

MEMORANDUM

April 16, 2020

TO: Mayor John P. Kahl and Members of the City Council

FROM: City Attorney's Office (Scott A. Brunton)

SUBJECT: Resolution Approving Utilization Management and Case Management Service Agreement for the City's Group Health Care Plan

DISCUSSION:

As part of the City Insurance & Benefits Committee's annual review of the City's Group Health Care Plan (the "Plan"), the Insurance & Benefits Committee also reviews from time to time the various contracts required for administration of the Plan and Plan benefits. One of these administrative contracts for the Plan includes an agreement for utilization management and case management services to assist the City's third party administrator for the Plan (Consociate) with these specialized services. This service agreement provides specialized large case management, utilization review, and pre-certification services for the Plan, which are critical for controlling costs under the Plan and for coordinating benefits with the City's reinsurance carrier. Additionally, this contract provides critical patient-orientated services for Plan participants who are experiencing difficult and challenging medical and mental health issues.

The Insurance & Benefits Committee has reviewed the contract for these important administrative services for the Plan and for Plan participants and has determined that entering into a new contract with Precedence, Inc. for these services will benefit the Plan and Plan participants by providing additional services not currently received by the Plan or Plan participants, providing excellent patient contact services, and creating anticipated cost savings for the Plan. Thus, the Insurance & Benefits Committee is recommending approval of a two-year contract with Precedence Inc. for these administrative services for the City's Plan.

RECOMMENDATION:

The Insurance & Benefits Committee, as well as our office, recommends that the Council pass this Resolution.

c: Teresa Durm
Jeff Becker
Dennis R. Triggs

RESOLUTION NO. 1920-141

East Peoria, Illinois

_____ , 2020

RESOLUTION BY COMMISSIONER _____

**RESOLUTION REGARDING THE UTILIZATION MANAGER
FOR THE CITY'S GROUP HEALTH INSURANCE PLAN**

WHEREAS, the City of East Peoria maintains a self-insured group health care plan ("Plan") for the benefit of its employees and retirees, and the City's Insurance and Benefits Committee oversees the Plan; and

WHEREAS, the City utilizes a third party administrator for administration of benefits under the Plan, with Consociate Inc. continuing to assist the City and the Plan as the Plan's third party administrator; and

WHEREAS, in addition to the third party administrator, the City also contracts for utilization management services to assist the third party administrator and the Plan with specialized large case management, utilization review services, and pre-certification services for the Plan, which are significant and valuable services for controlling costs incurred by the Plan; and

WHEREAS, the City's Insurance and Benefits Committee ("Insurance Committee") has reviewed the utilization management services for the Plan and determined that contracting with Precedence, Inc. ("Precedence") for utilization management services will provide additional services, excellent patient contact services, and potential cost savings for the Plan; and

WHEREAS, the Insurance Committee unanimously recommends that the City enter into a new two-year contract with Precedence for utilization management services that include specialized large case management, utilization review services, and pre-certification services for the Plan;

NOW, THEREFORE, BE IT RESOLVED BY THE COUNCIL OF THE CITY OF EAST PEORIA, TAZEWELL COUNTY, ILLINOIS, THAT:

Section 1. The City adopts the recommendation made by the Insurance and Benefits Committee, as set forth above, thereby approving the Service Agreement with Precedence, attached as "Exhibit A", which will be effective from May 1, 2020, through April 30, 2022.

Section 2. The Mayor, or his designee, is hereby authorized and directed to execute the Service Agreement with Precedence, attached as "Exhibit A", together with

such changes therein to the Agreement as the Mayor in his discretion may deem appropriate; provided, however that such Agreement shall not be binding upon the City until an executed original thereof has been delivered to Precedence. Furthermore, the Mayor shall be authorized to execute any agreement or documentation that is ancillary to fulfilling the terms and intent of the attached Service Agreement with Precedence.

APPROVED:

Mayor

ATTEST:

City Clerk

EXHIBIT A

Service Agreement with Precedence Inc.

UTILIZATION AND CASE MANAGEMENT AGREEMENT

This Utilization and Case Management Agreement (the “Agreement”) is entered into effective May 1st, 2020 (the “Effective Date”), by and between City of East Peoria, an Illinois municipal corporation (“City”) and Precedence, Inc. (“Precedence”). The City and Precedence shall collectively be referred to as the “Parties” and each separately as a “Party”.

Recitals

WHEREAS, the City maintains a self-funded Group Health Care Plan for employees and retirees of the City of East Peoria (the “Plan”), which provides for payment of certain benefits to and for certain eligible individuals as defined by the Plan’s master plan document(s), such individuals being referred to herein as “Participant(s)”; and

WHEREAS, the Plan is an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended (“ERISA”); and

WHEREAS, the City, as of the Effective Date, desires to retain Precedence to perform Medical and Behavioral Utilization Management, Case Management and appeals services for the Plan.

NOW THEREFORE, in consideration of the mutual covenants and agreements herein contained, the Parties agree as follows:

ARTICLE I PRECEDENCE OBLIGATIONS

1.1 Utilization Management and Case Management Services. Precedence shall provide the Plan with Utilization Management and Case Management Services as described in Exhibit 1.

1.2 Preauthorization, Concurrent, Retrospective Review, and Appeals

1.2.1. Pre-Service, Concurrent and Retrospective Review. Precedence shall be responsible for requests for prior authorization, concurrent and retrospective review of services, where required by the Plan, and also for concurrent review of ongoing care as required by and in accordance with Precedence’s Utilization Management procedures. In cases where Precedence denies a request for payment authorization (“Pre-Service”), or determines that an ongoing course of treatment should be reduced or terminated (“Concurrent Care Denials”), Precedence shall notify the Participant and the Network Provider of the denial and the Participant’s right to appeal the denial in accordance with the Plan, and in the time and manner set forth under ERISA and the regulations thereunder.

1.2.2. Pre-Service Appeals. Precedence shall process appeals of Pre-Service and Concurrent Care Denials in the time and manner required by Precedence’s internal and external appeals process, set forth in the Precedence, Inc. Quality Improvement/Utilization Management Program, a copy of which is attached hereto as Attachment 1 of Exhibit 1). Precedence shall timely provide all necessary information to the Plan or if applicable, to any Independent Review Organization (“IRO”) handling external reviews for the Plan, in order for the Plan, as may be applicable, to timely process any external claims appeals.

1.2.3. Fiduciary Appointment. The Plan hereby appoints Precedence as a named, ERISA fiduciary under the Plan with respect to performing (1) reviews of Pre-Service and concurrent care benefit determinations and (2) internal appeals of such determinations. As such, the Plan delegates to Precedence the discretionary authority to (i) construe and interpret the terms of the Plan, and (ii) make final determinations regarding the authorization or continuing authorization of services under the Plan's internal appeal process. Precedence acknowledges and agrees that, with respect to Section 503 of ERISA, Precedence will be the "appropriate named fiduciary" of the Plan but only to the extent described in this section for purposes of reviewing denied Pre-Service Appeals or Concurrent Care Denials under the Plan. In addition, Precedence shall be responsible for providing the notices required by ERISA section 503 and regulations promulgated thereunder, including notice of an adverse benefit determination, and the right to appeal same, and notice of an adverse determination on appeal. All such notices shall comply with ERISA's requirements.

1.2.4. External Reviews. Precedence acknowledges that the Plan has contracted with IROs for the performance of standard and expedited external claims review services in accordance PPACA. Precedence will timely provide all documents and information considered in the appeals process to the Plan or IRO, as applicable, and will notify claimants of the option to request an external review of adverse benefit determinations following the required internal appeal process described in the Plan. Precedence will, in accordance with applicable law, including PPACA, provide claimant with the necessary procedures to obtain the review.

1.3 Integration and Data Management. Precedence will devise and implement a system that is acceptable to the Plan to notify the Third Party Administrator of services that Precedence has authorized for payment under this Agreement. In addition, Precedence will interface with Network and Network Providers, as applicable, regarding its medical management and utilization management determinations under this Agreement. Finally, Precedence will use reasonable efforts to work with the Plan, the Plan's Third Party Administrator and, as appropriate, the Plan's other vendors, to establish detailed integration protocols and processes.

