

PARTICIPATING PROVIDER AGREEMENT

THIS PARTICIPATING PROVIDER AGREEMENT (“Agreement”) is made and entered into by and between WellCare of Kentucky, Inc. (“**Health Plan**”) and _____ (“**Contracted Provider**”). Health Plan and Contracted Provider are sometimes referred to together as the “**Parties**” and individually as a “**Party**”.

WHEREAS, Health Plan issues (or is pursuing a license allowing it to issue) health benefit plans and seeks to include health care providers in one or more provider networks for such plans; and

WHEREAS, Contracted Provider provides or arranges for the provision of health care items and services to the general public by health care providers employed by or subcontracted with Contracted Provider; and

WHEREAS, Health Plan and Contracted Provider desire to enter into this Agreement whereby Contracted Provider will provide or arrange for the provision of health care items and services to Health Plan’s health benefit plan enrollees in exchange for payments from Health Plan, all subject to and in accordance with the terms and conditions of this Agreement;

NOW THEREFORE, the Parties agree as follows:

1. Construction.

1.1 The base part of this Agreement is designed for use with a variety of providers and Benefit Plans. Provisions specific to particular providers and Benefit Plans are included in Attachments to the Agreement.

1.2 The following rules of construction apply to this Agreement: (a) the word “**include**”, “**including**” or a variant thereof shall be deemed to be without limitation; (b) the word “**or**” is not exclusive; (c) the word “**day**” means calendar day unless otherwise specified; (d) the term “**business day**” means Monday through Friday, except Federal holidays; (e) all words used in this Agreement will be construed to be of such gender or number as the circumstances require; (f) references to specific statutes, regulations, rules or forms, such as CMS 1500 and UB-04 forms, include subsequent amendments or successors to them; and (g) references to a government department or agency include any successor departments or agencies.

2. Definitions. In addition to terms defined elsewhere in this Agreement, the following capitalized terms when used in this Agreement shall have the meanings set forth below. If an identical term is defined in a Program Attachment, the definition in the Program Attachment shall control with respect to Benefit Plans governed by the Program Attachment.

2.1 “**Affiliate**” means, with respect to a particular entity, another entity that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with, the entity. An entity “**controls**” an entity in which it has the power to vote, directly or indirectly, 50 percent or more of the voting interests in such entity or in the case of a partnership if it is a general partner, or the power to direct or cause direction of management and policies of such entity, whether through the ownership of voting shares, by contract or otherwise.

2.2 “**Benefit Plan**” means a health benefit policy or other health benefit contract or coverage document (a) issued by Health Plan or (b) administered by Health Plan pursuant to a Government Contract. Benefit Plans and their designs are subject to change periodically.

2.3 “**Carve Out Agreement**” means an agreement between Health Plan and a third party Participating Provider whereby the third party assumes financial responsibility for or may provide certain management services related to particular Covered Services. Examples of possible Carve Out Agreements include agreements for radiology, laboratory, dental, vision, or hearing services.

2.4 “**Clean Claim**” means a claim for Covered Services that is (i) received timely by Health Plan, (ii) is on a completed, legible CMS 1500 form or UB 04 form, or electronic equivalent, (iii) is true, complete, accurate, and includes all necessary supporting documentation, (iv) includes all relevant information necessary to comply with Laws and Program Requirements and to determine payor liability, (v) is not subject to coordination of benefits, and (vi) is not under review for Medical Necessity. A Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse.

2.5 “**Covered Services**” means Medically Necessary health care items and services covered under a Benefit Plan.

2.6 “**Credentialing Criteria**” means Health Plan’s criteria for the credentialing or re-credentialing of Providers.

2.7 “**DHHS**” means the U.S. Department of Health and Human Services, including its agency the Centers for Medicare and Medicaid Services (“**CMS**”) and its Office of Inspector General (“**OIG**”).

2.8 “**Effective Date**” means the date countersigns this Agreement. Federal law prohibits Health Plan from contracting with individuals or entities that are barred from participation in Federal Health Care Programs. Accordingly, this Agreement shall be null and void if Health Plan determines that Contracted Provider was an ineligible Person at the execution of this Agreement.

