AMENDMENT TO AGREEMENT

This Amendment To Agreement ("**Amendment**") is hereby made and entered into by and between [INSERT APPLICABLE HUMANA ENTITIES] ("**Humana**"); **and** [INSERT PROVIDER ENTITY'S NAME] ("**Physician**").

WHEREAS, the parties entered into a [INSERT TYPE OF AGREEMENT] Participation Agreement which was effective as of _____ ("**Agreement**");

WHEREAS, to the extent that this Amendment conflicts with the terms and conditions of the Agreement, including any prior amendments, addenda, exhibits, or attachments, this Amendment controls the relationship between the parties with respect to the Medicaid HMO line of business;

WHEREAS, references to "**Physician**" herein are to the contracted provider of health care services as specified above and, as applicable, his/her/its employed or contracted providers who provide health care services under the Agreement; **and**

WHEREAS, any term not otherwise defined herein shall have the meaning as set forth in the Agreement.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree to amend the Agreement as follows:

1. The Recitals set forth above are hereby incorporated by reference into this Amendment.

2. "Medicaid HMO Plans" is added either to the Product Participation List Attachment (or its equivalent) or, if the Agreement contains no Product Participation List Attachment, to the Agreement as a plan type in which the Provider agrees to participate.

3. The attached Medicaid Required Provisions Attachment is hereby attached to the Agreement and incorporated therein by reference.

4. The attached Primary Care Provider (PCP) Responsibilities Attachment is hereby attached to the Agreement and incorporated therein by reference.

5. The attached HMO Provisions Attachment is hereby attached to the Agreement and incorporated therein by reference.

6. The attached Medicaid Payment Provisions Attachment is hereby attached to the Agreement and incorporated therein by reference.

Except as specifically amended hereby, all other terms and conditions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the parties have the authority necessary to bind the entities identified herein and have executed this Amendment to be effective as of _____.

PROVIDER	**HUMANA**
Signature: _____	Signature: _____
Printed Name: _____	Printed Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

MEDICAID REQUIRED PROVISIONS
ATTACHMENT

The following additional provisions apply specifically to **Humana's** Kentucky Medicaid products and plans and are hereby incorporated by reference into the Agreement. In the event of a conflict between the terms and conditions of the Agreement and this Medicaid Required Provisions Attachment ("Attachment"), the terms and conditions of this Attachment shall control as they apply to **Humana's** Kentucky Medicaid products and plans.

1. This Attachment sets forth the rights, responsibilities, terms and conditions governing the **Physician's** participation in **Humana's** Kentucky Medicaid products and plans.

2. **Physician** agrees to provide "Covered Services" to **Humana** Kentucky Medicaid Members (solely for purposes of this Attachment hereinafter referred to as "Member(s)") in accordance with all applicable federal and state laws, rules, regulations, and policies and procedures relating to the provision of medical services rendered to such Members. For purposes of this Attachment, the term "Covered Services" means those Medically Necessary services which a Member is eligible to receive pursuant to their enrollment in a **Humana** Kentucky Medicaid product or plan.

3. **Physician** agrees that he, she or it is enrolled as a participating provider in the Kentucky Medicaid Program and will maintain at all times during the term of the Agreement a current provider participation agreement and Medicaid provider number with the Kentucky Department for Medicaid Services or its designated agent.

4. **Physician** agrees to indemnify and hold harmless the Commonwealth of Kentucky, the Kentucky Cabinet for Health and Family Services, the Kentucky Department for Medicaid Services, its officers, agents, and employees, and each and every Member from all claims, demands, liabilities, suits, judgments, or damages, including court costs and attorneys' fees, brought against such persons or entities because of **Physician's** failure to pay any debt or fulfill any obligation.

