

**UNIVERSITY HEALTH CARE, INC.
d/b/a PASSPORT HEALTH PLAN
HOSPITAL SERVICES AGREEMENT**

This Hospital Services Agreement (this "Agreement") is made and entered into as of the Effective Date (as defined in Section 1 herein) by and between University Health Care, Inc., d/b/a Passport Health Plan ("HMO"), and _____ for and on behalf of the employed and otherwise contracted Hospital Facilities, Providers and associated health services staff identified on the Appendices hereto (collectively referred to herein as "Hospital/Provider").

WHEREAS, HMO is licensed to operate a health maintenance organization under and subject to the requirements of the Commonwealth of Kentucky (the "Commonwealth") and has entered into a contract (the "State Contract") with the Commonwealth's Department for Medicaid Services (the "Department") to provide, or arrange for the provision of, comprehensive prepaid health services to eligible Medicaid recipients who have been assigned as Members of HMO by the Department.

WHEREAS, Hospital/Provider and their staff are duly licensed by the Commonwealth without restriction or limitation.

WHEREAS, HMO and Hospital/Provider mutually desire to enter into this Agreement under which Hospital/Provider shall provide Hospital Services (as defined in Section 1 herein) to Members of HMO.

NOW, THEREFORE, in consideration of the premises and the mutual covenants herein set forth, and intending to be legally bound, Hospital/Provider and HMO agree as follows:

1. DEFINITIONS

As used in this Agreement, each of the following terms shall have the meaning specified herein, unless the context clearly requires otherwise.

- 1.1. **AGREEMENT.** This Agreement between HMO and Hospital/Provider, including all Appendices and amendments hereto.
- 1.2. **COMMONWEALTH LAW.** The constitutional provisions, statutes, regulations and ordinances of the Commonwealth, its agencies and its political subdivisions which, in any circumstance or event described in or arising under this Agreement, are applicable to such circumstance or event.
- 1.3. **COVERED SERVICES.** Those medical and health services (a) that are Medically Necessary, (b) that Hospital/Provider normally furnishes to patients within the scope of Hospital/Provider's license, and (c) to which a Member is entitled as set forth in the Provider Manual.
- 1.4. **DISCLOSURE FORM.** The Disclosure of Ownership and Control Interest Form required by the Department to be completed by Hospital/Provider as a condition of participation in this Agreement.
- 1.5. **EFFECTIVE DATE.** The Effective Date of this Agreement shall be _____, 2020.
- 1.6. **EMERGENCY MEDICAL CONDITION.** Either (a) a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in (a) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part; or (d) with respect to a pregnant woman who is having contractions: (i) a situation in which there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) a situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.
- 1.7. **LAW.** The constitutional provisions, statutes and regulations of the United States of America and its agencies which, in any circumstance or event described in or arising under this Agreement, are applicable to such circumstance or event.
- 1.8. **FEE-FOR-SERVICE PAYMENT.** A payment to Hospital/Provider by HMO for authorized Covered Services that is equal to the amount designated in Appendix A for those Covered Services.
- 1.9. **GROUP.** A partnership, corporation, professional service corporation, limited liability company or other entity which provides medical and health services through individuals who are employees, partners, shareholders, members or contractors of the Group.
- 1.10. **HOSPITAL SERVICES.** Those Medically Necessary Covered Services that Hospital/Provider normally furnishes to patients within of the scope of its license and as indicated in Appendix A.

- 1.11. MEDICAL DIRECTOR. A physician licensed to practice medicine or osteopathy under Commonwealth Law who is appointed by HMO to coordinate and monitor the Quality Management Program and the Utilization Management Program of HMO.
- 1.12. MEDICALLY NECESSARY. Services which identify and treat a Member's illness or injury and which, as determined by HMO's Medical Director, are medically necessary as such term is defined by Commonwealth Law.
- 1.13. MEMBER. An individual who (a) is an eligible Medicaid recipient, (b) resides in HMO's service area, and (c) has been assigned as a Member of HMO by the Department.
- 1.14. PARTICIPATING HOSPITAL. A hospital that has entered into an agreement with HMO to provide Hospital Services to Members.
- 1.15. PROVIDER. Either (a) a physician who (i) is duly licensed to practice medicine or osteopathy, (ii) is a member of the medical staff of a Participating Hospital (or has an HMO-approved affiliation with a Provider who is a member of the medical staff of a Participating Hospital), and (iii) has entered into (or, if Provider is a Group, practices with a Group that has entered into) an Agreement with HMO to provide Covered Services to Members; or (b) in the case of emergency services, any duly licensed physician undertaking the treatment of a Member's condition that constitutes an Emergency Medical Condition; or (c) a licensed practical nurse, registered nurse or advanced practice registered nurse who is duly licensed as such in the Commonwealth and who is employed by and under the supervision of a physician who is a Provider as described in (a) above and who has been successfully met all HMO's applicable credentialing requirements.
- 1.16. PROVIDER MANUAL. The manual created by HMO which describes HMO's policies and procedures that are referenced in this Agreement and to which Provider has agreed to adhere.
- 1.17. QUALITY MANAGEMENT PROGRAM. An ongoing review process and plan adopted by HMO which functions to define, monitor, review, and recommend corrective action for managing and improving the quality of Covered Services rendered to Members.
- 1.18. SPECIALTY CARE PROVIDER. A duly licensed physician who has been successfully met all HMO's applicable credentialing requirements and who has entered into an agreement with HMO to provide specialty care services to Members referred to such Specialty Care Provider.
- 1.19. UTILIZATION MANAGEMENT PROGRAM. A process adopted by HMO for the review of the appropriateness and necessity of health care services rendered to Members.