1.4 Insurance. Precedence shall maintain fiduciary liability insurance that covers itself and Precedence with limits of \$2,000,000 annual aggregate, as well as general liability and professional liability insurance of at least \$3,000,000 annual aggregate. Failure to secure and maintain such insurance or self-insurance, in sufficient amounts to cover any and all claims arising hereunder shall constitute a material breach of this Agreement. Upon request, Precedence shall submit to the Plan evidence of insurance and will notify the Plan promptly of any revocation or termination of such policy.

1.5 Standard of Care. To the extent that it acts as fiduciary under ERISA, Precedence agrees to perform its Services under this Agreement in accordance with the standard of care applicable to fiduciaries under ERISA. With respect to non-fiduciary Services, Precedence will perform all of such Services with the care, skill, prudence and diligence that an expert third party administrator would exercise under similar circumstances.

ARTICLE II THE PLAN'S OBLIGATIONS

2.1 Participant Identification Cards. For Participants who will receive Covered Services, the Plan agrees to include, or to cause its Third Party Administrator to include the Precedence name and telephone number on the back of the Participant identification card.

2.2. Authority over Plan. Unless otherwise specifically provided under the terms of this

Agreement, the City (as the “Plan Administrator”) retains full and final authority and responsibility for the Plan and its operation. Precedence is empowered to act on behalf of the Plan, but only as expressly stated in this Agreement or as mutually agreed upon in writing by the Parties.

2.3 Payment of Fees. The City shall pay Precedence for its Services under this Agreement as set forth in Section 1.C of Exhibit 1.

ARTICLE III TERM AND TERMINATION

3.1 Term. The initial term of this Agreement shall be twelve (12) months (the “Initial Term”) and this Agreement shall thereafter renew for one successive one (1) year term (a “Renewal Term”) unless terminated as provided herein.

3.2 Termination for Convenience. Either Party may terminate this Agreement without cause upon at least one hundred (120) days’ written notice to the other Party.

3.3 Termination for Breach. Either Party may terminate this Agreement for a material breach by the other party by giving the breaching party thirty (30) days written notice of the breach. The breaching party may cure the breach during the thirty (30) day period. If the breach is cured to the satisfaction of the non-breaching party, the Agreement shall remain in full force and effect. If the breach is not cured to the satisfaction of the non-breaching party, at the end of the thirty (30) day period, the non-defaulting party may declare by written notice that this Agreement shall terminate upon receipt of the written notice.

3.4 Termination for Insolvency. This Agreement will automatically terminate upon the declaration of insolvency, bankruptcy or receivership, or cessation of business by Precedence or the termination of the Plan.

3.5 Survival. If this Agreement is terminated or expires, its provisions will continue in effect with respect to the following sections: X (Confidentiality); X (Insurance), X (Audits), X (Use of Name), X (Governing Law), and X (Indemnification).

ARTICLE IV INDEMNIFICATION

4.1 Plan’s Indemnification. The City agrees to indemnify and hold harmless Precedence its officers, directors, agents, and employees from any and all suits, judgments, awards, debts, penalties, costs, claims, including any damages, losses, liabilities or expenses (including without limitation court costs and reasonable attorneys’ fees) which may be suffered or incurred under this Agreement as a result of (i) a material breach of the Plan’s obligations set forth in this Agreement, (ii) a material breach of Plan’s representations, warranties and/or covenants set forth in this Agreement, (iii) any acts that are negligent, fraudulent or criminal in carrying out its duties pursuant to this Agreement, unless such claim, liability, cost, loss, expense or damage results from Precedence’s breach of the applicable standard of care. Said indemnity is in addition to any other rights that the Precedence may have against the Plan and will survive termination of this Agreement.

4.2 Precedence’s Indemnification. Precedence will indemnify, defend and hold harmless the Plan Administrator, the City, the Plan, the Plan’s trustees, and the Plan Sponsor (including its respective

affiliates and subsidiaries and its and their officers, directors, employees, agents, consultants, successors and assigns) (collectively, "Plan Affiliates") from any and all suits, judgments, awards, debts, penalties, costs, claims, including any damages, losses, liabilities or expenses (including without limitation court costs and reasonable attorneys' fees) as a result of (i) a material breach of Precedence's obligations set forth in this Agreement, (ii) a material breach of any of Precedence's representations, warranties and/or covenants set forth in this Agreement, (iii) any acts or omissions of Precedence that are negligent, fraudulent or criminal in carrying out its duties pursuant to this Agreement; or (iv) Precedence's breach of the applicable standard of care in carrying out its duties pursuant to this Agreement. Said indemnity is in addition to any other rights that the Plan Affiliates may have against Precedence and will survive termination of this Agreement.

ARTICLE V RECORDS, REPORTS AND AUDIT RIGHTS

5.1 Record Retention. Precedence shall retain electronic records of its Pre-Service and Pre-Service Appeals determinations and other Plan information that comes into Precedence's possession for a period of seven (7) years from the date that the record is created or received by Precedence, and shall abide by the Business Associate Agreement between Plan and Precedence, effective May 1, 2020 (the "BAA"), which is expressly incorporated herein by reference, with respect to such information. All Plan Claim records in the possession of Precedence are and shall remain the property of the Plan upon termination of this Agreement, and shall be returned to the Plan or its designee unless the Parties mutually agree that return is infeasible, in which case Precedence shall retain the records and extend the protections required by HIPAA. At the end of seven (7) years' retention of records by Precedence stated herein, Precedence may destroy any records not returned to the Plan, provided that Precedence shall first give the Plan sixty (60) days' written notice of Precedence's intention to destroy such records in order to allow the Plan the opportunity to take possession of such records if it so chooses. Precedence will provide the Plan with reasonable access to its records while this Agreement is in effect and for a period of three (3) years following termination of this Agreement.

5.2. Reports. Precedence shall provide the Plan with reports and information in accordance with Section 1.C of Exhibit 1.

5.3. Audit. Upon reasonable prior written notice to Precedence, and subject to a mutually agreeable audit plan and process between the Plan and Precedence, the Plan or its designee shall have the right to audit Precedence's Care Management and Utilization Management Services, which for clarity, include Pre-Service and Appeals.

ARTICLE VI CONFIDENTIAL AND PROPRIETARY INFORMATION

6.1 Confidentiality and HIPAA.

6.1.1 Precedence recognizes that it will be provided with protected health information or PHI, as that term is defined in the Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), regarding Participants in the course of providing Services under this Agreement. Precedence will safeguard PHI to ensure that no Participant, no employee of Precedence or any other person who does not need to know such information has access to such information. All Claim information, including but not limited to medical records, received by Precedence in the performance of its duties hereunder, will be kept confidential by

Precedence in accordance with the Parties' BAA.

6.1.2 Upon request, Precedence shall release information in its possession in accordance with the terms of the Parties' BAA, if the information relates to Precedence's Services under this Agreement, and the Plan gives Precedence reasonable advance notice and an explanation of the need for such information, provided, however that any such release shall not be required if prohibited or restricted by applicable laws or regulations, including the Privacy Rule.

6.1.3 Precedence acknowledges that it is a business associate of the Plan and shall abide by the requirements of the parties' Business Associate Agreement effective May 1, 2020, a copy of which is attached to this Agreement as Exhibit 2 and incorporated herein by reference.

6.2 Marketing and Use of Data. Precedence shall not contact Participants for marketing purposes without the Plan's express, prior written permission. In addition, except as otherwise provided in Exhibit 1, Precedence agrees not to conduct any customer satisfaction surveys of Participants. Further, Precedence shall not sell or use PHI except as permitted in the Parties' BAA. Precedence may use non-individually identifiable information regarding Participants that has been de-identified in accordance with HIPAA's requirements for data compilations and reports, including, but not limited to statistical reports, cost containment analyses, and claims studies as long as Precedence does not use or disclose such individually identifiable information in any manner other than is necessary to perform its Services under this Agreement or as required by law.

6.3 Proprietary Information. As a result of this Agreement, each party and its respective agents and contractors may have access to information of a proprietary nature owned or licensed by the other, for example without limitation, information regarding the other Party's systems, programs, processes, methods, finances, volume of business, manuals, contracts, the reimbursement rates of any healthcare providers contracted with Network, the terms of this Agreement, and any other material specifically labeled as confidential, etc. (referred to herein collectively as "Proprietary Information"). Both parties acknowledge that the Proprietary Information of the other party has great value to the other and, if disclosed or used in violation of this provision, would cause the other party immediate and irreparable harm. Both parties agree to not disclose to anyone or use for their own benefit any Proprietary Information of the other except as otherwise permitted by this Agreement and to take reasonable precautions to prevent disclosure to any third party. The parties agree that upon termination of this Agreement each party shall upon written request promptly return or destroy all Proprietary Information of the other party.