5. **Physician** agrees to maintain such records, including electronic storage media, as are necessary to document the extent of services furnished to Members for a minimum of five (5) years or as otherwise required by state and federal laws, and for such additional time as may be necessary in the event of an audit, quality of care issue, or other dispute, and to furnish **Humana** and authorized state and federal agencies with any information requested regarding payments claimed for furnishing services under a **Humana** Kentucky Medicaid product or plan. **Physician** further agrees to permit representatives of the state and federal government an unrestricted right to examine, inspect, copy and audit all records pertaining to the provision of services furnished to Members. Such examinations, inspections, copying and audits may be made without prior notice to **Physician**. This right shall include the ability to interview **Physician's** staff during the course of any inspection, review, investigation or audit.

6. **Physician** agrees to comply with the Civil Rights requirements set forth in 45 C.F.R. Parts 80, 84, and 90 and the Americans with Disabilities Act, 42 U.S.C. § 12101. Payments will not be made to **Physician** in the event **Physician** is found to have discriminated on the basis of race, color, national origin, sex, disability, religion, age or marital status in the provision of services.

7. **Physician** agrees to cooperate with applicable public health agencies to coordinate appropriate medical care for Members in order to ensure quality of care and to avoid the provision of duplicate or unnecessary medical services.

8. **Physician** assures that he, she or it is aware of, and shall comply with, the provisions of 42 U.S.C. § 1320a-7b, and of the provisions of KRS 205.8451 to KRS 205.8483 relating to Medicaid program fraud and abuse, and applicable Kentucky Administrative Regulations as specified in Title 907.

9. **Physician**, upon request, agrees to disclose to **Humana**, in writing, all, direct or indirect, individual beneficial holders of ownership in **Physician**, all persons under the control of **Physician**, all subsidiaries, and all entities under common ownership or control with **Physician**. **Physician** agrees to inform

Humana, and any appropriate state or federal agency to which they are required to report, within thirty-five (35) days of any change in **Physician's** name, ownership, control or address; and, within five (5) days of information concerning **Physician's** change in licensure or certification, regulation status, criminal charges, or disciplinary action against **Physician** by the applicable professional association or other professional review body or society.

10. **Physician** further agrees to assume full responsibility for appropriate, accurate and timely submission of claims and encounter data consistent with applicable laws, regulations, and Medicaid instructions, whether submitted directly by **Physician** or by its agents or subcontractors.

11. **Physician** agrees that any information submitted by **Physician** to **Humana** under the Agreement is true, accurate and complete, and any subsequent correction which alters such information will be transmitted promptly. **Physician** acknowledges and understands that payment and satisfaction of claims will be, in whole or in part, from federal and state funds, and that any false claims, statements, or documents or concealment of falsification of a material fact, may be prosecuted under applicable federal and state law.

12. **Physician** agrees to participate in any **Humana** Kentucky Medicaid product or plan quality assurance program or any other quality assurance program to which **Physician** is required to participate by state or federal law, and understands that the data generated from any such program will be used for analysis of medical services provided to assure quality of care according to professional standards.

13. **Physician** agrees that a contract for the sale or a change of ownership in, or controlling interest of, **Physician** shall specify whether the buyer or seller is responsible for any amounts that may be owed to **Humana** by **Physician**, regardless of whether the amounts have been identified at the time of sale or the change of ownership or controlling interest. In the absence of such specification in the contract for the sale or the transaction involving the change of ownership of or controlling interest in **Physician**, the owners or the partners at the time **Humana** made an overpayment have the responsibility for liabilities arising from such overpayments, regardless of when identified.

14. **Physician** agrees that failure of **Physician** to comply with the terms of the Agreement applicable to **Humana's** Kentucky Medicaid products and plans may result in the initiation of the following sanctions: (a) freezing Member enrollment with **Physician**; or (b) if applicable, **Humana's** referral of **Provider** to the Office of Inspector General for investigation of potential fraud or quality of care issues. **Humana** may allow **Physician** two (2) weeks to cure any violation that could result in the sanctioning of **Physician**. If **Physician** does not or refuses to cure the violation, **Humana** will report the action to the appropriate professional boards and agencies, as applicable.

15. **Physician** agrees to notify **Humana** and any appropriate state or federal agency to which they are required to report in writing of having filed for protection from creditors under the Bankruptcy Code within five (5) days of having filed a petition with the court. Notification shall include the number assigned the case by the court, and the identity of the court in which the petition was filed.