2. HMO'S OBLIGATIONS

- 2.1. HMO shall perform the administrative, claims processing, marketing, advertising, Member services, Provider services, quality management and utilization management functions described in this Agreement.
- 2.2. HMO shall make the Provider Manual available to Hospital/Provider via HMO's website and shall provide it in a written format to Hospital/Provider upon Hospital/Provider's request. HMO may revise the Provider Manual as it deems necessary and will provide Hospital/Provider with prior notice of any revised or new material to be made part of the Provider Manual in accordance with the notice requirements of Commonwealth Law. HMO shall post any such revised or new material in the Provider Manual on HMO's website or provide it in a written format to Hospital/Provider upon Hospital/Provider's request.
- 2.3. HMO shall provide or arrange for identification cards or other materials for Members to enable Hospital/Provider to identify Members who are eligible to receive Covered Services from Hospital/Provider.
- 2.4. HMO shall compensate Hospital/Provider in accordance with the applicable Appendix or Appendices of this Agreement.
- 2.5. HMO shall monitor the quality of health care provided to Members in accordance with the Provider Manual and all applicable requirements of Federal Law and Commonwealth Law.
- 2.6. Unless otherwise mandated by Federal Law or Commonwealth Law, and subject to Section 2.2 above, HMO shall provide thirty (30) days written notice to Hospital/Provider of all changes to HMO's operational policies with which Hospital/Provider must comply with as a condition of participation.
- 2.7. This Agreement only allows HMO to market Hospital/Provider's services to the Commonwealth for the purpose of providing Hospital Services to eligible Medicaid recipients who have been assigned as Members in the HMO by the Department.

3. HOSPITAL/PROVIDER'S OBLIGATIONS

Hospital/Provider and their staff shall comply with the conditions and obligations in this Article 3 during the Term of this Agreement:

- 3.1. Hospital/Provider and their staff shall (a) have and maintain a valid license or, where required, certificate, without limitation, issued by the Commonwealth to provide health services necessary to satisfy Hospital/Provider's obligations under this Agreement; and (b) be in compliance with the credentialing criteria established by HMO.
- 3.2. Hospital/Provider shall provide or arrange for the provision of the staff, personnel, equipment and facilities necessary for Members to obtain the Hospital Services described in Appendix A in accordance with the terms and conditions of this Agreement and the Provider Manual.
- 3.3. Hospital/Provider agrees to notify HMO in writing immediately whenever there is any change in the status of Hospital/Provider's compliance with the conditions enumerated in Section 3.1 of this Agreement.
- 3.4. Hospital/Provider shall give written notice to HMO of: (a) any situation which develops regarding Hospital/Provider, when notice of that situation has been given to the State agency that licenses Hospital/Provider, or any other licensing agency or board, or any situation involving an investigation or complaint filed by the State agency that licenses Hospital/Provider, or any other licensing agency or board, regarding a complaint against Hospital/Provider's license; (b) when a change in Hospital/Provider's license to practice medicine is affected or any form of reportable discipline is taken against such license; (c) suspension or exclusion under a federal health care program, including, but not limited to, Medicaid; (d) any government agency request for access to records; (e) any filing by Hospital/Provider of a petition for protection under the federal bankruptcy laws; (f) any lawsuit or claim filed or asserted against Hospital/Provider alleging professional malpractice, regardless of whether the lawsuit or claim involves a Member, or (g) any action, suit or counterclaim filed against Hospital/Provider pertaining to a Member, HMO or the Commonwealth. In any such instance described above, Hospital/Provider must notify HMO in writing within ten (10) days from the date Hospital/Provider first receives notice, whether written or oral, with the exception of those lawsuits or claims which do not involve a Member or HMO, with respect to which Hospital/Provider has thirty (30) days to notify HMO.
- 3.5. Upon restriction of and for so long as Hospital/Provider's license is restricted for any reason, Hospital/Provider shall not provide services to HMO members. During any period during which Hospital/Provider's license is restricted, any and all health professionals employed by, contracted with or supervised by Hospital/Provider shall not provide services to HMO members unless such health professionals are supervised by another Hospital/Provider holding an unrestricted license.
- 3.6. Hospital/Provider shall provide Covered Services to Members with the same standard of care, skill and diligence customarily used by similar Hospital/Provider in the community in which such services are rendered. If Hospital/Provider is, employs, or otherwise contracts with a Specialty Care Provider, Specialty Care Provider will provide the specialty care services described in the Appendices hereto, to members with the same standard of care, skill, and diligence customarily used by similar providers of such specialty care services.
- 3.7. Hospital/Provider shall comply with all administrative policies and procedures of HMO (as set forth in the Provider Manual), as well as with all provisions of Federal Law and Commonwealth Law applicable to the delivery of Hospital Services. Hospital shall also comply with all final determinations of HMO rendered pursuant to such administrative policies and procedures. Hospital/Provider may appeal adverse determinations in accordance with the procedures established by HMO and set forth in the Provider Manual.
- 3.8. Hospital/Provider shall ensure that its employees, physicians and health professionals, employed by or under contract with Hospital/Provider shall be appropriately licensed or certified as required by Commonwealth Law, have met and continue to meet all applicable provisions of Federal Law and Commonwealth Law, and shall submit evidence of such licensure or compliance to HMO upon request. A Hospital/Provider performing laboratory services shall meet all applicable requirements of the Clinical Laboratory Improvement Act of 1988 (CLIA).
- 3.9. Hospital/Provider shall not differentiate or discriminate in the treatment of any Member because of the Member's race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of payor, source of payment, physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991 ("ADA").
- 3.10. Hospital/Provider agrees that all covered services shall be as accessible to Members (in terms of timeliness, amount, duration, and scope) as the same services as are available to commercial insurance members.
- 3.11. Hospital/Provider shall complete the Disclosure Form, deliver a copy to HMO, and notify HMO in writing of any update or other change to the information required by the Disclosure Form throughout the Term of this Agreement. Hospital/Provider acknowledges that the certifications, representations and warranties contained in the Disclosure Form (and Addendum 1 thereto) constitute a material part of this Agreement, the breach of which shall constitute a material breach of this Agreement.
- 3.12. Hospital/Provider shall be responsible for submitting encounter data, and such other data as may be required by Department or the Commonwealth, in accordance with the requirements set forth in the Provider Manual, including the submission of such data to HMO within the allotted time frame.