2.9 “**Emergency Services**” shall be as defined in the applicable Program Attachment.

2.10 “**Encounter Data**” means encounter information, data and reports for Covered Services provided to a Member that meets the requirements for Clean Claims.

2.11 “**Federal Health Care Program**” means a Federal health care program as defined in section 1128B(f) of the Social Security Act, and includes Medicare, Medicaid, and CHIP.

2.12 “**Government Contract**” means a contract between Health Plan and a Governmental Authority or government authorized entity for Health Plan to provide health benefits coverage for Federal Health Care Program beneficiaries.

2.13 “**Governmental Authority**” means the United States of America, the States, or any department or agency thereof having jurisdiction over Health Plan, a Provider or their respective Affiliates, employees, subcontractors or agents.

2.14 “**Ineligible Person**” means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) Federal procurement or non-procurement programs, as may be identified in the System for Award Management maintained by the General Services Administration, (b) has been convicted of a criminal offense subject to OIG’s mandatory

exclusion authority for Federal Health Care Programs described in section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in State medical assistance programs, including Medicaid or CHIP, or State procurement or non-procurement programs as determined by a State Governmental Authority.

2.15 “**Laws**” means any and all applicable laws, rules, regulations, statutes, orders, standards, guidance and instructions of any Governmental Authority, as adopted, amended, or issued from time to time, including (a) the Social Security Act, including Titles XVIII (“**Medicare**”), XIX (“**Medicaid**”) and XXI (State Children’s Health Insurance Program or “**CHIP**”), (b) the Health Insurance Portability and Accountability Act of 1996 (“**HIPAA**”), (c) Federal and State privacy laws other than HIPAA, (d) Federal and State laws regarding patients’ advance directives, (e) State laws and regulations governing the business of insurance, (f) State laws and regulations governing third party administrators or utilization review agents, and (g) State laws and regulations governing the provision of health care services.

2.16 “**Medically Necessary**” or “**Medical Necessity**” shall be as defined in the applicable Program Attachment.

2.17 “**Member**” means an individual properly enrolled in a Benefit Plan and eligible to receive Covered Services at the time such services are rendered.

2.18 “**Member Expenses**” means copayments, coinsurance, deductibles, or other cost share amounts, if any, that a Member is required to pay for Covered Services under a Benefit Plan.

2.19 “**Non-Contracted Services**” means Covered Services that are (a) subject to Carve Out Agreements and not approved by Health Plan in advance as further described in this Agreement, or (b) provided by an Ineligible Person.

2.20 “**Overpayment**” means the payments a Provider receives from Health Plan or its Affiliates to which the Provider is not entitled, including payments (a) for items and services that are not Covered Services, (b) paid in error, (c) resulting from enrollment errors, (d) resulting from claims payment errors, data entry errors or incorrectly submitted claims, or (e) for claims paid when Health Plan was the secondary payor and the Provider should have been reimbursed by the primary payor. An Overpayment also includes any payment Health Plan makes to satisfy an obligation of a Provider, including refunds of improperly collected Member Expenses to a Member or reimbursement to subcontracted Providers.

2.21 “**Participating Provider**” means an individual or entity that has entered into an agreement with Health Plan or a Health Plan contractor to provide or arrange for the provision of Covered Services to Members.

2.22 “**Principal**” means a person with a direct or indirect ownership interest of five percent or more in Provider.

2.23 “**Program**” means (a) a Federal Health Care Program, or (b) a commercial insurance program, including a program created under Laws regarding commercial health insurance exchanges.

2.24 “**Program Attachment**” means an attachment to this Agreement describing the terms of a Provider’s participation in Health Plan’s provider network for a Program.

2.25 “**Program Requirements**” means the requirements of Governmental Authorities governing a Provider’s participation in Health Plan’s provider network and rendering Covered Services to

Members pursuant to a Benefit Plan, including where applicable the requirements of a Government Contract, which include those terms set forth in a Program Attachment.