ARTICLE VII REPRESENTATIONS AND WARRANTIES

7.1 Precedence and the Plan each is properly organized and operated to undertake its duties as described in this Agreement and has secured and will maintain any and all licenses, certifications, or other authorizations required to conduct its business in the manner contemplated by this Agreement. Precedence and the Plan each has secured all authorizations necessary to execute this Agreement and the officer or employee signing this Agreement on behalf of Precedence and the Plan is authorized to do so and accordingly does bind Precedence and the Plan.

7.2 Precedence and the Plan each will act in compliance with all applicable laws and regulations that relate to Precedence's performance or the Plan's obligations pursuant to this Agreement. In addition, Precedence shall maintain a corporate compliance program or plan and make the program or plan available to the Plan upon request.

ARTICLE VIII
MISCELLANEOUS PROVISIONS

8.1 Independent Contractor. Precedence is an independent contractor with respect to the Plan, and nothing in this Agreement shall create or be construed to create, a joint venture, partnership, or employer/employee relationship between the parties hereto, nor shall either party's agents, officers or employees be considered or construed to be employees of the other party for any purpose whatsoever. In addition, neither party shall have any power or authority to act for or on behalf of, or to bind the other except as expressly granted, and no other or greater power or authority shall be implied by the grant or denial of power or authority specifically mentioned.

8.2 Force Majeure. In the event the operations of Precedence's facilities or a substantial portion thereof are interrupted by war, fire, explosion, insurrection, riots, government requirement, civil or military authority, pandemic or widespread infectious disease, flood, the elements, earthquakes, acts of God, act or omission of transportation, energy, utility or communication facilities, services or companies, or other similar causes beyond its control, the provisions of this Agreement shall be suspended for the duration of such interruption. Should a substantial part of the services be interrupted pursuant to such event for a period in excess of fifteen (15) days, the Plan shall have the right to terminate this Agreement effective upon five (5) days written notice to Precedence.

8.3 No Obligation to Continue Plan. Nothing in this Agreement shall constitute an obligation on the part of City to continue to offer the Plan, Plan benefits, or any specific type of benefit under the Plan to its Participants, and the City retains the right to terminate or amend the Plan at any time.

8.4 Counter Parts. This Agreement may be executed in counterparts and, when taken together with the other signed counterpart, shall constitute one agreement which shall be binding upon and effective as to all signatory Parties.

8.5 Amendment. The Parties may amend this Agreement upon mutual consent of both Parties by executing an Amendment to this Agreement signed by both parties.

8.6 Severability. In the event one or more of the provisions contained in this Agreement are declared invalid, illegal, or unenforceable in any respect, the validity, legality, and enforceability of the remaining provisions shall not in any way be impaired thereby unless the effect of such invalidity is to substantially impair or undermine either party's rights and benefits hereunder.

8.7 Assignment and Subcontracting. This Agreement is personal to the Parties and may not be assigned or transferred, nor may any of the duties and responsibilities of the Parties be assigned, r transferred or subcontracted, without the written consent of both Parties which shall not be unreasonably withheld or delayed.

8.8 Waiver. The failure of either Party to insist in any one or more instances upon performance of any terms or conditions of this Agreement shall not be construed as a waiver of future performance of any such term, covenant, or condition; but the obligations of such Party with respect thereto shall continue in full force and effect.

8.9 Recitals. The recitals are intended to describe the intent of the Parties and the circumstances under which this Agreement is executed and shall be considered in the interpretation of this Agreement.

8.10 Applicable Law. The validity, interpretation and performance of this Agreement shall be governed and construed in accordance with the laws of the State of Illinois to the extent not preempted by ERISA or other federal law; provided however that with respect to Precedence's conduct in providing the Medical Management and Behavioral Health Services described in Exhibit 1 and Attachment 1 thereto (other than claims and appeals services, which are governed by ERISA), the laws of the State of Illinois, as applicable, shall govern, without regard to choice of law principles.

8.11 Entire Agreement. This Agreement constitutes the entire agreement between the Parties with respect to the subject matter hereof and supersedes all prior written and oral statements and understandings relating thereto.

8.12 Headings. The headings of the various sections of this Agreement are inserted merely for the purpose of convenience and do not expressly or by implication limit, define or extend the specific terms of the section so designated.

8.13 No Third Party Beneficiaries. This Agreement will be construed to confer no rights whatsoever on any third parties, including Participants, Network, Network Providers, or other individuals or entities.

8.14 Notices. Any notice required pursuant to this Agreement shall be in writing, and shall be sent by certified or registered mail or courier, return receipt requested, to the Plan or Network Provider at the address set forth below. The notice shall be effective on the date indicated on the return receipt. Such addresses may change from time to time by written notice to the other party.

To the Plan:

City of East Peoria
401 West Washington Street
East Peoria, IL 61611
Attention: Mayor

To Precedence:

Precedence, Inc.
1409 East Kimberly Road
Davenport, IA 52807
Attention: Dennis Duke, President RYC

9.15 Negotiation of Disputes. Resolution of disputes shall be subject to good faith negotiation between the parties. The complaining party shall notify the other party in writing of such dispute and the parties shall meet attempting in good faith to resolve the dispute within thirty (30) days of the date of such notice, or within such time as is mutually agreed upon in writing by the parties. In the event the dispute is not resolved within such time period, it may, in lieu of court action, with mutual written agreement submitted in writing to a mutually agreed upon mediator who shall recommend a resolution of the dispute to the Parties. The mediation shall be conducted at a time and place mutually agreed to by the Parties. The expense of engaging a mediator shall be shared equally by the Parties. Each Party shall be solely liable for all other costs it incurs related to mediation, including the payment of attorney's fees. In lieu of mediation, either Party may pursue such other remedies as may be available at law or in equity, including court action.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by their duly authorized representatives.

PRECEDENCE, INC.

By: _____
Print Name: _____
Title: _____

CITY OF EAST PEORIA

By: _____
Print Name _____
Title: _____

EXHIBIT 1
TO
UTILIZATION AND CASE MANAGEMENT AGREEMENT
BETWEEN
CITY OF EAST PEORIA GROUP HEALTH CARE PLAN
AND
PRECEDENCE, INC.

This Exhibit 1 outlines the roles & responsibilities associated with the assumption of medical management and behavioral health utilization and case management services by Precedence and the Plan's payment for such services. . This Exhibit 1 also incorporates the Quality Improvement (QI) Program and the Utilization Management (UM) Program as described and set forth in Attachment 1 hereto.

1. Medical Management and Behavioral Health Services. In addition to reviewing and deciding Pre-Service requests and Pre-Service Appeals as described in the Agreement, Precedence shall provide the services listed in Sections 1A-1C below ("Services") for the fees set forth in Section 4. Precedence shall not be entitled to any additional compensation for its Services except as may be mutually agreed in writing by Precedence and the Plan. Precedence's procedures with respect to its Behavioral Health Utilization Management and Medical Utilization and Case Management Services are set forth in Attachment 1, hereto.

A. Behavioral Health Services - Levels of care to be managed include the following:

Behavioral Health:

- Inpatient Facility
- Intensive outpatient program (IOP)
- Partial hospital program (PHP)
- Partial hospital with boarding
- Electro convulsive treatment (ECT)
- Psychological testing over 3 hours

Chemical Dependency:

- Detoxification
- Residential
- Inpatient facility
- Intensive outpatient program (IOP)
- Partial hospital program (PHP)
- Partial hospital with boarding

B. Medical Utilization and Case Management Services. Precedence shall conduct Utilization Management services, including medical management for all levels of care for medical services considered Covered Services under the Unity Point ACP, including inpatient, outpatient, professional services, and ancillary services.

In addition, if a Participant requests a service that Precedence determines to be Medically Necessary but the service is not available in the Network from Network Providers, Precedence shall refer the Participant to the University of Iowa Clinic (which shall be

treated as a Network Provider for purposes of the ACP Network Agreement) or to one of the Plan's Centers of Excellence.