- 3.13. Hospital/Provider shall provide, and make readily available and accessible, Hospital Services to Members during normal business hours. Emergency Services shall be available and accessible on a twenty-four (24) hours a day, seven (7) days a week basis.
- 3.14. Hospital/Provider shall verify, in accordance with the Provider Manual, whether an individual seeking Covered Services is a Member. If HMO determines that such individual was not eligible for Covered Services at the time the services were rendered, such services shall not be eligible for payment under this Agreement, and Hospital/Provider may bill the individual or other responsible entity for such services in accordance with Commonwealth Law.
- 3.15. If applicable to the Member's coverage, Hospital/Provider shall abide by HMO's formulary or preferred drug list when prescribing medications for Members. In those circumstances where a different course of treatment is in the best interest of the member, Hospital/Provider shall follow HMO's authorization process as outlined in the Provider Manual.
- 3.16. Hospital/Provider acknowledges that it is Hospital/Provider's responsibility to provide appropriate and adequate medical care to all of Hospital/Provider's patients, including, without limitation, patients of Hospital/Provider who are Members. HMO shall not be liable for, nor will it exercise control over, the manner or method by which Hospital/Provider provides or arranges for Covered Services. Hospital/Provider understands that HMO's determinations, if any, to deny payments for services which HMO does not deem to constitute Covered Services or which were not provided in accordance with the requirements of this Agreement, the attachments to this Agreement or the Provider Manual, are administrative decisions only. Any such denial or other administrative action by HMO, or entity acting on HMO's behalf, will not absolve, relieve, or lessen Hospital/Provider's responsibility and duty to provide appropriate and adequate medical care to all patients under Hospital/Provider's care. Hospital/Provider and HMO agree that (a) Hospital/Provider may freely communicate with any Member regarding the treatment options available to the Member, including medication treatment options, regardless of the coverage limitations of the Plan and (b) nothing included within this Agreement shall be construed so as to limit or prohibit the communication described in (a) above or to otherwise limit or prohibit open clinical dialogue between Hospital/Provider and any Member.
- 3.17. Hospital/Provider agrees to render Covered Services only at locations approved by HMO and as listed in Appendix C to this Agreement. Hospital/Provider shall notify HMO at least ninety (90) days prior to making any addition or change to locations.
- 3.18. Hospital/Provider shall use Hospital/Provider's best efforts to notify HMO in writing, at least thirty (30) calendar days prior to any change in Hospital/Provider's business and/or billing address, business telephone number, office hours, tax identification number, malpractice insurance carrier or coverage, Commonwealth licensure number or DEA registration number.
- 3.19. Hospital/Provider authorizes HMO to include Hospital/Provider's name, address, telephone number, and other similar information in HMO's provider directory, which may be included in various marketing materials of HMO. Hospital/Provider agrees to afford HMO the same opportunity to display brochures, signs, or advertisements in Hospital/Provider's facilities or hospital as Hospital/Provider affords any other insurance company or other third party payor. Hospital/Provider may, with the prior written consent of HMO and the Commonwealth, engage in Hospital/Provider's own marketing activities designed to promote Hospital/Provider as a hospital with HMO.
- 3.20. Hospital/Provider agrees to cooperate with HMO's Quality Management Program and all other quality improvement activities of HMO. Such cooperation will include allowing HMO to have access to Hospital/Provider's medical records for such purposes.
- 3.21. Hospital/Provider agrees to return to HMO any duplicate payment or overpayment made by HMO resulting from any error in calculation of amount or review of submitted claims. If any overpaid amount is not returned promptly, HMO reserves the right to offset any overpaid amount against future claims payments in accordance with Commonwealth Law.
- 3.22. Hospital/Provider acknowledges that it is Hospital/Provider's responsibility to obtain the Member's written consent or authorization, when required for the purpose of using or disclosing Member health information, including mental health, substance abuse, human immunodeficiency, and auto-immune deficiency syndrome information.
- 3.23. Hospital/Provider agrees that when Members are transferred between hospitals, between hospitals and forensic psychiatric facilities, between hospitals and residential treatment centers or between residential treatment centers upon the mutual agreement of the administrative officer, his designated representative or an authorized staff physician of each facility, provided such agreement is based upon one (1) of the following findings by the officers, representatives or physicians: (1) That the transfer will improve the opportunities of the patient to receive care and treatment most likely to be of benefit to him; or (2) That the transfer will permit the patient to receive care and treatment in the least restrictive alternative mode of treatment, considering the degree of danger or threat of danger to self or others which the patient presents; or (3) That the transfer is part of an individual treatment plan which has been reviewed and approved by a court. (908 KAR 3:040).
- 3.24. Hospital/Provider shall schedule outpatient follow-up and/or continuing treatment within seven (7) days from date of discharge for Members receiving inpatient psychiatric services.
- 3.25. Hospital/Provider agrees not to disparage HMO in any manner during the Term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Hospital/Provider shall not interfere with HMO's contractual relationships including, but not limited to, those with other participating health care Providers. Nothing in this provision, however, shall be construed as limiting Hospital/Provider's ability to inform patients that this Agreement has been terminated or otherwise expired or to promote Hospital/Provider

to the general public or to post information regarding other health plans consistent with Hospital/Provider's usual procedures, provided that no such promotion or advertisement is directed at any specific Member or group of Members.