2.26 “**Provider**” means (a) Contracted Provider or (b) other individual or entity that is employed, or directly or indirectly subcontracted by Contracted Provider to provide or arrange for the provision of Covered Services to Members under this Agreement.

2.27 “**Provider Manual**” means, collectively, Health Plan’s provider manuals, quick reference guides, WellCare Companion Guide, and educational materials setting forth Health Plan’s requirements, rules, policies and procedures applicable to Participating Providers, as adopted or amended by Health Plan from time to time. The Provider Manual is available on Health Plan’s website.

2.28 “**State**” means any of the 50 United States, the District of Columbia or a U.S. territory.

2.29 “**WellCare**” means WellCare Health Plans, Inc., an Affiliate of Health Plan.

2.30 “**WellCare Companion Guide**” means the transaction guide that sets forth data requirements and electronic transaction requirements for Clean Claims and Encounter Data submitted to Health Plan or its Affiliates, as amended from time to time. The WellCare Companion Guide is part of the Provider Manual.

3. Scope.

3.1 Non-Contracted Services are outside the scope of this Agreement.

3.2 Providers may freely communicate with Members about their treatment regardless of benefit coverage limitations. Health Plan does not dictate or control clinical decisions respecting a Member’s medical treatment or care. Medical care is the responsibility of the treating Provider regardless of any coverage determination by Health Plan. Nothing in this Agreement shall be interpreted to permit interference by Health Plan with communications between a Provider and a Member regarding the Member’s medical condition or available treatment options.

3.3 This is not an exclusive agreement for either Party, and there is no guarantee (a) Health Plan will participate in any particular Program, or (b) any particular Benefit Plan will remain in effect.

3.4 Subject to Laws and Program Requirements, Health Plan reserves the right to create distinct provider networks for a Benefit Plan, and to determine Provider participation in such networks.

3.5 Subject to Laws and Program Requirements, Health Plan reserves the right to approve any Provider’s participation under this Agreement, or to terminate or suspend any Provider from participation under this Agreement or one or more particular Benefit Plans. Health Plan is not obligated to refer or assign a minimum number of Members to or maintain a minimum number of Members with a Provider.

3.6 There shall be no joint liability among the Health Plan Affiliates with regard to each Health Plan’s obligations under the Agreement. The parties further agree that only the legal entity issuing the applicable Benefit Plan shall incur any liability to Provider by virtue of the Agreement.

4. Provider Responsibilities.

4.1 Principals. Contracted Provider shall comply with requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against

Federal Health Care Programs as described in section 1124 of the Social Security Act, 42 CFR part 420 subpart C (Program Integrity: Medicare) and 42 CFR part 455 subpart B (Program Integrity: Medicaid). Prior to the Effective Date of the Agreement, Contracted Provider shall, for itself and its Principals, provide Health Plan with a complete, accurate, and current ownership disclosure form in a form and format acceptable to Health Plan or as required by Governmental Authorities to enroll in a Program. Contracted Provider shall notify Health Plan of any change in the information 30 days prior to the date of such change.

4.2 Providers. Contracted Provider shall provide Health Plan with the information listed on the Attachment titled “Information for Providers” for itself and the Providers as of the Effective Date, in a form and format acceptable to Health Plan. Provider participation in Health Plan’s contracted provider network is determined by Health Plan and is subject to the Provider completing credentialing in accordance with this Agreement. Contracted Provider shall provide notice to Health Plan of any change in the information for itself and the Providers within 30 days of the change. When Contracted Provider terminates a Provider, other than for cause, Contracted Provider will give Health Plan at least 90 days prior written notice of the termination.

4.2.1 Employed Providers. Contracted Provider shall maintain and enforce binding internal policies and procedures or agreements with its employed Providers that are consistent with and require adherence to this Agreement. Contracted Provider shall provide Health Plan with such information requested by Health Plan, or as required by a Governmental Authority or accreditation body, necessary to verify the employment of its employed Providers.

