with HPSM's Utilization Management and Quality Review Programs, including any revisions and updates that may occur upon review.

## APPENDIX 1-E
## GRIEVANCES AND APPEALS

BHRS shall process Member complaints if a Member or applicant is dissatisfied with his/her experience accessing or utilizing behavioral health and/or recovery services under the CareAdvantage Program. BHRS will accept complaints in writing, by phone, or through BHRS's website.

Complaints include both appeals and grievances, as follows:

- Appeals. Appeals are complaints related to BHRS or HPSM's decision to deny a benefit to the member to which he/she believes he/she is entitled. Appeals are generated in response to a denied request for authorization. BHRS differentiates between standard Appeals and expedited Appeals. BHRS processes an Appeal on an expedited basis when the standard timeframe for processing an appeal could seriously jeopardize the participant's life, health, or ability to regain maximum function.

- Grievances. Grievances are complaints related to any other aspect of HSPM or BHRS operations, excluding Appeals. Examples of grievances are complaints related to quality of care, access problems, or provider interactions.

BHRS acknowledges receipt of all Appeals or Grievances within 5 business days. Standard Appeals and Grievances shall be resolved within 30 calendar days from the date of receipt. Expedited Appeals shall be resolved within 72 hours from the time of receipt.

## APPENDIX 1-F
## QUALITY ASSESSMENT AND IMPROVEMENT

BHRS shall provide the following quality assessment and improvement services:

- BHRS shall regularly monitor HPSM Members' access to care, including wait times for appointments and office wait times. Target timeframes for new patients for routine appointments for longstanding problems is 30 days; for urgent appointments for stable conditions is 72 hours; for urgent appointments for less stable issues is same day/next day (depending on clinician triage), and immediately for emergency situations.
- BHRS shall regularly review grievances and appeals to address any quality of care concerns that arise. A clinical staff member needs to review any issues involving clinical quality of care; a physician needs to review any issues involving medication management.
- BHRS shall regularly monitor utilization to protect against overutilization and underutilization of behavioral health and recovery services. Quarterly reports shall be made available to HPSM for review.
- BHRS shall develop at least one clinical and one non-clinical quality improvement project annually that demonstrate its commitment to QAI services. Over time, these should represent the different age ranges, if they are not applicable at one time to all age ranges. Periodic monitoring to demonstrate maintenance of improvement should occur, even after the projects have been closed. Quality reports shall be submitted to HPSM at least annually describing the plans, their methodology, their implementation and their outcomes, in a Plan/Do/Study/Act format, or comparable, to demonstrate improvements achieved over the year(s).

HPSM acknowledges and agrees that it is the ultimate decision maker on quality assurance programs and that it agrees to the quality assurance services set forth herein.

**APPENDIX 1-G**
**REPORTING**

BHRS shall supply such encounter, quality and cost data as HPSM may require to perform its disclosure, reporting, administrative, supervisory, and other functions required under HPSM's contract with the Centers for Medicare and Medicaid Services and under applicable State and Federal laws and regulations or as requested. Standardized reports include the following (contingent upon services to be performed by BHRS under this Addendum).

**Quarterly Reports:**

- Prior Authorization. BHRS will report annually information about the use of the prior authorization tool, including but not limited to: (i) the number of requests denied due to the need for prior authorization; (ii) the number of prior authorizations requested; (iii) the number of prior authorizations approved.

- Grievances and Appeals. BHRS will report annuallly information about the receipt and processing of grievances and appeals, including detailed information on each case, including but not limited to the identify of the member, the member's complaint, the resolution, receipt and resolution dates, as well as summary data including but not limited to:

    - The number of grievances received;
    - The number of grievances resolved beyond 30 days;
    - The number of appeals received;
    - The number of appeals upheld;
    - The number of appeals overturned;
    - The number of appeals resolved beyond 30 days; and
    - Any quality of care concerns identified through grievances and appeals.

**Annual Reports:**

BHRS shall provide other ad hoc reports as required by HPSM to conduct cost and quality analyses.

**EXHIBIT "B"**
**PAYMENT**

For the Administrative services provided pursuant to the Agreement, HPSM shall pay BHRS a mutually agreed upon rate per participant per month. Participation shall be determined by the Member count determined each month by HPSM. HPSM Finance will prepare the invoice and payment by the 15th of the following month.