4. COMPENSATION

- 4.1. HMO agrees to pay Hospital/Provider for Hospital Services rendered in accordance with the applicable Appendices of this Agreement. HMO reserves the right to implement Incentive Programs that may result in additional payment to Hospital/Provider. At no time shall any incentive, monetary or otherwise be made to Hospital/Provider for the withholding from Members of Medically Necessary services.
- 4.2. Hospital/Provider shall provide HMO with itemized and accurate statements of all Hospital/Provider Services provided to Members using the appropriate forms and the most recent, applicable ICD-CM Codes, CPT-4 Codes and HCFA Common Procedure Coding System (HCPCS) or their successors. Hospital/Provider will use its best efforts to submit bills for Plan Benefits to HMO within thirty (30) days after the date of service in the case of an outpatient or the date of discharge in the case of an inpatient. HMO will not be liable for any bills relating to Hospital/Provider Services that are submitted more than one-hundred-and-eighty (180) days after the services were provided or the Member was discharged.
- 4.3. Provider agrees to accept the compensation provided in this Agreement as payment in full for Covered Services provided to Members. Notwithstanding anything in the Agreement, Provider shall collect any copayments or cost-sharing established by HMO as applicable from any Member receiving services under the Agreement. HMO may reduce Provider's reimbursement under the Agreement by the amount of Member copayments or cost sharing. HMO shall not be responsible to Provider for any Member copayment or cost sharing.
- 4.4. Hospital/Provider may directly bill Members for services that are not Covered Services if (a) the Member is told before the service is rendered (i) the nature of the service(s) to be rendered, (ii) that HMO does not cover the services, and (iii) that the Member will be financially responsible for the services, and (iv) the Member agrees in writing to be financially responsible for the service, and (b) Hospital/Provider complies with any other requirements imposed by Commonwealth Law with regard to such billing. Hospital/Provider shall indemnify and hold harmless HMO for any claim or expense arising from all such Non-Covered Services.
- 4.5. Hospital/Provider agrees that in the event of HMO's insolvency, or other cessation of operations, or if this Agreement is terminated for any reason, other than a quality of care issue or fraud, Hospital/Provider shall continue to provide services and be reimbursed in accordance with this Agreement, provided that (a) services to non-Foster Care Members shall continue through the end of the calendar month for which Hospital/Provider has been paid by HMO, (b) services to Members confined in an inpatient facility (and, in the event of HMO's insolvency or other cessation of operations, services to Foster Care Members) shall continue until the Member is discharged from an inpatient facility or the active course of treatment is completed, whichever time is greater, and (c) in the case of a pregnant woman, services shall continue to be provided through the end of the post- partum period if the pregnant woman is in her fourth or later month of pregnancy at the time of such insolvency or other cessation of operations. Hospital/Providers who have a valid contract with the Commonwealth to provide care under the Medicaid Program shall revert to such status in the event of insolvency or cessation of operations of HMO. Hospital/Providers who do not have such a contract shall cooperate with the transfer of Members and their medical record to physicians who do have valid contracts.
- 4.6. Hospital/Provider will cooperate with HMO in coordinating benefits with other payors as follows:
 - 4.6.1. Hospital/Provider will make a reasonable attempt to determine whether any other payor has primary responsibility for the payment of a claim for services that Hospital/Provider rendered to a Member. If another payor is primarily responsible, Hospital/Provider will bill that payor before billing HMO, and Hospital/Provider will bill HMO only for the difference, if any, between the payment made, or to be made, by the primarily responsible payor and the payment rate stated in this Agreement. If, after Hospital/Provider submits a claim to HMO, HMO determines that another payor is primarily responsible for payment of the claim, HMO will deny the claim for Hospital/Provider to bill the primarily responsible payor. HMO will provide to Hospital/Provider information known by HMO regarding the primarily responsible payor. If, after HMO pays a claim Hospital/Provider has submitted, HMO determines that another payor is primarily responsible for all or a portion of the claim, HMO will recover payment from Hospital/Provider until Hospital/Provider bills and receives payment or final denial from the primarily responsible payor. Hospital/Provider agrees to cooperate with HMO in all coordination of benefits activities.
 - 4.6.2. In situations in which Hospital/Provider is receiving Fee-For-Service payments the following shall apply: Hospital/Provider will make a reasonable attempt to determine whether any other payor has primary responsibility for the payment of a claim for services that Hospital/Provider rendered to a Member. If another payor is primarily responsible, Hospital/Provider will bill that payor before billing HMO, and Hospital/Provider will bill HMO only for the difference, if any, between the payment made or to be made by the primarily responsible payor and the payment rate stated in this Agreement. If, after Hospital/Provider submits a claim to HMO, HMO determines that another payor is primarily responsible for payment of the claim, HMO will pay Hospital/Provider only the difference, if any, between the payment to be made by the primarily responsible payor and the

payment rate stated in this Agreement. If, after HMO pays a claim Hospital/Provider has submitted, HMO determines that another payor is primarily responsible for all or a portion of the claim, Hospital/Provider agrees to cooperate with HMO in its efforts to collect from the primarily responsible payor, including executing any documents reasonably required or appropriate for this purpose.

