ELEVENTH AMENDMENT
TO THE
U.S. BEHAVIORAL HEALTH PLAN, CALIFORNIA
FACILITY PARTICIPATION AGREEMENT

THIS **ELEVENTH** AMENDMENT, effective on the date specified by USBHPC ("Effective Date"), is to the Behavioral Health Network Facility Participation Agreement between U.S. Behavioral Health Plan, California ("USBHPC ") and **BHC FREMONT Hospital INC.** ("Facility").

1. The Agreement is amended by deleting the current Payment Appendix in its entirety and replacing it with the attached new Payment Appendix.

2. The Agreement is amended by updating the adolescent PHP age ranges to 12-17 years old for Commercial and Medicare.

3. All other provisions of the Agreement remain in full force and effect.

The Effective Date of this Amendment is May 08, 2024
(To Be Completed By USBHPC Only)

U.S. BEHAVIORAL HEALTH PLAN, CALIFORNIA
P.O. BOX 9472
Minneapolis, MN 55440-9472

Theresa Carter
Signature (Mar 7, 2024 11:48 CST)

Theresa Carter
Associate Vice President
Network Contracting/Provider Relations
National Provider & Specialty

03/07/2024
Date

BHC FREMONT HOSPITAL INC.
39001 Sundale Drive
Fremont, CA 94538

Signature (Mar 6, 2024 15:15 PST)

Patricia W illiams
Print Name

CEO
Title

03/06/2024
Date

Federal Tax ID Number: 621658532

Medicare Number: 054110

Medicaid Number: HSM34110G

NPI: 1245346741

Effective Date May 08, 2024

(UBH purposes only)

Facility Name **BHC Fremont TIN 621658532**

Timely Filing/Submission of Claims (in days or months)

90 days	☒ Commercial
90 days	☒ Medicare
# of days/months	☐ Medicaid
# of days/months	☐ Other: _____ Please list

STANDARD PAYMENT APPENDIX

Unless otherwise provided by additional Appendices, the provisions of this Standard Payment Appendix apply to Mental Health ("MH") and/or Substance Use Disorder ("SUD") Services ("MHSUD Services" or "MHSA Services") provided by Provider to Members covered by Benefit Plans sponsored or issued by any Payor for which USBHPC has agreed to provide access to one of its networks of Facility Participating Providers. Payment of Covered Services will be paid pursuant to the applicable rate of reimbursement referenced below and applicable state claims payment laws.

Covered facility-based services contracted with a single HCPC or HCPC + CPT code must be billed on a CMS 1500 form. Covered services contracted with a Revenue Code or Revenue Code + HCPC or CPT must be billed on a UB-04 form. Failure to bill in this manner may result in a claim denial.

SECTION 1 (Fee for Service)
Definitions

Per Diem: The contracted rate of payment made to Provider for each day of an admission of a Member. The Per Diem shall be considered payment in full for all MHSUD Services provided to the Member during each day of the admission, including but not limited to, aftercare, discharge planning, ~~emergency room~~, ~~ECT IP, ECT OP, anesthesiology (which includes anesthesia and anesthesiologist)~~ EEG, EKG, laboratory/pathology, medical and surgical supplies, ~~medical history & physical~~, medications, primary therapist (non-MD), non-MD professional fees, ~~ambulance~~, psychosocial programs/services, radiology, recreational/occupational therapy, room and board charges and team meetings. Such payment is exclusive of MD fees.

Excluded ancillary services under this Section will not be reimbursed by UBH:

1) *Emergency Room – does not provide service*
2) *ECT IP, ECT OP – does not provide service*
3) *Anesthesiology – reimburse under medical plan. Optum will not pay.*
4) *Medical history & physical*
5) *Ambulance – does not provide service*

There may be instances where freestanding substance use disorder facilities may not be eligible for substance use disorder service reimbursement unless the services are covered under CMS Medicare and/or a part of the members Managed Care Plan.