Precedence's Medical Management services include the following:

Utilization Management Care, including:

- Coordination of prior authorization process
- Initial payment prior authorization
- Review of admissions
- Concurrent review
- Discharges
- Post-discharge services
- Discharge follow-up

Case Management

- Coordination of appropriate care for those requiring more comprehensive care and/or resources

Clinic Care Management

- Utilizing clinic care managers when appropriate

In addition, if a Participant requests a service that Precedence determines to be Medically Necessary but the service is not available in the Network from Network Providers, Precedence shall refer the Participant to the University of Iowa Clinic (which shall be treated as a Network Provider for purposes of the ACP Network Agreement) or to one of the Plan's Centers of Excellence.

C. Reporting Services. Precedence will provide quarterly reports to Plan which include:

- Response time to phone calls
- Timeliness of clinical decisions
- Number of behavioral health and medical admissions
- Average lengths of inpatient stays
- Readmission rate
- Any denials or complaints
- Quality improvement activities
- Enrollee satisfaction with access, provider location, provider selection, treatment progress, and cultural diversity

If more frequent reporting is requested or additional reporting needs are identified by the Plan, Precedence will make reasonable efforts to cooperate with Plan to provide the additional information.

2. Fees.

A. Per Employee Per Month Payment. To compensate Precedence for the Services outlined in this Agreement, the Plan agrees to pay Precedence a fee equal to \$10.88 Per Employee Per Month ("PEPM") for each Participant that is covered under the Unity Point ACP (the "Monthly PPEM Payment"). The Plan will self-report and pay this amount by the 30th of the month following the month in which the Services are rendered. The payment for the month shall be calculated by multiplying the number of employees by \$10.88.

The sum of the Monthly PEPM Payments for any Measurement Period (as defined below) shall be referred to as the Annual Care Management Fees.

Payments not made via electronic funds transfer should be mailed to the following address:

Robert Young Center
Attn: Jill Westhoff, CFO
4600 3rd Street
Moline IL 61265

- B. Fee Adjustments. Upon request of Precedence, Plan and Precedence will meet no more than annually to review the fees payable under this Agreement. No change shall take effect absent the Plan's express written consent.

ATTACHMENT 1 to EXHIBIT 1

PRECEDENCE, INC.

QUALITY IMPROVEMENT/UTILIZATION MANAGEMENT PROGRAMS

PROGRAM DESCRIPTIONS

QUALITY IMPROVEMENT PROGRAM:

PURPOSE: The purpose of the Precedence Quality Improvement (QI) Program is to monitor and improve the quality of clinical care and services that are delivered to our clients and consumers. It addresses the needs of our internal and external customers. The program addresses both clinical and non-clinical services.

GOVERNING BOARD: The Precedence Board of Directors is responsible for the organizational governing of the QI/UM program. Annually the Chairman of the Board of Directors reviews and approves the QI/UM program description, QI/UM work plan and the annual QI/UM evaluation. The board grants the QI/UM committee authority for Precedence's quality management.

QUALITY IMPROVEMENT COMMITTEE: The QI Committee provides oversight and guidance for the quality management program. The committee is comprised of content experts. It is the duty of the QI committee to design and operate a program which is comprehensive and functional. The QI duties include: evaluating the effectiveness of the program at least annually; recommending policy decisions; identifying, designing, approving, reviewing, and re-evaluating QI project activities; monitoring progress in meeting the QI goals; providing guidance to staff on quality management priorities and projects; along with identifying actions to improve services and guarantee that identified and needed actions are carried out.

- The QI Committee meets, at a minimum, quarterly. Clear and accurate QI minutes are taken at each meeting. These minutes include the date, discussion, and actions taken by the committee. Each set of minutes are typed and signed. Approved records of all committee meetings are maintained. They are available before the next QI meeting.
- The QI Committee develops the annual QI work plan, monitors its progress, analyzes its data and initiates action plans to correct opportunities to improve quality of care, service or meet acceptable levels of performance measures.
- When applicable, the committee includes at least one participating provider or receives input from participating providers
- The committee conducts the annual QI evaluation.
- The QI/UM Committee reports to the Board of Directors.

PRECEDENCE MEDICAL DIRECTOR: -The Medical Director has oversight and responsibility for the overall operation of the QI/UM, and serves on the QI/UM committee. At times the Medical Director may delegate some of his/her duties.

PRECEDENCE DIRECTOR OF MANAGED CARE - The Director is responsible to collect monthly data as outlined in the QI/UM work plan. The director compiles this information for monthly reports, which are then submitted to the QI/UM Committees.

ANNUAL QUALITY IMPROVEMENT WORK PLAN - Annually the QI/UM Committees design a QI work plan. This plan includes a program scope, along with objectives and approaches utilized in the QI activities for the year. These activities are designed for improvement of health, clinical care, and services to our members. A timeline is identified for each activity, which includes how each activity will be monitored. A designated person is identified to be responsible for each activity. The plan also includes the annual evaluation of the QI work plan as one of its activities.

QUALITY IMPROVEMENT PROCESS: Precedence Inc. implements a systemic, evidence-based quality improvement process that includes:

- Selection of quality indicators
- Defined performance metrics
- Defined and regular performance measurement and reporting timeframes
- Measurements of process, errors/adverse events/near misses, satisfaction of population served, complaints, access or outcome trends using valid and accurate methods
- Implementation of activities designed to improve identified problems, including reduction of errors/adverse events/near misses, or indication that Precedence has met acceptable levels of performance.

QUALITY IMPROVEMENT ACTIVITIES – A minimum of two QI projects are identified yearly to promote continuous quality improvement, supporting organizational efforts to maintain and refine client and consumer services.

The following areas are addressed by the QI work plan on an annual basis:

1. Clinical Scope Activity: A minimum of two clinical activities are determined yearly. The activities include at least one clinical issue from inpatient, outpatient or ambulatory services. When a QI project is clinical in nature, QI documents demonstrate the involvement of a senior clinical staff person in the judgments about the use of clinical quality measures and clinical aspects of performance.

2. Ensure the following policies and procedures are being adhered to:

- a) Availability of Practitioners
- b) Accessibility of Service Standards
- c) Continuity of Care

3. Customer satisfaction:

A.) Satisfaction surveys are conducted with the member population or a representative sample. Members are surveyed annually on:

- a) Organizational services
- b) Accessibility, availability, and acceptability of healthcare practitioners' programs and services.
- c) Satisfaction of logistic and cultural needs being met.

B.) Complaints and appeals are tracked and reported on quarterly. These complaints and appeals are organized into the following categories: denial of care, denial of diagnostic procedure,

denial of referral request, sufficient choice and accessibility of health care providers, underwriting, marketing and sales, claims and utilization review, member services, provider relations, quality of care, provider complaints, and miscellaneous.

C.) Review and updating of staff scripts.

D.) Reporting timeliness of utilization management decisions and notifications. Precedence monitors and reports quarterly adherence to the time standards including authorizations for: urgent concurrent, urgent pre-service, non-urgent pre-service and post service requests. The percentages of compliance to the time frames are reported to the quality improvement committee.

4. Patient Safety Issues: Precedence identifies at least two activities to help monitor and or improve client safety.
5. Corporate compliance: Trainings are conducted on compliance along with signed statements and adherence.

MEASUREMENT OF ACTIVITIES: The QI activities identified by the QI Committee are documented, measured, and evaluated using the following:

- a) Areas to assess or improve quality are identified and prioritized.
- b) Strategies to improve the identified area(s) for improvement are designed and implemented.
- c) Valid and reliable data are collected in a methodically sound manner using the affected population, or a sample identified in the activity.
- d) Measurements are identified to evaluate the performance of the activities. To demonstrate that an improvement is measurable, a sound study is used which includes:
 - i. A clear rationale which is relevant to the target population.
 - ii. A clear statement of purpose.
 - iii. Measure baseline level of performance.
 - iv. Clear timeframes for meeting the identified goals.
 - v. Appropriate, quantifiable measures to establish acceptable levels of performance.
 - vi. Document changes or improvements related to the baseline measurement.
 - vii. Re-evaluate level of performance at least annually.
 - viii. Analysis of data and target actions for improvement.
- e) Goals are identified for each activity.
- f) Once the data are collected, measured, and compared to the goal and benchmark, the information is then analyzed and compared to previous performance, if one exists.
- g) The data is reported back to the QI/UM committee, as well as any relevant staff through the QI/UM meeting minutes and staff meeting agendas.
- h) The QI/UM Committee analyzes the data in order to identify whether the performance is adequate, or if administrative barriers to quality are found.