HPSM is fully responsible for the health care costs incurred under Agreement in so far as they are properly adjudicated and paid by BHRS in accordance with the Benefit Plan for services provided to Members. BHRS shall pay providers, and HPSM shall reimburse BHRS, in accordance with the following rate table. Payment for these health care costs shall vary by contract year.

| Year | Payment provided as part of Medicare Services | Payment provided under Medicare Supplemental Services | Total Payment Rate |
|---|---|---|---|
| 2009 | 80% of Medicare incurred expenses, which is equal to 50% of the Medicare Fee Schedule | 45% of the Medicare Fee Schedule | 95% of the Medicare Fee Schedule |
| 2010 | 80% of Medicare incurred expenses, which is equal to 54.8% of the Medicare Fee Schedule | 25.2% of the Medicare Fee Schedule | 80% of the Medicare Fee Schedule |
| 2011 | 80% of Medicare incurred expenses, which is equal to 54.8% of the Medicare Fee Schedule | TBD | TBD |

Total payment shall reflect 100 percent of the Medicare Fee Schedule adjudicated for benefits based on the Medicare Fee Schedule effective on the date of service. Benefits reflect coverage under the standard Medicare benefit package, as well as coverage of additional supplemental benefits (i.e. reductions in cost-sharing) incorporated into HPSM's annual bid. HPSM shall issue reimbursement only for those Covered Services provided to Eligible Members.

HPSM shall issue reimbursement to BHRS in response to clean claims submitted by BHRS to HPSM within sixty (60) days of receipt of the clean claim.

**EXHIBIT "C"**
**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**
**BUSINESS ASSOCIATE REQUIREMENTS**

## Definitions

Terms used, but not otherwise defined, in this Schedule shall have the same meaning as those terms are defined in 45 Code of Federal Regulations section 160.103 164.304 and 164.501. (All regulatory references in this Schedule are to Title 45 of the Code of Federal Regulations unless otherwise specified.)

a. *Designated Record Set.* "Designated Record Set" shall have the same meaning as the term "designated record set" in Section 164.501.
b. *Electronic Protected Health Information.* "Electronic Protected Health Information" ("EPHI") means individually identifiable health information that is transmitted or maintained in electronic media, limited to the information created, received, maintained or transmitted by Business Associate from or on behalf of Covered Entity.
c. *Individual.* "Individual" shall have the same meaning as the term "individual" in Section 164.501 and shall include a person who qualifies as a personal representative in accordance with Section 164.502(g).
d. *Privacy Rule.* "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations Part 160 and Part 164, Subparts A and E.
e. *Protected Health Information.* "Protected Health Information" shall have the same meaning as the term "protected health information" in Section 164.501 and is limited to the information created or received by BHRS from or on behalf of HPSM.
f. *Required By Law.* "Required by law" shall have the same meaning as the term "required by law" in Section 164.501.
g. *Secretary.* "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his or her designee.
h. *Security Incident.* "Security Incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system, but does not include minor incidents that occur on a daily basis, such as scans, "pings", or unsuccessful random attempts to penetrate computer networks or servers maintained by Business Associate
i. *Security Rule*. "Security Rule" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 160 and Part 164, Subparts A and C.

## Obligations and Activities of BHRS

a. BHRS agrees to not use or further disclose Protected Health Information other than as permitted or required by the Agreement or as required by law.
b. BHRS agrees to use appropriate safeguards to prevent the use or disclosure of the Protected Health Information other than as provided for by this Agreement.