5. PROFESSIONAL LIABILITY INSURANCE AND INDEMNITY

- 5.1. Hospital/Provider, at its sole cost and expense, shall maintain such policies of professional liability, and other insurance as shall be deemed necessary by HMO to insure against any claim or claims for damages arising by reason of personal injuries or death occasioned, directly or indirectly, in connection with the Hospital/Provider's performance of any service pursuant to this Agreement. Such policies of insurance shall include, but not be limited to, tail or prior acts coverage necessary to avoid any gap in coverage. Hospital/Provider, at its sole cost and expense, shall maintain policies of comprehensive general liability, including contractually assumed liability, and other insurance of the type and with coverages in the amounts customarily carried by similar type entities, and policies of workers' compensation and unemployment insurance as required by law. Hospital/Provider shall require that each of its subcontractors performing services pursuant to this Agreement, if any, shall maintain policies of professional liability, comprehensive general liability and other insurance of the type and with coverages in the amounts customarily carried by similar type entities. Upon written request, Hospital/Provider shall provide proof of such coverages under such policies to HMO. Hospital/Provider will provide HMO with at least fifteen (15) days' notice of the cancellation, non-renewal, lapse, or adverse material modification of any policy described in this Section 5.1.
- 5.2. Hospital/Provider agrees to defend, indemnify and hold harmless HMO, its officers, directors, employees and agents from and against any and all actions, liabilities, claims for damages and demands, and against all costs, expenses and attorney fees for or by reason of (i) any breach of this Agreement by Hospital/Provider, (ii) any HIPAA Breach (as defined in 42 C.F.R. § 164.402) by Hospital/Provider, or (iii) any actual or alleged death or injury to person or property arising from, or as a consequence of the negligence or willful misconduct of Hospital/Provider and/or Hospital's employees or agents in connection with the terms and conditions of this Agreement.
- 5.3. Hospital/Provider agrees to defend, indemnify and hold harmless the Commonwealth, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with this Agreement for the payment of any debt of or the fulfillment of any obligation of Hospital/Provider.
- 5.4. HMO agrees to defend, indemnify and hold harmless Hospital/Provider, its officers, directors, employees and agents from and against any and all actions, liabilities, claims for damages and demands, and against all costs, expenses and attorney fees for or by reason of HMO's breach of this Agreement or the negligence or willful misconduct of HMO and/or HMO's employees or agents in connection with the terms and conditions of this Agreement.
- 5.5. The obligations of HMO under this Article 5 shall survive the termination or expiration of this Agreement for any reason.

6. RECORDS

- 6.1. Hospital/Provider shall maintain a complete and accurate permanent medical record for each Member to whom Hospital/Provider renders services under this Agreement in accordance with usual and customary practices and shall include in that record all reports from health care providers and all other documentation required by Federal Law and Commonwealth Law. Subject to applicable legal restrictions, Hospital/Provider shall forward to HMO, at no cost, within ten (10) business days or fourteen (14) calendar days, any clinical information pertaining to Members necessary for HMO to conduct any functions specified by this Agreement.
- 6.2. The parties agree that all Member medical records shall be treated as confidential so as to comply with all Federal Law and Commonwealth Law regarding the confidentiality of medical records. Hospital/Provider specifically agrees to protect the privacy and security of Member information shared in the Patient Clinical Summary. Hospital/Provider specifically agrees to protect the privacy, security, and confidentiality of family planning services, including family planning services for Members under eighteen (18) years of age, in accordance with state and federal laws and judicial opinions, and any follow-up involving such services shall assure the Member's privacy. Without limitation of the foregoing, Hospital/Provider specifically agrees to (a) abide by the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and its implementing regulations regarding the disclosure of medical records and other health information of a Covered Person (as defined in HIPAA), including safeguarding the privacy and confidentiality of any protected health information ("PHI") that identifies a particular Covered Person, (b) to notify HMO of any HIPAA Breach experienced by Hospital/Provider, whether or not the HIPAA Breach affects any Member, in accordance with the requirements for such notice set forth in the Provider Manual, and (c) to assure both Hospital/Provider's own compliance and that of its business associates with HIPAA.
- 6.3. Hospital/Provider shall permit HMO and its designees and appropriate Commonwealth and federal regulatory agencies to have access to, and upon request to inspect and copy, at no cost, within ten (10) business days or fourteen (14) calendar days, any accounting, administrative and medical records maintained by Hospital/Provider, relating to the provision of Covered Services rendered by or through Hospital/Provider to Members under this Agreement, the cost thereof, the amount of any payments received therefor from Members or from others on Members' behalf, claims by and payments to Hospital/Provider, Member appeals and complaints, or coordination of benefits. Additionally, Hospital/Provider agrees to permit the Commonwealth to interview Provider's staff regarding the contents of any Member's medical records. Notwithstanding the foregoing, Hospital/Provider's obligations under this Section 6.3 shall not exceed the requirements imposed on HMO, and its subcontractors, by the Department.

- 6.4. Hospital/Provider shall maintain all accounting, administrative and medical records maintained by Hospital/Provider, relating to the provision of Covered Services rendered by or through Hospital/Provider to Members under this Agreement, for the greater of five (5) years or the period required under applicable Federal Law or Commonwealth Law to maintain such types of records.
- 6.5. The obligations of Hospital/Provider under this Article 6 shall survive the expiration or termination of this Agreement for any reason.

7. REGULATORY OVERSIGHT

- 7.1. Hospital/Provider and HMO agree that each party shall carry out its obligations in accordance with terms of the State Contract and applicable Federal Law and Commonwealth Law, including, but not limited to, the requirements of the Stark law (42 U.S.C. § 1395nn) and applicable provisions of Federal Law and Commonwealth Law regarding self-referral and fraud and abuse. If, due to Hospital/Provider's noncompliance with any such law, the State Contract or this Agreement, sanctions or penalties are imposed on HMO, HMO may, in its sole discretion, offset the amount of any such sanction or penalty against any amounts due Hospital/Provider from HMO, or may require Hospital/Provider to reimburse HMO for the amount of any such sanction or penalty.
- 7.2. Hospital/Provider agrees to comply with all applicable ethics provisions of Commonwealth Law and further certifies that no member of or delegate of Congress, the General Accounting Office, Department of Health and Human Services, the Center for Medicare and Medicaid Services or any other Federal or Commonwealth agency will benefit financially or materially from any contract(s) Hospital/Provider enters into with HMO.
- 7.3. Hospital/Provider agrees to permit access to the Commonwealth, Department and/or federal regulatory agencies, or their authorized representatives or agents, at all reasonable times upon demand, to inspect the physical facilities maintained or utilized by Hospital/Provider in the provision of Hospital Services under this Agreement.

8. RESOLUTION OF DISPUTES

- 8.1. HMO and Hospital/Provider shall each fully cooperate in resolving any and all controversies among or between HMO and Hospital/Provider, or their respective directors, officers, employees, agents, or representatives pertaining to their respective duties under this Agreement. Such disputes shall be submitted for resolution in accordance with the Hospital/Provider appeal procedures as set forth in the Provider Manual.