SECTION 2 (Fee for Service)

MHSUD Services Provided During an Inpatient Admission. For MHSUD Services authorized by USBHPC and provided to a Member during each day of an inpatient admission, Provider shall be paid by Payor the lesser of (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the Per Diem Payment(s) set forth below, less any applicable Member Expenses. In the event an inpatient admission of a Member occurs within 24 hours of the provision of Emergency MHSUD Services, the Member shall not be charged any emergency room Member Expenses which would otherwise be applicable; and charges for such Emergency MHSUD Services shall not be billed by Provider, but shall be included in the inpatient admission charges; provided that the emergency room and inpatient services are performed at the same location.

Level of Care	**Revenue Code**	**HCPC Code**	**Per Diem Rates**	**Site Location #**
			Commercial	
MH Inpatient	**0114, 0124, 0134, 0144, 0154, 204**			
Geriatric (65 years or more)			2023- $1401 2024- $1485	1
Adult (18 to 64 years)			2023- $1401 2024- $1485	1
Adolescent (12 to 17 years)			**2024: $1485**	1
Medically Managed Intensive Services ASAM 4 [SUD Acute Inpatient Detoxification]	**0116, 0126, 0136, 0146, 0156**			
Geriatric (65 years or more)			2023- $1401 2024- $1485	1
Adult (18 to 64 years)			2023- $1401 2024- $1485	1
Adolescent (12 to 17 years)			**2024 - $1485**	1

Level of Care	**Revenue Code**	**HCPC Code**	**Per Diem Rates**	**Site Location #**
			Commercial	
Medically Monitored Intensive Inpatient Services [SUD Inpatient] ASAM 3.7	**0118, 0128, 0138, 0148, 0158**			
Geriatric (65 years or more)			2023- $1401 2024- $1485	1
Adult (18 to 64 years)			2023- $1401 2024- $1485	1
Adolescent (12 to 17 years)			2024 - $1485	1

SECTION 1 (MS-DRG)
Definitions

MS-DRG (Medicare Severity Diagnosis-Related Groups): A system of classification for inpatient hospitals services based on the principal and secondary diagnosis (including the Present on Admission indicator), surgical procedures, sex, and discharge status. For the purpose of determining the contract rate under this Appendix, the MS-DRG at discharge, as the term is defined in Final Rule, as published by CMS and most recently made effective under this Appendix, will be controlling. Until changes in the definitions are implemented under this Appendix, (as described in the previous sentence) the previous definition will apply.

1.1 Inpatient Cost Outliers (applicable if published by the State). An Admission qualifies for an Inpatient Cost Outlier when cost of case exceeds the MS-DRG specific Cost Outlier Limit. The cost of case is calculated by multiplying the CCR by Eligible Charges ("Cost of Case"). If the Cost of Case exceeds the MS-DRG specific Cost Outlier Limit, the Facility is eligible for an Inpatient Cost Outlier. The Inpatient Cost Outlier will be calculated by determining the difference between the Cost of Case and the MS-DRG specific Cost Outlier Limit, with such difference multiplied by the Adjustment Percentage, as defined by the State. The final contract rate is the sum of the calculated Inpatient Cost Outlier plus the MS-DRG contract rate.

1.2 Inpatient Day Outlier (applicable if published by the State). An Admission qualifies for an Inpatient Day Outlier when the length of stay for an Admission exceeds the MS-DRG specific Day Outlier Limit. Each MS-DRG is assigned a specific Day Outlier Limit, as determined by the State. The Inpatient Day Outlier will be calculated by determining the difference between the Average Length of Stay (ALOS) and the MS-DRG specific Day Outlier Limit, then multiply that difference by the MS-DRG specific daily rate. This product is then multiplied by the Adjustment Percentage, as defined by the State. The final contract rate is the sum of the calculated Inpatient Day Outlier plus the MS-DRG contract rate.

There may be instances where freestanding substance use disorder facilities may not be eligible for substance use disorder service reimbursement unless the services are covered under CMS Medicare and/or a part of the members Managed Care Plan.