- i) If barriers are found, an action plan is developed to address these barriers.

INTERVENTION AND FOLLOW UP FOR CLINICAL ISSUES: When an opportunity is identified which could improve quality, Precedence develops QI/UM activities to address the areas. The QI/UM Committee then addresses the effectiveness of the activities, along with the revisions of ineffective activities. Periodic re-measurement of the level of performance is monitored for as long as necessary to ensure sustained improvement.

The QI/UM Committee identifies areas for improvement. These areas are identified through routine quality improvement reporting, which include tracking and trending complaints logs, appeal logs, access to service and satisfaction surveys. Other areas identified may come from suggestions by providers, primary care physicians, members, and/or staff.

The QI/UM Committee selects which areas to address. The basis for the selection is documented in the QI/UM meeting minutes. Once the area is identified an activity is designed, measured and analyzed. Based on the analysis, interventions are then identified to address improving either practitioner or system performance. These interventions are then measured for effectiveness. The interventions are to begin early enough, and to specifically identify causes of poor quality, to facilitate some positive change.

The original area identified for Quality Improvement is then re-measured to evaluate the effectiveness of the intervention.

DATA MANAGEMENT:

- a) Supports performance indicator collection, analysis, and reporting.
- b) Includes data management whereby the organization:
- c) Selects performance indicators and sets quantified metrics that are used to establish acceptable levels of performance.
- d) Benchmark identified performance.
- e) Collects analyses and ensures data integrity prior to integrating data that is used to manage key work processes.

EFFECTIVENESS OF THE QUALITY IMPROVEMENT / UTILIZATION MANAGMENT

PROGRAM: Precedence evaluates its QI/UM program annually. The annual written QI/UM evaluation includes the following:

- a) Description of the QI/UM activities, both complete and ongoing.
- b) An evaluation of progress made on each activity.
- c) An analysis summary outlining improvement made in the quality of healthcare and services to our members.
- d) Whether resources were adequate and appropriate
- e) Whether the right people were involved
- f) Assessment of the program impact. Did the program make a difference?

Upon request, members, medical healthcare providers/relevant medical delivery systems and panel practitioners may receive information about the QI/UM program. This would include a description of

the QI/UM program, the annual goals, and progress on those goals.

UTILIZATION MANAGEMENT PROGRAM:

PURPOSE: Precedence has a well-structured utilization management (UM) program that makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner. The UM Program has decision-making structures and processes in place along with a clear designation of responsibility and accountability.

APPROVAL OF THE PROGRAM: This program was originally reviewed and approved on May 26th, 2016 by the UM committee. The most recent review and approval occurred on 1/15/19.

UTILIZATION MANAGEMENT COMMITTEE: The committee consists of a minimum of the senior level Precedence physician, a health care practitioner and Precedence program manager. The committee meets at a minimum of quarterly. Minutes are taken of each meeting. Urgent issues that arise between meetings will be assigned to the Director of Precedence who may delegate to an appropriate subcommittee. The UM committee is combined with the Quality Improvement committee.

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION: The Precedence UM program includes the following:

- a) A Written description of the program structure
- b) The healthcare aspects of the program
- c) Involvement of a designated senior physician in the UM program implementation
- d) The program scope and process used to determine benefit coverage and medical necessity
- e) Information sources used to determine benefits coverage and medical necessity
- f) The process for an annual evaluation, approval and revisions, if applicable, the UM program and the staff assigned each activity.

UM PROGRAM STRUCTURE:

UM Staff assigned activities: Triage and referral decisions that require clinical judgment are made by Care Managers who are licensed in the United States and, at a minimum, are a master's degree level mental health therapists or Registered Nurses. In cases where a clinical utilization management decision is needed by a specialist outside of the utilization management staff expertise, an outside expert is used. Initial screenings involve non-clinical administrative staff's ability to authorize or non-certify payment to providers for health services which do not require evaluation or interpretation of clinical data.

UM Staff who has authority to deny coverage: Decisions for denials are based on medical or clinical necessity by a Board Certified licensed psychiatrist, licensed doctorate level clinical psychologist, or certified addiction medicine specialist. Clinical peer reviewers are licensed in the United States. Benefit denials may be done by Care Managers, UM Technicians or Care Coordinators.

Involvement of an assigned health care practitioner: Involvement of an assigned psychologist or psychiatrist to participate in the UM program and committee meetings.

Process for evaluating, approving and revising the UM program, and the staff responsible for each step: The Utilization Management program is designed yearly, which includes the item, measurement, date for

completion and assigned staff responsible. The UM program is and reviewed quarterly by the UM committee and evaluated annually.

The UM programs role in the Quality Improvement (QI) program: The following UM reports are generated monthly and are analyzed by the Quality Improvement team to ensure no over or underutilization is taking place:

1. inpatient acute care days
2. member complaints
3. appeals
4. recidivism and average length of stay
5. chart reviews

The process for handling appeals and appeal determinations (in addition to any requirements set forth in the Agreement):

If a care request is denied by a Peer Reviewer, specific reasons for the denial are conveyed to the member and provider/facility in accordance with the Plan and ERISA's requirements. The member and provider are informed of the appeals procedures in accordance with the Plan and ERISA's requirements.

All members and providers/facilities are educated on the appeal process. The appeal is conducted by an appeal reviewer who was not involved in the initial determination. During this first level of appeal, a full investigation of the case is made which includes all clinical care in question. Documentation is collected on the reason for the appeal and the action taken.

If the member is dissatisfied with the appeal findings, and the appeal is eligible for federal external review, the member or its authorized representative may request an external, independent review by an IRO who issues the final determination.

HEALTHCARE ASPECTS OF THE PROGRAM:

- 1) The utilization management functions include:
 - a. Triage and referral services
 - b. Review of benefit coverage
 - c. Authorization and denial of requests for payment for inpatient and outpatient mental health and substance abuse services
- 2) Utilization management authorization requests may be made by telephone, fax, email or mail
- 3) Utilization management services are provided to all identified members needing health services. Members are identified on the enrollment material provided to Precedence. A secondary identifier is asked to verify the enrollee.
- 4) Provider participation is verified.
- 5) If a member does not know which provider they would like to receive services from, the Care Manager/Intake Coordinator will review appropriate options. The Utilization Review (UR) staff will take into consideration provider specialties and geographical location to the member.
- 6) Level of care criteria are utilized in making clinical care determinations.
- 7) Care Managers who conduct clinical reviews have access to consult with a psychiatrist or health

professional with the same educational and licensure category of the ordering provider.

- 8) Members are referred to the least restrictive level of care utilizing medical necessity criteria.
- 9) On inpatient cases, information regarding continued stay is provided verbally and an authorization letter is sent once the client is discharged. The Precedence Care Manager documents confirmation of authorizations for continued hospitalization or services in the client's chart. This documentation includes the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services. This data and other pertinent case information are available to Precedence authorized staff.
- 10) Discharge planning is conducted while the client is inpatient to help coordinate outpatient care and follow up appointments.
- 11) No authorization is required for a second opinion by an in-network provider. However, upon request, Precedence will review in-network options or coordinate obtaining an out-of-network expert if one is not available on the provider panel.
- 12) Utilization reviews are typically conducted by telephone. However, occasionally a Care Manager may review an inpatient chart at the hospital where the client is hospitalized. In such cases, the utilization management (UM) staff provide picture identification with full name and Precedence name to show hospital personnel.
- 13) On-site reviews are scheduled at least one day in advance, unless otherwise agreed upon by Precedence and hospital personnel.
- 14) Precedence Care Manager reviewers follow reasonable hospital/facility procedures so as not to interfere with hospital/facility operations. This includes checking in with the designated personnel.
- 15) Data collected during onsite reviews are kept confidential and secure.
- 16) The frequency of reviews is based on the complexity of the patient status, and /or necessary discharge planning and not routinely conducted on a daily basis.
- 17) Precedence staff collects only the information needed to authorize payment for the admissions, continued stay, procedure or treatment length of stay, or frequency or duration of service.
- 18) Care Managers do not routinely require hospitals, physicians, or other providers to numerically code diagnoses or procedures to be considered for payment authorization, however they may request such codes if available.
- 19) The Care Managers do not routinely request copies of medical records in all client reviews.
- 20) When client medical records are requested, Precedence only requires copies of the sections relevant to the authorization of payment.
- 21) When making determinations based on medical necessity, only information reasonably necessary to make the decision is requested.
- 22) The collection of information is shared on a need to know basis within Precedence so as to avoid different Precedence departments requesting duplicate copies of the record
- 23) Prospective and concurrent review decisions are based on the information available at the time the service is requested
- 24) Retrospective reviews are based on the information available to the provider at the time the care was provided.
- 25) During clinical utilization management reviews, if the information does not meet utilization management criteria for authorization the provider is given an offer to speak with a peer reviewer.