c. BHRS agrees to mitigate, to the extent practicable, any harmful effect that is known to BHRS of a use or disclosure of Protected Health Information by BHRS in violation of the requirements of this Agreement.
d. BHRS agrees to report to HPSM any use or disclosure of the Protected Health Information not provided for by this Agreement.
e. BHRS agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by BHRS on behalf of HPSM, agrees to the same restrictions and conditions that apply through this Agreement to BHRS with respect to such information.
f. If BHRS has protected health information in a designated record set, BHRS agrees to provide access, at the request of HPSM, and in the time and manner designated by HPSM, to Protected Health Information in a Designated Record Set, to HPSM or, as directed by HPSM, to an Individual in order to meet the requirements under Section 164.524.
g. If BHRS has protected health information in a designated record set, BHRS agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that HPSM directs or agrees to make pursuant to Section 164.526 at the request of HPSM or an Individual, and in the time and manner designed by HPSM.
h. BHRS agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by BHRS on behalf of, HPSM available to HPSM, or at the request of HPSM to the Secretary, in a time and manner designated by HPSM or the Secretary, for purposes of the Secretary determining HPSM's compliance with the Privacy Rule.
i. BHRS agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for HPSM to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with Section 164.528.
j. BHRS agrees to provide to HPSM or an Individual in the time and manner designated by HPSM, information collected in accordance with Section (i) of this Schedule, to permit HPSM to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with Section 164.528.
k. BHRS shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that BHRS creates, receives, maintains, or transmits on behalf of HPSM.
l. BHRS shall conform to generally accepted system security principles and the requirements of the final HIPAA rule pertaining to the security of health information.
m. BHRS shall ensure that any agent to whom it provides EPHI, including a subcontractor, agrees to implement reasonable and appropriate safeguards to protect such EPHI.
n. BHRS shall report to HPSM any Security Incident within 5 business days of becoming aware of such incident.
o. BHRS shall makes its policies, procedures, and documentation relating to the security and privacy of protected health information, including EPHI, available to the Secretary of the U.S. Department of Health and Human Services and, at HPSM's request, to HPSM for purposes of the Secretary determining HPSM's compliance with the HIPAA privacy and security regulations.

**Permitted Uses and Disclosures by BHRS**

Except as otherwise limited in this Schedule, BHRS may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, HPSM as specified in the Agreement; provided that such use or disclosure would not violate the Privacy Rule if done by HPSM.

**Obligations of HPSM**

a. HPSM shall provide BHRS with the notice of privacy practices that HPSM produces in accordance with Section 164.520, as well as any changes to such notice.
b. HPSM shall provide BHRS with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, if such changes affect BHRS's permitted or required uses and disclosures.
c. HPSM shall notify BHRS of any restriction to the use or disclosure of Protected Health Information that HPSM has agreed to in accordance with Section 164.522.

Permissible Requests by HPSM

HPSM shall not request BHRS to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by HPSM, unless BHRS will use or disclose Protected Health Information for, and if the Agreement provides for, data aggregation or management and administrative activities of BHRS.

Duties Upon Termination of Agreement

Upon termination of the Agreement, for any reason, BHRS shall return or destroy all Protected Health Information received from HPSM, or created or received by BHRS on behalf of HPSM. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of BHRS. BHRS shall retain no copies of the Protected Health Information.

In the event that BHRS determines that returning or destroying Protected Health Information is infeasible, BHRS shall provide to HPSM notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, BHRS shall extend the protections of the Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as BHRS maintains such Protection Health Information.

**Miscellaneous**

a. *Regulatory References.* A reference in this Schedule to a section in the Privacy Rule means the section as in effect or as amended, and for which compliance is required.
b. *Amendment.* The Parties agree to take such action as is necessary to amend this Schedule from time to time as is necessary for HPSM to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.

c. *Survival.* The respective rights and obligations of BHRS under this Schedule shall survive the termination of the Agreement.
d. *Interpretation.* Any ambiguity in this Schedule shall be resolved in favor of a meaning that permits HPSM to comply with the Privacy Rule.
e. *Reservation of Right to Monitor Activities.* HPSM reserves the right to monitor the security policies and procedures of BHRS

| BHRS's Signature | Date | BHRS's Name (Please Print) |
|---|---|---|

**REQUIREMENTS FOR DELEGATED ENTITIES**
**BHRS**

Note: All references to the Medicare Advantage Organization (MAO) apply to the delegated entities with whom HPSM has contracted for services

| MARKETING/MEMBER MATERIALS | Applicable to Contract? | Notes |
|---|---|---|
| Appropriate Submission and Distribution of Marketing Materials<br>The MAO follows the requirements contained in the regulations and Medicare Marketing Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.<br>42 C.F.R. § 422.80(a), (c), and (e)(1)(v); Section 613 of BIPA; Manual Ch. 3 – Section 20; Chapter 9 of the Medicare Marketing Guidelines | X | Such requirements would apply to materials such member letters, notices of denial of authorization, notices of denial of claims payment, and other materials providing benefit information to CareAdvantage members. |
| Materials Provided for Significant Non-English Speaking Population<br>For markets with a significant non-English speaking population, the MAO provides materials in the language of these individuals.<br>42 C.F.R. § 422.80(c)(5); Manual Ch. 3 – Section 60.4 | X | HPSM currently provides information to members in English, Spanish, Chinese, Tagalog, and Russian. HPSM may assist in obtaining translations of documents as needed. |