SECTION 2 (MS-DRG)
MS-DRG MH/SA Inpatient & ECT Reimbursement

MS – DRG Payment. The Payment Method designated "MS-DRG" in this Payment Appendix is applicable to Covered Services rendered to a Member for an entire Admission or episode of care. The contract rate is determined by applying the MS-DRG Payment method, less any applicable Member Expenses, is payment in full for all Covered Services rendered to the Member including, but not limited to, Physician and other professional fees billed by the Facility on an Institutional Claim (UB04 form), services rendered by non-Physician personnel (regardless of whether those personnel are employed by the Facility and regardless of whether those services are characterized as professional services), "readmission diagnostic and non-diagnostic services" (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, after care, anesthesiology, discharge planning, emergency room, ECT, EEG, EKG, laboratory/pathology, medical and surgical supplies, medical history & physical, medications, ambulance, psychosocial programs/services, radiology, recreational/occupational therapy, room and board charges and team meetings.

Level of Care	Revenue Code	HCPC Code	Base Rate	Site Location #
			Medicare	
MH Inpatient	**0114, 0124, 0134, 0144, 0154, 204**			
Geriatric (65 years or more)			2023- 100% of published CMS (Medicare) 2024- 100% of published CMS (Medicare)	1
Adult (18 to 64 years)			2023- 100% of published CMS (Medicare) 2024- 100% of published CMS (Medicare)	1
Adolescent (12 to 17 years)			2024: 100% of published CMS (Medicare)	1
Medically Monitored Intensive Inpatient Services [SUD Inpatient] ASAM 3.7	**0118, 0128, 0138, 0148, 0158**			
Geriatric (65 years or more)			2023- 100% of published CMS (Medicare) 2024- 100% of published CMS (Medicare)	1
Adult (18 to 64 years)			2023- 100% of published CMS (Medicare) 2024- 100% of published CMS (Medicare)	1
Adolescent (12 to 17 years)			2024: 100% of published CMS (Medicare)	1
Medically Managed Intensive Inpatient Services ASAM 4 [SUD Acute Inpatient Detoxification]	**0116, 0126, 0136, 0146, 0156**			
Geriatric (65 years or more)			2023- 100% of published CMS (Medicare) 2024- 100% of published CMS (Medicare)	1
Adult (18 to 64 years)			2023- 100% of published CMS (Medicare) 2024- 100% of published CMS (Medicare)	1
Adolescent (12 to 17 years)			2024: 100% of published CMS (Medicare)	1

SECTION 1 (APR-DRG)
Definitions

APR-DRG (All Patient Refined Diagnosis-Related Groups): An inpatient hospital classification system that classifies patients according to their reason of admission, severity of illness and risk of mortality. For purposes of determining the contract rate under this Appendix, the APR-DRG at discharge will be controlling.

1.1 **Inpatient Cost Outliers (applicable if published by the State).** An Admission qualifies for an Inpatient Cost Outlier when cost of case exceeds the APR-DRG specific Cost Outlier Limit. Pursuant to State mandate only, if the Cost of Case exceeds the APR-DRG specific Cost Outlier Limit, the Facility may be eligible for an Inpatient Cost Outlier. The Inpatient Cost Outlier may be determined by applicable state methodology for payment. The final contract rate is the sum of the calculated Inpatient Cost Outlier plus the APR-DRG contract rate.

1.2 **Inpatient Day Outlier (applicable if published by the State).** An Admission qualifies for an Inpatient Day Outlier when the length of stay for an Admission exceeds the APR-DRG specific Day Outlier Limit. Each APR-DRG is assigned a specific Day Outlier Limit, as determined pursuant to State mandate only. The Inpatient Day Outlier may be determined by applicable state methodology for payment. The final contract rate is the sum of the calculated Inpatient Day Outlier plus the APR-DRG contract rate.

There may be instances where freestanding substance use disorder facilities may not be eligible for substance use disorder service reimbursement unless the services are covered under CMS Medicare and/or a part of the members Managed Care Plan.