- 26) A Peer Reviewer is a health professional who is qualified, as determined by the Medical Director or Clinical Director, to make a clinical determination regarding a medical condition, procedure or treatment and;
- a) Is a clinical peer; and
 - b) Holds an active, current, unrestricted valid license to practice medicine or health profession in the United State(s); (unless expressly allowed by state and federal law or regulation, are located in a state of the United States when conducting a peer clinical review) and
 - a. Is of the same licensure category as the ordering provider; and
 - b. Is in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate; and
 - c. Is board certified by the *American Board of Medical Specialties* (Doctor of Medicine) or the *Advisory Board of Osteopathic Specialists from the Major Areas of Clinical Services* (Doctor of Osteopathic Medicine); and
 - c) Is neither the individual who made the original denial, nor a subordinate of such an individual.
 - d) Current Peer Reviewers listing: Tom Hansen MD, Tony Thrasher MD, Robert Sharpe MD, Shane Moisiso MD, Sean Weldon MD, Christina Girgis MD, Kimberly Sanders MD, and Prashanth Tamragouri MD.

SENIOR LEVEL PHYSICIAN INVOLVEMENT: An assigned senior health care practitioner supervises the Utilization Management program. The senior level physician's responsibilities may include, but are not limited to:

- 1. Setting utilization management policies.
- 2. Implementing the Utilization Management program
- 3. Providing oversight of the program
- 4. Supervising program operations.
- 5. Reviewing UM cases.
- 6. Participating in the UM Committee.
- 7. Evaluating the overall effectiveness of the UM program.

DESIGNATED HEALTHCARE PRACTITIONER INVOLVEMENT:

A designated healthcare practitioner is actively involved in the healthcare aspects of the UM program. This practitioner may be a designated healthcare physician, or a doctoral-level healthcare practitioner is involved in implementing and evaluating the healthcare aspects of the UM program. The practitioner duties include:

- 1. Establish UM policies and procedures relating to healthcare.
- 2. Review and decision making of UM healthcare cases.
- 3. Participate in UM Committee meetings.

PROCESS USED TO MAKE DETERMINATIONS:

For Precedence commercial book of business, written medical necessity criteria have been developed with the input and approval of local mental health practitioners. The effectiveness and appropriateness of the criteria are reviewed as needed. However, the Quality Improvement program conducts an annual formal review of the medical necessity level of care criteria.

Utilization management decisions are based on written criteria, along with input from the attending provider and primary care physician when appropriate. Utilization management decisions take into account the following:

1. urgency of the situation
2. presence of suicidal or homicidal thinking
3. presence of psychosis
4. ability of the local delivery system to meet the identified needs
5. age of the member
6. progress in treatment, if applicable
7. complications
8. home environment, if applicable
9. any other pertinent information

Utilization management decisions are based on information collected from any reasonably reliable source including the member, their family, provider and primary care physician when appropriate.

The following are considered when applying criteria to each client case in order to determine appropriate level of care:

1. Age
2. Co-morbidities
3. Psychosocial situation, including home environment (as applicable)
4. Medical history
5. Mental health and substance use History
6. History of present illness
7. Presenting symptoms
8. Current clinical status/progress
9. Plan of care
10. Emergency department treatment
11. Current treatment
12. Complications
13. Level of care criteria
14. Disposition
15. Discharge Plan
16. Information regarding condition and instructions at prior discharge if re-admission is at the same facility
17. Any other pertinent information

Orientation of Utilization Management staff includes training in application of utilization management

criteria. Yearly in-services for all staff are also conducted to ensure consistent application of UM criteria.

Monthly quality assurance chart reviews are conducted on all Care Managers. The reviews are conducted to evaluate whether the utilization management criteria are being followed consistently, and whether each client's specific needs are being met.

The monthly random review outcomes are reflected in the Care Manager's performance evaluations.

The names and qualifications of the participants involved in the development of the utilization management criteria are documented in the Quality Improvement minutes.

The Precedence behavioral health criteria are based on current principles and processes and are reviewed and evaluated yearly by licensed health providers.

Precedence utilized Milliman Care Guidelines (MCG) for medical level of care criteria.

Medical necessity criteria are reviewed and updated yearly by actively participating providers. The names and qualifications of the providers called upon to review the criteria are documented in the quality improvement minutes.

Utilization Management criteria and application are reviewed, updated and approved yearly by the Quality Improvement Committee.

Updated criteria and policies are distributed to all clinical staff.

Providers may obtain the Utilization Management/Level of Care criteria upon request by calling our Utilization Management staff. This is conveyed to all providers in their provider manual.

Enrollees and providers may obtain the Utilization Management/Level of Care criteria upon request by calling our Utilization Management staff. This is conveyed to all enrollees in the 'Rights and Responsibilities'.

Precedence, or its contracted delegate, administers an inter-rater reliability (IRR) test at a minimum of annually to the Utilization Management Review Staff who utilize criteria/guidelines and Plan policies when making medically necessary determinations for requested services.

BENEFIT COVERAGE: Decisions about coverage for medical benefits are defined by the Plan's Summary Plan Description, Level of Care criteria, and eligibility files. The Plan determine the sources of information to be used to determine coverage.

None of the plans Precedence administers have a pre-existing clause for behavioral health.

If the member is an eligible Participant, a service is a Covered Service and the clinical situation meets Plan's Medical Necessity criteria, the service is authorized for payment.

DENIALS:

Benefit denial: The requested service is expressly excluded from the Plan as a non-covered service or the member is not an eligible Participant.

Medical Necessity denial:

a.) Covered medical benefits: When the Plan covers the Participant's service but Precedence denied authorization due to the service not meeting Medical Necessity criteria.

b.) Experimental treatments: Precedence denies a service due to its experimental nature,

however the provider reports the service as not being experimental. (If the specific experimental treatment is excluded from the benefit package, it cannot be appealed, i.e. smoking cessation.)

PROCESS FOR AN ANNUAL EVALUATION OF THE UM PLAN

A.) ANNUAL UTILIZATION MANGEMENT WORK PLAN - Annually the UM Committee designs an UM work plan. This plan includes a program scope, along with identifying objectives and approaches to be utilized in the UM activities for the year. These activities are designed to determine whether the UM program remains current and appropriate.

A time-line is identified for each activity below, which includes how each activity will be monitored, with a designated person responsible for the activity:

- a) The program structures.
- b) Evaluation of the work plan
- c) The program scope, processes and information sources used to determine benefit coverage and medical necessity.
- d) The level of involvement of the senior-level physician and designated healthcare practitioner in the UM program.
- e) Inpatient acute care days
- f) Member complaints
- g) Appeals
- h) Recidivism and average length of stay
- i) Chart reviews

B.) EFFECTIVENESS OF THE UTILIZATION MANAGMENT PROGRAM: Precedence senior utilization management staff and the Utilization Management Committee evaluate the UM program annually, and the Director of UM Operations presents the annual evaluation and necessary revisions to the program description to the Utilization Management Committee for review and approval. The annual written evaluation includes the following:

- a) Evaluation of program structure
- b) Evaluation of program scope, processes, information sources used to determine benefit coverage and medical necessity
- c) Evaluation of the level of involvement of the senior-level physician and designated healthcare practitioner in the UM program.
- d) Consideration of consumer and practitioner experience data.
- e) Description of the UM activities, both complete and ongoing.
- f) An evaluation of progress made on each activity.

EXHIBIT 2
TO
UTILIZATION MANAGEMENT AGREEMENT
BETWEEN
CITY OF EAST PEORIA GROUP HEALTH CARE PLAN
AND
PRECEDENCE, INC.