16. **Physician** certifies that **Physician** and its principals, employees, agents and subcontractors have not been excluded, suspended, or debarred from participation in any federally-funded health care program. **Physician** shall notify **Humana** immediately upon becoming aware that **Physician** or its principals, employees, agents, or subcontractors have been excluded, suspended, or debarred from participation in any federally-funded health care program.

17. **Physician** agrees to comply with the policies and procedures set forth in **Humana's** provider manual applicable to Kentucky Medicaid, any other applicable **Humana** policies and procedures, and any Kentucky Medicaid Program services manual or manuals applicable to **Physician**, the provisions of which are incorporated by reference herein.

18. **Physician** agrees to comply with all applicable requirements of the Deficit Reduction Act of 2005, Section 6032, including employee education for false claims recovery.

19. **Physician** agrees that payment by **Humana** for Covered Services rendered to a Member shall be considered payment in full. **Physician** further agrees that: (a) a bill for the same service shall not be

tendered to a Member; (b) a payment for the same service shall not be tendered to a Member; and (c) a payment for the same service shall not be accepted from a Member.

20. **Physician** agrees not to bill a Member for Covered Services, with the exception of applicable co-pays or other cost sharing requirements, or for a bill that was denied due to incorrect billing. **Physician** may bill a Member for a service not covered by the applicable **Humana** Kentucky Medicaid product or plan, provided the Member was previously informed of the non-covered service and agreed in advance in writing to pay for such service.

21. **Humana** shall immediately terminate **Physician's** participation in **Humana's** Kentucky Medicaid products or plans if Medicare or Medicaid terminates **Physician**.

22. **Physician** agrees to schedule, as applicable, outpatient follow up and/or continuing treatment prior to discharge of all Members receiving inpatient psychiatric services.

23. The following provisions apply solely to the persons or entities specified below:

    (a) If **Physician** is a specialty hospital providing psychiatric services to persons age twenty-one (21) and under, **Physician** shall be approved by the Joint Commission on Hospitals or the Council on Accreditation of Services for Families and Children or any other accrediting body with comparable standards that are recognized by Kentucky. In the event **Physician** is a general hospital, **Physician** shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on Accreditation of Healthcare Organizations.

    (b) If **Physician** renders Home Care Waiver Services, **Physician** agrees to comply with the conditions for participation established under 907 KAR 1:070. **Physician** and its staff shall meet all training requirements prior to providing such services.

    (c) If **Physician** renders services under Personal Care Assistance Programs, **Physician** agrees to comply with the conditions for participation established in 907 KAR 1:090. **Physician** and its staff shall meet all training requirements prior to providing such services.

    (d) If **Physician** is a long term care facility (NF, ICF/MR or mental hospital), or if **Physician** renders home community based waiver services (HCB, SCL, Model Waiver II, Acquired Brain Injury, etc.), as a result of the Medicare Catastrophic Coverage Act of 1988, each **Physician** providing long term care services agrees to advise all new admissions of resource assessments to assist with financial planning performed by the Kentucky Department for Community Based Services through a contractual arrangement with the Kentucky Department for Medicaid Services.

    (e) If **Physician** is a nursing facility, **Physician** agrees to comply with the preadmission screening and resident review requirement specified in Section 1919 of the Social Security Act.

    (f) If **Physician** is required to participate or hold a certification under Title XVIII of the Social Security Act to provide Title XIX services, **Physician** assures such participation or certification is current and active.

PRIMARY CARE PROVIDER ("PCP")

RESPONSIBILITIES ATTACHMENT

This attachment applies solely to a **Physician** who may serve as a PCP for **Humana's** Kentucky Medicaid Members in accordance with Kentucky Medicaid laws, regulations, rules and/or guidelines. Unless otherwise specified by applicable Kentucky Medicaid laws, regulations, rules and/or guidelines, for purposes of this attachment a PCP includes, but is not limited to, a physician, an advanced practice registered nurse, a physician assistant, or clinic (including a federally qualified health center, primary care centers and rural health clinics).