SECTION 2 (APR-DRG)
APR-DRG MH/SA Inpatient & ECT Reimbursement

APR–DRG Payment. The Payment Method designated "APR-DRG" in this Appendix and applicable to Covered Services rendered to Member for an entire Admission. Unless otherwise specified in this Appendix, payment under the APR-DRG Payment Method, less any applicable Member Expenses, is payment in full for all Covered Services rendered to the Member including, but not limited to, Physician and other professional fees, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), individual, group or family therapy, preadmission services related to the Admission (as defined by USBHPC) that occur prior to Admission, after care, anesthesiology, discharge planning, emergency room, ECT, EEG, EKG, laboratory/pathology, medical and surgical supplies, medical history & physical, medications, ambulance, psychosocial programs/services, radiology, recreational/occupational therapy, room and board charges and team meetings.

Partial Hospitalizations/Day Treatment Programs for MHSUD Services. For MHSUD Services that are authorized by USBHPC and provided to a Member during an admission for a partial hospitalization/day treatment program, Provider shall be paid by Payor the lesser of (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the Per Diem Payment(s) set forth below, less any applicable Member Expenses.

Level of Care	Revenue Code	HCPC Code	Per Diem Rates		Site Location #
			Commercial	Medicare	
Partial Hospitalization Full Day	**0912, 0913**		2023- $562 2024- $595	2023 - $500 2024- $500	1
MH Geriatric (65 years or more)			2023- $562 2024- $595	2023 - $500 2024- $500	1
MH Adult (18 to 64 years)			2023- $562 2024- $595	2023 - $500 2024- $500	1
MH Adolescent (12-17 years)			**2024- $595**	**2024- $500**	
SUD Partial Hospitalization ASAM 2.5	**0912, 0913**				
Geriatric (65 years or more)			2023- $562 2024- $595	2023 - $500 2024- $500	1
Adult (18 to 64 years)			2023- $562 2024- $595	2023 - $500 2024- $500	1
Adolescent (12 to 17 years)			**2024- $595**	**2024- $500**	1

Intensive Outpatient Treatment Programs. For MHSUD Services that are authorized by USBHPC and provided to a Member during each day of an admission for an intensive outpatient mental health and/or substance use disorder treatment program, Provider shall be paid by Payor the lesser of (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the Per Diem Payment(s) set forth below, less any applicable Member Expenses. The charges for the assessment and aftercare are included in the per diem and shall not be billed separately by Facility/Provider.

Level of Care	Revenue Code	HCPC Code	Per Diem Rates		Site Location #
			Commercial	Medicare	
MH IOP	**0905**				
MH Geriatric (65 years or more)			2023- $280 2024- $297	2023- $250 2024- $250	1
MH Adult (18 to 64 years)			2023- $280 2024- $297	2023- $250 2024- $250	1
MH Adolescent (12 to 17 years)			**2024- $297**	**2024- $250**	1
SUD IOP ASAM 2.1	**0906**				
Geriatric (65 years or more)			2023- $280 2024- $297	2023- $250 2024- $250	1
Adult (18 to 64 years)			2023- $280 2024- $297	2023- $250 2024- $250	1
Adolescent (12 to 17 years)			**2024- $297**	**2024- $250**	1

Site Locations

(For Internal Use Only)

Address Types:

P = Primary
M = Mailing/Notice
S = Service
R = Remit

Site #	Address Type	Address	Address 2	City	State	Zip	Business Phone	Secure Fax #	Effective Date	Term Date
1	P, S, M	39001 Sundale Dr.		Fremont	CA	94538	510-796-1100			

BHC Fremont Hsp_AMD11_Pay App_Adol Age Range_Final

Interim Agreement Report 2024-03-07

Created:	2024-02-23
By:	Al Alvidera (al.alvidera@uhc.com)
Status:	Out for Filling
Transaction ID:	CBJCHBCAABAAnK8gzMrdstybtfYj8J81Pf_PxVfLYcst

Agreement History

Agreement history is the list of the events that have impacted the status of the agreement prior to the final signature. A final audit report will be generated when the agreement is complete.

"BHC Fremont Hsp_AMD11_Pay App_Adol Age Range_Final" History

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