[Replace this page with Business Associate Agreement]

**EXHIBIT 2
BUSINESS ASSOCIATE AGREEMENT**

THIS BUSINESS ASSOCIATE AGREEMENT (“Agreement”) amends and is made a part of all Services Agreement(s) (as defined below) between the City of East Peoria, a Covered Entity under HIPAA (“Covered Entity”) and Precedence, Inc., its Business Associate (“Business Associate”). This Agreement is effective on the same date as the Utilization and Case Management Agreement between the Covered Entity and the Business Associate.

1. Definitions. Terms used but not otherwise defined in this Agreement shall have the meaning ascribed in section 160.103, 164.501, or elsewhere, in the Regulations.
 - a. **“Breach”** means, with respect to PHI, the impermissible acquisition, access, use or disclosure of Unsecured PHI which compromises the security or privacy of the PHI.
 - b. **“Business Associate Functions”** means all functions performed by Business Associate under one or more Service Agreements which involve the creation, receipt, transmission or maintenance of PHI on behalf of Covered Entity by Business Associate or its agents or subcontractors.
 - c. **“Covered Entity”** means a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered under the HIPAA regulations.
 - d. **“ePHI”** means PHI that is maintained or transmitted in electronic media.
 - e. **“HIPAA”** means the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §§ 1320d to 1320d-7, and future amendments thereto and the Regulations issued thereunder.
 - f. **“PHI”** means protected health information as defined in the Regulations, which is created, obtained or used by Business Associate in the performance of one or more Business Associate Functions for Covered Entity.
 - g. **“Regulations”** means the final Regulations implementing the provisions of HIPAA as amended from time to time. The Regulations are presently codified at 45 C.F.R. Parts 160 and 164.
 - h. **“Services Agreement(s)”** means all agreements, whether written or oral, and whether now in effect or hereafter entered into, between Covered Entity and Business Associate for the performance of Business Associate Functions by Business Associate.
 - i. **“Security Incident”** means the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system.
 - j. **“Unsecured PHI”** means PHI that has not been rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.

2. Purpose. HIPAA requires Covered Entity to obtain satisfactory written contractual assurances from its business associates before furnishing them with PHI or permitting them to obtain or create PHI to perform Business Associate Functions. HIPAA also requires Business Associate to obtain similar contractual assurances from any agents or subcontractors who will create, receive, use or disclose PHI to perform Business Associate Functions on behalf of the Business Associate. This Agreement is intended to provide Covered Entity with the contractual assurances required under HIPAA.
3. Permitted Uses and Disclosures of PHI. Business Associate shall only use and disclose PHI as permitted or required under this Agreement or as required by law. Business Associate shall not, and shall ensure that its employees, agents and subcontractors do not, use or disclose PHI received from Covered Entity in any manner that would constitute a violation of HIPAA or state privacy law if used or disclosed by Covered Entity. To the extent Business Associate carries out any of Covered Entity's obligations under HIPAA, Business Associate shall comply with the requirements of HIPAA that apply to Covered Entity in the performance of such obligations. Without limiting the generality of the foregoing, Business Associate is permitted to use or disclose PHI as set forth below:
 - a. Business Associate may use PHI to perform Business Associate Functions.
 - b. Business Associate may use or disclose PHI as needed for the proper management and administration of Business Associate and to carry out the legal responsibilities of Business Associate. Disclosures for the purposes in Section 3(b) must be either:
 - i. Required by law; or
 - ii. Made pursuant to Business Associate obtaining reasonable assurances from the person to whom the PHI is disclosed that the PHI will: (1) remain confidential and will only be used or further disclosed as required by law or for the purposes for which it was disclosed to the person; and (2) the person will notify Business Associate in writing of any instances of which it is aware in which the confidentiality of the PHI has been breached.
 - c. Business Associate may use PHI to provide Data Aggregation services relating to the Health Care Operations of Covered Entity if required or permitted under the Services Agreement.
 - d. Business Associate may, if expressly permitted in writing by Covered Entity or in the Services Agreement, de-identify PHI, provided that such de-identification meets the applicable HIPAA requirements set out in 45 CFR 164.514(a)-(c). In accordance with any additional terms in the Services Agreement, Business Associate may disclose properly de-identified data that no longer meets the definition of PHI.
4. Obligations of Business Associate. Business Associate agrees to:
 - a. Comply with all applicable requirements of Title XIII, Subtitle D of the Health Information Technology for Economic and Clinical Health (HITECH) Act, codified at 42 U.S.C. §§17921-17954, and comply with all regulations issued by the Department of Health and Human Services (HHS) to implement HITECH. Such requirements are hereby incorporated by reference into this Agreement.

- b. Use and disclose PHI only as permitted or required by this Agreement, or as otherwise required by law. Business Associate shall not use or disclose information in a manner that would violate any applicable law if done by a Covered Entity.
- c. Use appropriate safeguards to prevent use or disclosure of PHI other than as provided for in this Agreement. In addition, Business Associate shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of ePHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate shall comply with the HIPAA Security Rule with respect to ePHI.
- d. Report to Covered Entity, without unreasonable delay, but in no event later than five (5) business days from discovery by Business Associate, any use or disclosure of PHI not provided for in this Agreement by Business Associate, its employees, agents or contractors or by a person to whom Business Associate disclosed PHI under Section 3 of this Agreement (each, an "Unauthorized Use or Disclosure"), including any Unauthorized Use or Disclosure that is a Breach of Unsecured PHI, or any Security Incident. Such notice shall include:
- i. any remedial or mitigating action taken or proposed to be taken, or further investigation planned with respect to the Unauthorized Use or Disclosure or Security Incident;
 - ii. the results of a risk assessment conducted by Business Associate with respect to the Unauthorized Use or Disclosure or Security Incident to determine if there is a low probability that the PHI has been compromised;
 - iii. a brief description of how the Unauthorized Use or Disclosure or Security Incident occurred and how and when it was discovered; and
 - iv. a description of whether Unsecured PHI was involved in the Unauthorized Use or Disclosure or Security Incident.
- e. Cooperate with Covered Entity, at Covered Entity's direction, in making any required notification to individuals in the case of a Breach (as determined by Covered Entity).
- f. Reimburse Covered Entity for all costs, expenses, damages and other losses resulting from any breach of this Agreement, Unauthorized Use or Disclosure, Security Incident or Breach involving PHI maintained by Business Associate, including, without limitation: costs incurred by Covered Entity in investigation of such an occurrence; fines or settlement amounts owed to a state or federal government agency; the cost of any notifications to Individuals or government agencies; credit monitoring for affected Individuals for a one year period (if reasonable and appropriate under the circumstances); or other mitigation steps taken by Covered Entity to comply with HIPAA or state law.
- g. Cooperate with Covered Entity in taking reasonable steps to mitigate, to the extent practicable, any harmful effects of any Unauthorized Use or Disclosure, Breach of Unsecured PHI, or Security Incident.

- h. Enter into a written agreement meeting the requirements of 45 C.F.R. §§ 164.504(e) and 164.314(a)(2) with each subcontractor (including, without limitation, a subcontractor that is an agent under applicable law) that creates, receives, maintains or transmits PHI on behalf of Business Associate. Business Associate shall ensure that the written agreement with each subcontractor obligates the subcontractor to comply with restrictions and conditions that are the same as the restrictions and conditions that apply to Business Associate under this Agreement.
- i. Promptly notify Covered Entity in the event that Business Associate either (i) enters into an arrangement contemplated under Section 4(h) with a subcontractor that is subject to the jurisdiction of any country other than the United States, or (ii) intends to perform the Business Associate Functions at locations outside of the United States. Such notification shall include, at a minimum, the name of any subcontracted entity, the location where Business Associate Functions shall be performed, and a description of the safeguards in place as required by this Agreement to prevent an Unauthorized Use or Disclosure. If Business Associate fails to provide such notice or if Covered Entity, in its sole discretion, determines the planned safeguards are insufficient to protect the PHI, Covered Entity may terminate this Agreement immediately upon written notice.
- j. Within five (5) business days of a request by Covered Entity for access to PHI about an Individual contained in any Designated Record Set of Covered Entity maintained by Business Associate, Business Associate shall make available to Covered Entity such PHI for so long as Business Associate maintains such information in the Designated Record Set. If Business Associate receives a request for access to PHI directly from an Individual, Business Associate shall forward such request to Covered Entity within five (5) business days.
- k. Notify Covered Entity within five (5) business days of any request by individuals to amend PHI maintained by Business Associate in designated record sets, direct the requesting individual to Covered Entity for handling of such request, cooperate with Covered Entity in the handling of such request, and incorporate any amendment accepted by Covered Entity in accordance with §164.526 of the Regulations. Business Associate is not authorized to independently agree to any amendment of PHI.
- l. Maintain a record of those disclosures of PHI by Business Associate or its agents or subcontractors which are subject to the individual's right to an accounting under §164.528 of the Regulations, and report such disclosures to Covered Entity within five (5) business days of request by Covered Entity in a form permitting Covered Entity to respond to an individual's request for an accounting.
- m. Make its internal practices, books and records relating to the use and/or disclosure of PHI available to the Secretary of HHS or his or her designees for purposes of determining the parties' compliance with the Regulations.
- n. Comply with any restriction on use or disclosure of PHI accepted by Covered Entity under § 164.522(a) of the Regulations which is properly communicated to Business Associate, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