9. TERM; TERMINATION

- 9.1. The term of this Agreement (the "Term") shall commence as of the Effective Date and, unless earlier terminated in accordance herewith, shall continue for an initial one (1) year term. The Term hereof shall be automatically renewed thereafter for successive one (1) year Terms, unless either party gives written notice to the other of its intention not to renew this Agreement at least thirty (30) days before the end of the current Term. Notwithstanding the foregoing, either party may terminate this Agreement at any time by providing at least ninety (90) days prior written notice of its intention to terminate this Agreement. If, after the Effective Date, HMO revises the Provider Manual pursuant to Section 2.2 or otherwise changes its operational policies pursuant to Section 2.6, and Hospital/Provider does not agree with such revisions or changes, Hospital/Provider may exercise its right to terminate this Agreement on the date on which the revisions or changes shall become effective. If Hospital/Provider opts to terminate this Agreement because Hospital/Provider does not agree with any such revisions or changes, then during the interim period between the effective date of the revisions or changes and the termination of this Agreement, Hospital/Provider will not be obligated to comply with the revisions or changes; provided, however, Hospital/Provider must have delivered prior written notice of termination to HMO at least ten (10) days prior to implementation of the revisions or changes, and the revisions or changes must not be required by the Department or by any change in Federal Law or Commonwealth Law.
- 9.2. Notwithstanding the above, HMO may terminate this Agreement immediately if any of the following occur:
- 9.2.1. In the event that Hospital/Provider is expelled, disciplined, barred from participation in, or suspended from receiving payment under any state's Medicaid Program or the Medicare Program;
- 9.2.2. In the event that the license issued by the Commonwealth to Hospital/Provider to provide the health services necessary to satisfy Provider's obligations under this Agreement is revoked;
- 9.2.3. Upon the loss or suspension of the Hospital/Provider's professional liability coverage as required by this Agreement;
- 9.2.4. If Hospital/Provider (a) fails to satisfy any or all of the credentialing requirements of HMO, (b) fails to cooperate with or abide by HMO's Quality Management Program, including data reporting, or (c) is guilty of any conduct tending to injure the business reputation of HMO; or
- 9.2.5. Upon termination of the State Contract for any reason.
- 9.3. In the event that either party commits a material breach of this Agreement, other than those described in Section 9.2, the non-breaching

party may terminate this Agreement by giving thirty (30) days written notice to the breaching party; provided, however, termination shall not be effective if the breach or default is corrected in a manner reasonably satisfactory to the non-breaching party within such 30 day period.

- 9.4 HMO may execute this Agreement pending Provider's screening and enrollment with the Department. HMO shall immediately terminate this Agreement if the Department sends notification that Provider cannot be enrolled or if enrollment is not completed within one hundred and twenty (120) days of execution of this Agreement.

10. MISCELLANEOUS

- 10.1. Neither party shall disclose the substance of this Agreement or any information received from the other party during the course of or pursuant to this Agreement to any third party, unless (a) such disclosure is required by Federal Law or Commonwealth Law, or (b) the information has become known to the public generally through no fault of the receiving party. Hospital/Provider acknowledges and agrees that all information relating to HMO's programs, policies, protocols and procedures is proprietary information and is subject to the provisions of the preceding sentence.
- 10.2. It is understood that each of Hospital/Provider and HMO is an independent contractor and that neither shall be considered an employee, agent, or representative of the other. It is further understood that Hospital/Provider shall provide specific services to Members in exchange for agreed upon compensation. This Agreement shall not create, nor be deemed or construed to create, any relationship between HMO and Hospital/Provider other than that of independent contractors, contracting with each other solely for the purpose of performing this Agreement.
- 10.3. This Agreement, being for the purpose of retaining the professional services of Hospital/Provider, shall not be assigned, sublet, delegated or transferred by Hospital/Provider without the express written consent of HMO and the Department.
- 10.4. In the event that any provision under this Agreement is declared null or void, the remaining provisions of this Agreement shall remain in full force and effect.
- 10.5. If HMO desires to amend, modify or alter this Agreement (an "Amendment"), it shall send a written explanation of the proposed Amendment to Hospital/Provider (the "Notice"). Hospital/Provider shall have thirty (30) days from the date of the Notice to send a written objection to the Amendment to HMO (the "Thirty Day Period"). If Hospital/Provider objects in writing within the Thirty-Day Period, Hospital/Provider may terminate this Agreement effective as of the end of the month for which Hospital/Provider has last received a payment from HMO. If Hospital/Provider does not send written notice of objection to HMO within the Thirty Day Period, Hospital/Provider will be deemed to have accepted the terms of the Amendment and the Amendment shall become effective immediately upon the expiration of the Thirty Day Period. HMO and Hospital/Provider may also amend this Agreement pursuant to a mutually agreeable written amendment executed by both parties. Any Amendment to this Agreement shall be subject to the approval of the Department. Notwithstanding any of the foregoing, this Agreement shall be automatically amended as necessary to comply with any change in Federal Law or Commonwealth Law or any amendment of any applicable provision of the State Contract.
- 10.6. With respect to questions of interpretation of HIPAA and other Federal Law under this Agreement, this Agreement shall be governed by, and construed in accordance with, such Federal Law. With respect to questions of Commonwealth Law, this Agreement shall be governed by, and construed in accordance with, Commonwealth Law without regard to conflicts of law principles. Any action or claim arising from, under or pursuant to this Agreement shall be brought in the courts, state or federal, within Jefferson County in the Commonwealth of Kentucky, and the parties expressly waive the right to bring any legal action or claims in any other courts. The parties hereby consent to venue in any state or federal court within Jefferson County in the Commonwealth of Kentucky for all purposes in connection with any action or proceeding commenced between the parties in connection with or arising from this Agreement.
- 10.7. This Agreement constitutes the entire understanding and Agreement between HMO and Hospital/Provider concerning the subject matter hereof. This Agreement supersedes all prior written or oral Agreements or understandings existing between HMO and Hospital/Provider concerning the subject matter hereof.
- 10.8. Written notices to be given hereunder shall be sent by certified mail, return receipt requested, or by an overnight delivery service which provides a written receipt evidencing delivery to the address set forth by the party. All notices called for hereunder shall be effective upon receipt. Written notices to be given hereunder to HMO shall be sent to HMO at HMO's administrative office address set forth in the Provider Manual. Written notices to be given hereunder to Hospital/Provider shall be sent to Hospital/Provider at the office address set forth below Hospital/Provider's signature to this Agreement.
- 10.9. Each of the parties agrees to cooperate with the other to carry out the purpose and intent of this Agreement, including without limitation the execution and delivery of any further agreements or other related documents and the taking of any action as may be reasonably required to effectuate the provisions of this Agreement.
- 10.10. The failure of any party to insist upon strict performance of any of the terms of this Agreement shall not be deemed a waiver by that party of any of its rights or remedies, and shall not be deemed a waiver of any subsequent breach or default by the other party in any of the terms contained in this Agreement.