| ARRANGEMENT OF SERVICES | Applicable to Contract? | Notes |
|---|---|---|
| Services Provided with Cultural Competence<br>The MAO ensures that all services, both clinical and non-clinical, are accessible to all members and are provided in a culturally competent manner, including those with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds.<br>42 C.F.R. § 422.112(a)(8); Manual Ch. 4 – Section 120.2 | X | |
| Confidentiality of Member Information<br>The MAO implements procedures to ensure the confidentiality of member medical records and other member information.<br>42 C.F.R. § 422.118; Manual Ch. 4 – Section 140.1 | X | |
| No Member Discrimination in Delivery of Health Care<br>The MAO implements procedures to ensure that members are not discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.<br>42 C.F.R. § 422.110; Manual Ch. 4 – Section 100.1 and 100.3 | X | |
| Call Center Performance Standards<br>The MAO's call center meets the following call center performance standards:<br>- 80 percent of incoming calls must be answered within 30 seconds.<br>- Abandonment rate of incoming calls must not exceed 5 percent.<br>CMS Medicare Marketing Guidelines for MA, MA-PDs, PDPs, and 1876 Cost Plans, July 2006, Addendum | X | |

| PROVIDER NETWORK AND CONTRACTING | Applicable to Contract? | Notes |
|---|---|---|
| Adequate and Appropriate Provider Network<br>The MAO maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to and availability of covered services.<br>42 C.F.R. § 422.112(a)(1); Manual Ch. 4 – Section 120.2 | X | |
| Required Contract Provisions: Privacy and Confidentiality<br>The MAO's written contracts with first tier and downstream entities must contain the provisions that contracting providers agree to safeguard beneficiary privacy and confidentiality, consistent with all Federal and State laws, and ensure accuracy of beneficiary medical, health, and enrollment information and records.<br>42 C.F.R. § 422.118; Manual Ch. 11 – Section 100.4 | X | It should be noted that BHRS is considered a first tier entity, and that the contracted providers are considered downstream entities. The BHRS's contracts with providers must include the provisions indicated in this section on Provider Network and Contracting. |
| Required Contract Provision: Prompt Payment<br>The MAO's written contracts with first tier and downstream entities must contain a prompt payment provision.<br>42 C.F.R. § 422.520(b); Manual Ch. 11 – Section 100.4 | X | |
| Required Contract Provision: Hold Harmless<br>The MAO's written contracts with first tier and downstream entities must contain a provision that Medicare members are held harmless for payment of fees that are the legal obligation of the MAO.<br>42 C.F.R. § 422.504(g)(1)(i) and (i)(3)(i); Manual Ch. 11 – Section 100.4 | X | |

| PROVIDER NETWORK AND CONTRACTING | Applicable to Contract? | Notes |
|---|---|---|
| Required Contract Provisions: Abide by Federal Requirements<br>The MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information, as requested; and maintain records a minimum of 10 years.<br>42 C.F.R. § 422.504(e)(4), (h), (i)(2), and (i)(4)(v); Manual Ch. 11 – Section 100.4 | X | |
| Required Contract Provisions: Compliance with MAO's Policies and Procedures<br>The MAO's written contracts with first tier and downstream entities must specify that providers agree to comply with the MAO's policies and procedures.<br>42 C.F.R. § 422.504(i)(4)(v); Manual Ch. 11 – Section 100.4 | X | |

| CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS | Applicable to Contract? | Notes |
|---|---|---|
| <u>Correct Claim Determinations</u><br>The MAO must make correct claim determinations, which include developing the claim for additional information, when necessary, for:<br>• Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO;<br>• Ambulance services dispatched through 911;<br>• Emergency services;<br>• Urgently needed services;<br>• Post-stabilization care services; and<br>• Renal dialysis services that Medicare members obtain while temporarily out of the service area.<br>42 C.F.R. § 422.100(a) and (b)(1); § 422.132; § 422.504(g)(1); Manual Ch. 4 – Section 10.2 | X | |
| <u>Reasonable Reimbursement for Covered Services</u><br>The MAO must provide reasonable reimbursement for:<br>• Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO;<br>• Ambulance services dispatched through 911;<br>• Emergency services;<br>• Urgently needed services;<br>• Post-stabilization care services;<br>• Renal dialysis services that Medicare members obtain while temporarily out of the service area; and<br>• Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.<br>42 C.F.R. § 422.100(a) and (b)(1)-(2); Manual Ch. 4 – Section 10.2 | X | |
| <u>Timely Payment of Non-Contracting Provider Clean Claims</u><br>The MAO must pay 95 percent of “clean” claims from non-contracting providers within 30 calendar days of receipt. | X | |

| CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS | Applicable to Contract? | Notes |
|---|---|---|
| 42 C.F.R. § 422.500; § 422.520(a)(1); Manual Ch. 11 – Section 100.2 & Ch. 13 – Section 40.1 | | |
| Interest on Clean Claims Paid Late<br>If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842(c)(2)(B).<br>42 C.F.R. § 422.520(a)(2); Manual Ch. 11 – Section 100.2 | X | |
| Timely Adjudication of Non-Clean Claims<br>The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.<br>42 C.F.R. § 422.520(a)(3); Manual Ch. 11 – Section 100.2 & Ch. 13 – Section 40.1 | X | |
| Claim Denials (Notice Content)<br>If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.<br>42 C.F.R. § 422.568(d) and (e); Manual Ch. 13 – Section 40.2.2 | X | BHRS must use the template for claims denials that CMS has approved for HPSM. |
| Medicare Secondary Payer (Claims)<br>The MAO must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits.<br>42 C.F.R. § 422.108; Manual Ch. 4 – Section 80.2 | X | |

| CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS | Applicable to Contract? | Notes |
|---|---|---|
| Adverse Standard Pre-Service Organization Determinations (Timeliness)<br>If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).<br>42 C.F.R. § 422.568(a) | X | This is a request for prior authorization.<br><br>BHRS must use the template for claims denials that CMS has approved for HPSM. |
| Adverse Standard Pre-Service Organization Determinations (Notice Content)<br>If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.<br>42 C.F.R. § 422.568(d) and (e) | X | BHRS must use the template for authorization denials that CMS has approved for HPSM. |
| Receipt and Documentation of Expedited Organization Determination Requests<br>The MAO must establish an efficient and convenient means for individuals (including members, their applicable representatives, or their physicians) to submit oral or written requests for expedited organization determinations, document all oral requests in writing, and maintain the documentation in a case file.<br>42 C.F.R. § 422.570(c)(1) | X | |

| CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS | Applicable to Contract? | Notes |
|---|---|---|
| Requests for Expedited Organization Determinations (Timeliness)<br>The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice.<br><br>If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.<br>42 C.F.R. § 422.570(c)(2) and (d); § 422.572(a)-(c) | X | |
| Adverse Expedited Organization Determinations (Notice Content)<br>If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.<br>42 C.F.R. § 422.572(e) | X | BHRS must use the template for authorization denials that CMS has approved for HPSM. |
| Organization Determination Extensions (Notice Content)<br>If an extension is granted for an organization determination, the written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.<br>42 C.F.R. § 422.568(a); § 422.572(b) | X | BHRS must use the template for extension of authorization timelines that CMS has approved for HPSM. |
| Decision Not to Expedite an Organization Determination (Notice Content)<br>If the MAO decides not to expedite an organization determination, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the 14-day standard timeframe, inform the member of the right to file an | X | BHRS must use the template for denials of decisions to expedite authorizations that CMS has approved for HPSM. |

| CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS | Applicable to Contract? | Notes |
|---|---|---|
| expedited grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited determination with any physician's support, and provide instructions about the MAO grievance process and its timeframes.<br>42 C.F.R. § 422.570(d)(2) | | |
| Correctly Distinguishes Between Organization Determinations and Reconsiderations<br>The MAO must correctly distinguish between organization determinations and reconsiderations.<br>42 C.F.R. § 422.564(b); § 422.566(b); § 422.580 | X | |

| CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS | Applicable to Contract? | Notes |
|---|---|---|
| Acceptance of Standard Reconsideration Requests<br>The MAO must accept written requests for standard reconsiderations of requests for services or payment filed within 60 calendar days of the notice of the organization determination (or if good cause is shown, accepts written requests for standard reconsideration after 60 calendar days).<br>42 C.F.R. § 422.582(a)-(c) | X | |
| Appropriate Person(s) Conduct the Reconsideration<br>A person or persons who were not involved in making the organization determination must conduct the reconsideration. When the issue is a denial based on lack of medical necessity, the reconsidered determination must be made by a physician with the expertise in the field of medicine that is appropriate for the service at issue. The physician making the reconsidered determination need not be, in all cases, of the same specialty or subspecialty as the treating physician.<br>42 C.F.R. § 422.590(g)(1)-(2) | X | |
| Favorable Claims Reconsiderations (Timeliness)<br>If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.<br>42 C.F.R. § 422.590(b)(1); Manual Ch. 13 – Section 140.1.3 | X | |
| Adverse Claims Reconsiderations (Timeliness)<br>If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request.<br><br>The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.<br>42 C.F.R. § 422.590(b)(2), (c), and (e) | X | |

| CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS | Applicable to Contract? | Notes |
|---|---|---|
| <u>Effectuation of Third-Party Claims Reconsideration Reversals</u><br>If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.<br>If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.<br>42 C.F.R. § 422.618(b)(2) and (c) | X | |

| CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS | Applicable to Contract? | Notes |
|---|---|---|
| Favorable Standard Pre-Service Reconsiderations (Timeliness)<br>If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).<br>42 C.F.R. § 422.590(a)(1) | X | |
| Adverse Standard Pre-Service Reconsiderations (Timeliness)<br>If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.<br>42 C.F.R. § 422.590(a)(2) and (e) | X | |
| Effectuation of Third-Party Standard Pre-Service Reconsideration Reversals<br>If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date). The MAO must also inform the independent review entity that the organization has effectuated the decision.<br><br>If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.<br>42 C.F.R. § 422.618(b)(1) and (c) | X | |
| Receipt and Documentation of Expedited Reconsideration Requests<br>The MAO must establish an efficient and convenient means for individuals to submit oral or written requests for expedited reconsiderations, document all oral requests in writing, and maintain the documentation in a case file. | X | |

| CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS | Applicable to Contract? | Notes |
|---|---|---|
| 42 C.F.R. § 422.584(c)(1) | | |

| CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS | Applicable to Contract? | Notes |
|---|---|---|
| <u>Requests for Expedited Reconsiderations (Timeliness)</u><br>The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice.<br><br>If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified).<br><br>If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.<br><br>If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination, and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity. | X | |

| CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS | Applicable to Contract? | Notes |
|---|---|---|
| 42 C.F.R. § 422.584(c)(2) and (d); § 422.590(d)(1)-(3) and (5), (e), and (f) | | |
| Decisions Not to Expedite a Reconsideration (Notice Content)<br>If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician's support, and provide instructions about the MAO grievance process and its timeframes.<br>42 C.F.R. § 422.584(d)(2) | X | |
| Effectuation of Third-Party Expedited Reconsideration Reversals<br>If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires but no later than 72 hours after the date it receives notice reversing the determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.<br><br>If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal. The MAO must also inform the independent outside entity that the organization has effectuated the decision.<br>42 C.F.R. § 422.619(b) and (c) | X | |
| Reconsideration Extensions (Notice Content)<br>If the MAO grants an extension on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.<br>42 C.F.R. § 422.590(a)(1); 42 C.F.R. § 422.590(d)(2) | X | |

| CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS | Applicable to Contract? | Notes |
|---|---|---|
| <u>Organization Determinations and Reconsiderations Not Categorized as Grievances</u><br>The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.<br>42 C.F.R. § 422.564(b); § 422.566(b); § 422.580; Manual Ch. 13 – Sections 10.1 & 20.2 | X | |
| <u>Grievance Decision Notification (Timeliness)</u><br>The MAO must notify the member of its decision as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the complaint involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the complaint involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours.<br><br>Exception: If the member requests an extension, or if the MAO justifies a need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.<br>42 C.F.R. § 422.564(e)(1)-(2) and(f) | X | |
| <u>Grievance Decision Notification (Notice Content)</u><br>The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written complaint with the QIO.<br>42 C.F.R. § 422.564(e)(3) | X | |
| <u>Method of Grievance Decision Notification</u><br>The MAO must respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.<br>42 C.F.R. § 422.564(e)(3) | X | |