- o. Comply with any reasonable limitation in the Covered Entity's notice of privacy practices, publicly available at the Covered Entity website, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
 - p. Comply with any reasonable requests by individuals under § 164.522(b) of the Regulations to receive communications of PHI by alternative means or at alternate locations when communicated to Business Associate by Covered Entity or directly by the individual.
 - q. Limit the request for, and use and disclosure of, PHI for purposes described in this Agreement to the minimum necessary to perform the required Business Associate Function(s) or other permitted purpose. Business Associate shall comply with any additional requirements for the determination of minimum necessary as are required from time to time by the Regulations, as amended.
 - r. Obtain and maintain throughout the term of this Agreement reasonable commercial insurance to cover the liabilities which may arise from the activities and obligations contemplated herein, with coverage amounts of no less than one million dollars (\$1 million) per occurrence and three million dollars (\$3 million) in the aggregate, and list Covered Entity as an additional insured on such policy.
5. Qualified Service Organization Responsibilities. To the extent that Business Associate provides services under this Agreement to a program that is subject to the regulations at 42 CFR Part 2, the following additional requirements apply:
- a. Business Associate acknowledges and agrees that in receiving, storing, processing or otherwise dealing with any patient records from a program subject to 42 CFR Part 2, Business Associate is fully bound by the regulations set forth at 42 CFR Part 2, including without limitation all privacy and security restrictions; and
 - b. Business Associate shall comply with Part 2 in responding to judicial requests to obtain access to patient identifying information related to substance use disorder diagnosis, treatment, or referral for treatment. This may require Business Associate to resist the judicial request, if necessary. Business Associate shall only disclose Part 2 records in response to judicial requests as permitted by Part 2.
6. Responsibilities of Covered Entity. Covered Entity agrees to:
- a. Notify Business Associate promptly if Covered Entity agrees to any restrictions on the use or disclosure of PHI which will affect Business Associate's use or disclosure of PHI under the Services Agreement.
 - b. Notify Business Associate of any reasonable requests by individuals under §164.522(b) of the Regulations to receive communications of PHI by alternative means or at alternative locations, if such requests will affect Business Associate's services.
 - c. Provide Business Associate with a copy of any amendment to PHI which is accepted by Covered Entity under §164.526 of the Regulations which Covered Entity believes will apply to PHI maintained by Business Associate in Designated Record Sets.

7. Supervening Law. Upon the enactment of any law or regulation affecting the use or disclosure of PHI, or the publication of any decision of a court of the United States or of this state relating to any such law, or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, Covered Entity may, by written notice to Business Associate, amend this Agreement in such manner as it determines necessary to comply with such law or regulation. If Business Associate disagrees with any such amendment, it shall so notify Covered Entity in writing within thirty (30) days of Covered Entity's notice. If the parties are unable to agree on an amendment within thirty (30) days thereafter, either party may terminate the Services Agreement on not less than thirty (30) days' written notice to the other. If not so terminated, the amendment or amendments proposed by Covered Entity shall become effective.

8. Term and Termination.
 - a. *Term.* This Agreement shall continue in effect until all obligations of the parties have been met, including return or destruction of all PHI in Business Associate's possession (or in the possession of Business Associate's agents and subcontractors), unless sooner terminated as provided herein. The terms and conditions of this Agreement designed to safeguard PHI shall survive expiration or other termination of the Services Agreement and shall continue in effect until Business Associate has performed all obligations under this Agreement and no longer retains any PHI.

 - b. *Termination by Covered Entity.* Notwithstanding any contrary provision of the Service Agreement(s), Covered Entity may terminate the Services Agreement and this Business Associate Agreement upon thirty (30) days' advance written notice to Business Associate in the event that Business Associate materially breaches this Agreement and such breach is not cured to the reasonable satisfaction of Covered Entity within such thirty (30) day period. If Business Associate does not take reasonable steps to cure the breach during such period, Covered Entity may terminate this Business Associate Agreement and the Services Agreement immediately upon written notice.

 - c. *Termination by Business Associate.* If Business Associate determines that Covered Entity has materially breached this Agreement, Business Associate shall notify Covered Entity and provide Covered Entity an opportunity to cure the alleged material breach upon mutually agreeable terms. If Covered Entity does not take reasonable steps to cure the breach during such period, Business Associate may terminate this Business Associate Agreement immediately upon written notice.

 - d. *Return/Destruction of PHI upon Termination.* Upon termination of the Service Agreement(s) or this Business Associate Agreement, business Associate shall, if feasible, either return or destroy (and not retain a copy) any and all PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity. In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the parties that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

9. **Miscellaneous.**

a. *Covered Entity.* For purposes of this Agreement, and as applicable to the Business Associate Functions of Business Associate under all Services Agreements covered by this Agreement, references to Covered Entity shall include the named Covered Entity and all other entities covered by a joint Notice of Privacy Practices with Covered Entity, whether as part of an affiliated covered entity or an organized health care arrangement.

b. *Notice.* Any notice required herein may be delivered via mail, certified mail, or electronic mail if delivered to the address provided by each party below, provided that each party may notify the other of a new preferred address at any time by delivering such notice in accordance with this provision:

To the Covered Entity:
City of East Peoria Health
401 West Washington Street
East Peoria, IL 61611
Attention: Teresa Durm, HR Director

To the Business Associate:
Precedence, Inc.
1409 East Kimberly Road
Davenport, IA 52807
Attention: Dennis Duke, President RYC

c. *Survival.* The respective rights and obligations of Business Associate and Covered Entity hereunder shall survive termination of this Agreement with respect to any PHI obtained or maintained by Business Associate under this Agreement.

d. *Interpretation; Amendment.* This Agreement shall be interpreted and applied in a manner consistent with Covered Entity's obligations under HIPAA. All amendments shall be in writing and signed by both parties, except that this Agreement shall attach to additional Services Agreements entered into between the parties in the future without the necessity of amending this Agreement. This Agreement is intended to cover the entire Business Associate *relationship* between the parties, as amended, from time to time, through Services Agreements or other means.

e. *Waiver.* A waiver with respect to one event shall not be construed as continuing, or as a bar to or waiver of any right or remedy as to subsequent events.

f. *No Third-Party Beneficiaries.* Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and their respective successors or assigns, any rights, remedies or obligations.

g. *Effect.* The provisions of this Agreement shall control with respect to PHI Business Associate receives from or on behalf of Covered Entity, and the terms of this Agreement shall supersede any conflicting or inconsistent terms and provisions of the Services Agreement.

h. *Counterparts.* This Agreement may be executed in multiple counterparts, each of which shall be deemed an original but both of which together shall constitute one and the same instrument. Copies of signatures sent by facsimile transmission or scanned and sent by email are deemed to be originals for purposes of execution and proof of this Agreement.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf.

CITY OF EAST PEORIA

PRECEDENCE, INC.

By: _____

By: _____

Print Name: _____

Print Name: _____

Print Title: _____

Print Title: _____

Date: _____

Date: _____

EXHIBIT 3
TO
UTILIZATION MANGEMENT AGREEMENT
BETWEEN
CITY OF EAST PEORIA GROUP HEALTH CARE PLAN
AND
PRECEDENCE, INC.

SPD to be inserted here.