- 10.11. Any conflict between the terms of this Agreement and any ancillary documents such as the Provider Manual shall be resolved in favor of this Agreement.
- 10.12. Each party recognizes that all material concerning this Agreement or the obligations set forth herein (including this Agreement itself) provided to it by the other party is confidential (the "Confidential Material"). The Confidential Material shall not be disclosed or released by either party for any purpose without the approval of the other party except, and to the extent, as may be required by law.
- 10.13. The parties agree that the Department is a third party beneficiary of this Agreement and as such is entitled to all rights and remedies available to a third party beneficiary under Commonwealth Law. No other provision of this Agreement is intended to create any third party rights or status in any person or entity.
- 10.14. The Appendices hereto are incorporated herein, in full.
- 10.15. Any obligations that cannot be fully performed prior to the termination of this Agreement including, but not limited to, the obligations under Sections 3.25 and 4.3, Articles 5 and 6, and Sections 7.1, 8.1 and 9.1, shall survive the termination of this Agreement.
- 10.16. The parties whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement.

IN WITNESS WHEREOF, the parties hereto have signed and executed this Agreement on the dates written below, to be effective as of the Effective Date.

“HMO”

**UNIVERSITY HEALTH CARE, INC.
d/b/a PASSPORT HEALTH PLAN**

By: _____

Title: President/COO

Date: _____

Print Name: _____

“HOSPITAL/PROVIDER”

By (Signature): _____

Title: _____

Date: _____

Print Name: _____

KY Medicaid ID #: _____

Hospital/Provider Tax I.D. #: _____

NOTICE ADDRESS*

Address

City, State, Zip

Phone Number

*This address will be used for all correspondence with Hospital/Provider(s) and notices required under this Agreement unless otherwise directed.

UNIVERSITY HEALTH CARE, INC. d/b/a PASSPORT HEALTH PLAN APPENDIX A

ACUTE-CARE HOSPITAL SERVICES AND COMPENSATION

Inpatient Services

For inpatient Covered Services rendered to a Covered Person during a single admission and billed under the Hospital/Provider's tax identification number ("TIN"), HMO shall pay Hospital/Provider based on the DRG methodology as defined by the Centers for Medicare and Medicaid Services (CMS). The HMO shall pay Hospital/Provider on a fully-prospective per discharge basis using the Medicare Severity DRG (MS-DRG) grouping software released by the Centers for Medicare and Medicaid Services (CMS). The HMO will establish DRG relative weights obtained from the Medicare IPPS Final Rule Data Files and Tables corresponding to the grouper version in effect. When CMS releases subsequent versions of the DRG grouper, the HMO shall implement changes to the DRG relative weights and the geometric length-of-stay values within one hundred and twenty (120) days of the CMS release date. There will be no retroactive adjustment to claims for discharge dates occurring after the CMS effective date of such changes. All changes to the DRG grouper will be implemented on a prospective basis.

Payment rates shall approximate ninety percent (90%) for all Hospital's IPPS Medicare reimbursement excluding Medicare specific reimbursement including but not limited to

1. A Medicare low-volume hospital payment;
2. A Medicare end stage renal disease payment;
3. A Medicare new technology add-on payment;
4. A Medicare routine pass-through payment;
5. A Medicare ancillary pass-through payment;
6. A Medicare value-based purchasing payment or penalty;
7. A Medicare readmission penalty;
8. A Medicare hospital-acquired condition penalty;

The HMO shall separately reimburse for a mother's stay and a newborn's stay based on the DRGs assigned to the mother's stay and the newborn's stay.

Outpatient Services

For outpatient Covered Services rendered to a Covered Person during a single episode and billed under the Hospital/Provider's tax identification number ("TIN"), HMO shall pay Hospital/Provider based on the APC methodology as defined by the Centers for Medicare and Medicaid Services (CMS). The HMO shall pay Hospital/Provider on a fully-prospective per episode basis using the Medicare APC grouping software released by the Centers for Medicare and Medicaid Services (CMS). The HMO will establish APC rates obtained from the Medicare OPSS Final Rule Data Files and Tables corresponding to the grouper version in effect. When CMS releases subsequent versions of the APC grouper, the HMO shall implement changes to the APC rates within one hundred and twenty (120) days of the CMS release date. There will be no retroactive adjustment to claims for service dates occurring after the CMS effective date of such changes. All changes to the APC grouper will be implemented on a prospective basis.

Payment rates shall approximate ninety percent (90%) for all Hospital's OPSS Medicare reimbursement excluding Medicare specific reimbursement.