Physician agrees to:

1. Supervise, coordinate, and provide initial, primary and preventative care, including EPSDT services.

2. Provide or arrange for the provision of Covered Services on a routine, urgent, and emergency care basis for Members.

3. Accept Members without discrimination or screening of such Members based upon their health status.

4. Be responsible twenty-four (24) hours a day, seven (7) days a week for providing, prescribing, directing and authorizing all Covered Services, including all urgent and emergency care.

5. Maintain and provide to **Humana** a description of formalized arrangements with other PCPs to refer Members for urgent and emergency care and service coverage in the event **Physician** or another PCP is unavailable due to vacation, illness or after-hours or for other reasons to extend **Physician's** practice, and will assure that the PCP providing coverage will provide services under the same terms and conditions and in compliance with all provisions of the Agreement. **Physician** shall be responsible for any and all compensation for such other PCP(s). Neither **Physician** nor the PCP(s) providing coverage shall seek additional compensation from **Humana** or Members for services rendered.

6. Issue referrals for Members in accordance with **Humana's** referral guidelines.

7. Maintain hospital admitting privileges or a formal referral agreement with a PCP who participates with Kentucky Medicaid and has hospital admitting privileges.

8. Have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problem or disorder.

9. Within ten (10) days from receipt of request, transfer the medical records of a Member to a new PCP when the Member changes PCPs.

10. Not to request the reassignment of a Member to a different PCP for the following reasons:

    (a) A change in the Member's health status or treatment needs;
    (b) A Member's utilization of health services;
    (c) A Member's diminished mental capacity; or
    (d) Disruptive behavior of a Member due to the Member's special health care needs unless the behavior impairs the PCP's ability to provide services to the Member or others.

11. Not to base a PCP change request on race, color, national origin, disability, age or gender. **Physician** agrees that **Humana**, in its sole discretion, shall have the authority to approve or deny a PCP change.

12. Maintain:

    (a) Continuity of a Member's health care; and
    (b) A current medical record for a Member in accordance with applicable federal and state law requirements as well as **Humana's** provider manual applicable to Kentucky Medicaid.

13. Refer a Member for specialty care and other medically necessary services, both in and out of network, if the services are not available within **Humana's** Kentucky Medicaid provider network.

14. Discuss advance medical directives with a Member.

15. Refer a Member for a behavioral health service if clinically indicated.

16. Have an after-hours phone arrangement that ensures that a PCP or a designated medical practitioner returns the call within thirty (30) minutes.

HMO PROVISIONS
ATTACHMENT

The following provisions apply to HMO products and plans, as applicable.

I. **Services to Members**. In the event **Physician** provides a Member a non-covered service or refers a Member to an out-of-network provider without pre-authorization from **Humana**, **Physician** shall, prior to the provision of such non-covered service or out-of-network referral, inform the Member: (i) of the service(s) to be provided or referral(s) to be made; (ii) that **Humana** will not pay or be liable financially for such non-covered service(s) or out-of-network referral(s); and (iii) that Member will be responsible financially for non-covered service(s) and/or out-of-network referral(s) that are requested by the Member.

II. **Continuity of Care**. Subject to and in accordance with all applicable state and/or federal laws, rules and/or regulations, treatment following termination or expiration of this Agreement must continue until the Member: (i) has been evaluated by a new participating provider who has had a reasonable opportunity to review or modify the Member's course of treatment, or until **Humana** has made arrangements for substitute care for the Member; and (ii) until the date of discharge for Members hospitalized on the effective date of termination or expiration of this Agreement. **Physician** agrees to accept as payment in full from **Humana** for Covered Services rendered to such Members, the rates set forth in the payment attachment, less any Copayments due from such Members.

Notwithstanding the foregoing, if upon notice from **Physician** or a Member that Member is in a continuation of care situation as noted above or in accordance with applicable law and **Humana** does not use due diligence to make alternative care available to the Member within ninety (90) days after receipt of such notice, then **Humana** shall pay to **Physician** for continuity of care services the standard rates paid to non-participating physicians for that geographical area. The preceding sentence shall not apply if other participating physicians, physician groups or physician organizations are not available to replace the terminating **Physician** due to: (i) geographic or travel-time barriers; or (ii) contractual provisions between the terminating **Physician** and a facility at which the Member receives care that limits or precludes other participating physicians, physician groups or physician organizations from rendering replacement services to Members (for example, an exclusive contract is in place between the terminating **Physician** and a facility where the Member receives services).

III. **Medical Records**. Upon request from **Humana** or a Member, **Physician** shall transfer a complete copy of the medical records of any Member transferred to another physician and/or facility for any reason, including termination or expiration of this Agreement. The copy and transfer of medical records shall be made at no cost to **Humana** or the Member and shall be made within a reasonable time following the request, but in no event more than five (5) business days, except in cases of emergency where the transfer shall be immediate. **Physician** agrees that such timely transfer of medical records is necessary to provide for the continuity of care for Members. **Physician** agrees to pay court costs and/or legal fees incurred by Humana or the Member to enforce the terms of this provision.

IV. **Equal Access**. **Physician** agrees to accept **Humana** Members as patients within the normal scope of **Physician's** medical practice. If, due to overcapacity, **Physician** closes his/her practice to new patients, such closure will apply to all prospective patients without discrimination or regard to payor or source of payment for services. Should **Physician** subsequently reopen his/her practice to new patients, **Physician** agrees to accept **Humana** Members seeking assignment and/or referral to **Physician's** practice to the same extent and in the same manner as all other non-**Humana** patients seeking **Physician's** services.

V. **Physician Responsibilities**.

A. **Services**

Physician agrees to be responsible twenty-four (24) hours a day, seven (7) days a week for providing Covered Services for Members including, but not limited to, prescribing, directing and monitoring all urgent and emergency care for Members.

Physician agrees to provide **Humana** upon request a written description of its arrangements for emergency and urgent care and service coverage in the event of unavailability due to vacation, illness, and after regular office hours. **Physician** shall ensure that all physicians providing such coverage are contracted and credentialed physicians with **Humana**. **Physician** will ensure that all physicians providing such coverage render services under the same terms and conditions and in compliance with all provisions of this Agreement. Compensation to physicians for "on call" coverage will be the responsibility of **Physician**.

In the event that emergency or urgent care services are needed by a Member outside the service area, **Physician** agrees to monitor and authorize the out-of-area care to provide direct care as soon as the Member is able to return to the service area for treatment without medically harmful or injurious consequences.

B. Specific Referrals

Except in the case of a medical emergency, **Physician** agrees to use its best efforts to admit, refer, and cooperate with the transfer of Members for Covered Services only to providers designated, specifically approved by or under contract with **Humana**.

In addition, **Physician** acknowledges and agrees that certain Members may have health benefits contracts that limit coverage to certain types of participating providers. For such Members, referrals are required to be made to specific providers designated by **Humana**.

C. Disease/Case Management Programs

Physician agrees to participate in **Humana's** disease/case management programs as they are developed and implemented.

D. Humana First

Physician agrees to participate in **Humana's** twenty-four (24) hours nurse call program, HumanaFirst, or any such successor program.

E. Transplant Programs

Upon request by **Humana**, **Physician** agrees to cooperate with and participate in **Humana's** organ and tissue transplant programs as they are developed and implemented.

F. Health Improvement Studies

Physician agrees to participate in **Humana's** health improvement studies as they are developed and implemented.

G. Quality Improvement Activities

Physician agrees to cooperate with **Humana's** quality improvement activities and, upon request by **Humana**, to participate in **Humana's** quality improvement activities as they are developed and implemented.

MEDICAID PAYMENT PROVISIONS ATTACHMENT

The following terms apply only to the Kentucky Medicaid HMO product.

Physician agrees to accept as payment in full for the provision of Covered Services to Humana Medicaid HMO members one hundred percent (100%) of the Kentucky Medicaid Fee Schedule or **Physician's** billed charges, whichever is less, less any Member deductibles, coinsurance, copayments and/or other Member cost share amounts.