PRIMARY CARE PROVIDER SERVICES

In Provider's capacity as a Primary Care Provider, Provider shall provide Covered Services to Members who have selected or been assigned to Provider as their Primary Care Provider, including the following:

1. All primary ambulatory care visits, routine office procedures, and routine patient education and counseling;
2. Periodic physical examinations;
3. Routine injections and immunizations, including vaccinations;
4. Arrange for or provide inpatient medical care at an HMO Participating Hospital;
5. Referrals to HMO Specialty Care Providers when Medically Necessary, which Specialty Care Providers shall be reimbursed directly by HMO;
6. Early Periodic Screening, Diagnosis and Treatment ("EPSDT") equivalent services for all Title XIX Members under 21 years of age in accordance with established protocols;
7. Screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.
8. Provision of or arrangement for Covered Services to Members twenty-four (24) hours a day, seven (7) days a week;
9. Referrals to HMO Specialty Care Providers for lab and radiology and other appropriate ancillary services when Medically Necessary, for which the HMO Specialty Care Providers shall be reimbursed directly by HMO;
10. Exercise primary responsibility for arranging and coordinating the delivery of Medically Necessary health care services to Members;
11. Maintain appointment availability standards for Member office visits as set forth in HMO's Provider Manual; and
12. Comply with HMO's policies and procedures as set forth in HMO's Provider Manual.

PHYSICIAN AND THERAPY COMPENSATION

Updates to billing-related codes (e.g. CPT, HCPCS, ICD-9, ICD-10, DRG, and Revenue Codes) shall become effective on the date as established by the Centers for Medicare and Medicaid Service Fee Schedule (CMS) and/or Passport Health Plan.

Updates to fee schedules shall become effective on the effective date determined by the Centers for Medicare and Medicaid Service (CMS) Fee Schedule and/or Passport Health Plan. and/or Passport Health Plan. HMO will prospectively apply increase or decrease to HMO’s. The changes shall not be retroactive.

Fee-for-service payments to non-physician practitioners, including Advanced Practitioner Registered Nurses, Physician Assistants, Certified Registered Nurse Anesthetists, and Nurse Midwives, will be made at seventy-five percent (75%) of the rate paid to physicians. This reduction does not apply to drugs, supplies, laboratory or Imaging services billed by non-physician practitioners.

For Covered Services provided to Members, HMO shall pay Provider the lesser of: (i) the Provider’s billed charges; or (ii) contracted rate For Covered Services for which there is no established fee amount, HMO, shall pay Provider twenty-five percent (25%) of billed charges until the CMS establishes a rate.

Category	Methodology	Payment
Primary Care and Specialist Including Therapy Services	Fee Schedule	Seventy-five percent (75%) of the CMS fee schedule (excluding drugs).
Clinical Laboratory	Fee Schedule	80% of the current Clinical Laboratory fee schedule
Drugs	Average Sales Price (ASP)	100% of Average Sales Price (ASP) * Drugs must be billed using appropriate HCPCS codes and NDC codes.

AMBULANCE SERVICES and COMPENSATION

Provider shall provide to Members those Medically Necessary Covered Services, which are within the scope, capacity and license of Provider. All ancillary services require prior authorization, except as otherwise provided in the Provider Manual.

Provider’s reimbursement rate shall be 100% of the Centers for Medicare and Medicaid Service Fee Schedule (CMS) and/or Passport Health Plan. Reimbursement changes will be prospective from the date HMO is notified by CMS of fee schedule and/or methodology changes.

Updates to billing-related codes (e.g. CPT, HCPCS, ICD-9, ICD-10, DRG, and Revenue Codes) shall become effective on the date as established by Centers for Medicare and Medicaid Services (CMS).

Updates to fee schedules shall become effective on the effective date determined by Centers for Medicare and Medicaid Service Fee Schedule (CMS) and/or Passport Health Plan. HMO will prospectively apply increase or decrease to HMO’s. The changes shall not be retroactive.

DURABLE MEDICAL EQUIPMENT PROVIDER SERVICES and COMPENSATION

Provider shall provide to members those medically necessary covered services, with prior authorization from HMO when required as referenced in HMO’s policies and procedures, which are within the scope, capacity, and license of Provider.

Except as otherwise indicated below, HMO shall compensate Durable Medical Equipment and related services to Members at the rate required by the Kentucky Department for Medicaid Services pursuant to House Bill 224 (2019 Regular Session). At no time will HMO reimbursement on rental exceed the purchase rate according to this agreement for Durable Medical Equipment. This includes but not limited to, the following Durable Medical Equipment:

- Durable Medical Equipment and Accessories
- Prosthetic and Orthotic Devices
- Therapeutic Shoes
- Parenteral and Enteral Nutrition Pumps
- Rental Items
- Repairs of Purchased Durable Medical Equipment by Passport Health Plan

- Medical and Surgical Supplies
- Oxygen Equipment
- Transcutaneous and/or Neuromuscular Electrical Nerve Stimulators – TENS
- Customized Equipment and Accessories

Provider agrees to bill HMO at its usual and customary charges and accept the compensation under this Agreement as payment in full for covered services provided to member.

HMO shall compensate for covered services identified as manually priced on Kentucky Department for Medicaid Services Durable Medical Equipment fee schedule at the manufacturer's suggested retail price minus eighteen percent (18%) or at the invoice price plus twenty percent (20%) for miscellaneous codes where there is no manufacturer's suggested retail price.

HMO shall compensate for covered services, where no applicable HCPCS Level II code is present, at manufacturers' invoice cost plus twenty percent (20%). Manufacturer's invoice must be attached when claim is submitted to HMO. However, HMO shall have the right to negotiate a rate for any item provided.

Updates to billing-related codes (e.g. CPT, HCPCS, ICD-9, ICD-10, DRG, and Revenue Codes) shall become effective on the date as established by the Kentucky Cabinet for Health and family services: Department for Medicaid Services and/or Passport Health Plan.

Updates to fee schedules shall become effective on the effective date determined by the Kentucky Cabinet for Health and Family Services; Department for Medicaid Service and/or Passport Health Plan. HMO will prospectively apply increase or decrease to HMO's. The changes shall not be retroactive.