4.2.2 Subcontracted Providers. For purposes of this section only, “**Subcontracted Provider**” means a provider who renders Covered Services to Members within the scope of this Agreement, and has a contractual relationship with Contracted Provider but is not Contracted Provider’s employee. If Contracted Provider uses Subcontracted Providers to provide or arrange for the provision of health care items and services to Health Plan’s Members, Contracted Provider must secure prior written approval from Health Plan and follow Health Plan’s procedures with respect to adding Subcontracted Providers to this Agreement. If Contracted Provider has not obtained proper approval by Health Plan or followed the requisite procedures, Contracted Provider’s Subcontracted Providers may be deemed, at Health Plan’s sole discretion, to be participating under this Agreement and Contracting Provider and its Subcontracted Providers shall assume all applicable obligations stated herein:

(a) Contracted Provider represents and warrants that it has full authority, under power of attorney granted by Subcontracted Providers to Contracted Provider, to bind Subcontracted Providers to this Agreement, and all matters connected to this Agreement, including, but not limited to, the granting any waivers of any of the terms of this Agreement and entering into any amendments or modifications thereof. In the event of false representation or warranty, breach, or failure to comply with this covenant, Contracted Provider shall indemnify and hold harmless Health Plan against any loss, liability, claim, damage and expense arising from such. Any obligation of Contracted Provider in this Agreement shall apply to Subcontracted Providers to the same extent that it applies to the Contracted Provider. Contracted Provider shall require the timely and faithful performance of this Agreement by Subcontracted Providers.

(b) Any obligation of Contracted Provider in this Agreement shall apply to subcontracted Providers to the same extent that it applies to Contracted Provider. Contracted Provider shall require the timely and faithful performance of this Agreement by subcontracted Providers.

(c) Contracted Provider shall maintain and enforce written agreements with its subcontracted Providers that are consistent with and require adherence to this Agreement. Upon

Health Plan's request, Contracted Provider shall provide Health Plan with copies of (a) entire agreements between itself or other Providers and the subcontracted Providers, or (b) copies of Health Plan's opt-in form. If submitting copies of entire agreements, the compensation terms in such agreements may be redacted unless required by Governmental Authorities. In the event of a conflict, this Agreement shall control over the terms of any such agreement in all respects as to matters covered by this Agreement.

(d) Contracted Provider waives any non-compete provisions in its agreements with subcontracted Providers to the extent that, if enforced, would prohibit a subcontracted Provider from contracting directly with Health Plan.

(e) Subcontracted Provider shall maintain and enforce binding internal policies and procedures or agreements with its employed Providers that are consistent with and require adherence to this Agreement. Subcontracted Provider shall provide Health Plan with such information requested by Health Plan, or as required by a Governmental Authority or accreditation body, necessary to verify the employment of its employed Providers.

(f) Each Subcontracted Provider has reviewed its obligations under this Agreement and agrees to the terms and conditions herein. Wherever in the Agreement an action is required to be taken by a Contracted Provider or a Provider, Subcontracted Provider agrees to perform such action. Wherever in the Agreement any representation or warranty is made by a Contracted Provider or a Provider, Subcontracted Provider agrees to comply with such representation or warranty.

(g) Any obligation of Subcontracted Provider in this Agreement shall apply to its Providers to the same extent that it applies to Subcontracted Provider. Subcontracted Provider shall maintain and enforce internal policies and procedures or written agreements with its employed Providers that are consistent with and require adherence to the terms and conditions of this Agreement. Subcontracted Provider has the authority to bind its subcontracted Providers to this Agreement, and shall require the timely and faithful performance of this Agreement by its subcontracted Providers.

(h) Subcontracted Provider shall not assign any of its rights or delegate any of its duties or obligations under this Agreement, in whole or in part, without the prior written consent of Health Plan.

(i) In no event including nonpayment by Health Plan, Health Plan's insolvency or breach of this Agreement, shall Subcontracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons other than Health Plan acting on any Member's behalf, for amounts that are the legal obligation of Health Plan. This provision (i) shall be construed for the benefit of Members, (ii) does not prohibit collection of Member Expenses where lawfully permitted or required, and (iii) supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Subcontracted Provider and Members or persons acting on their behalf.

(j) If this Agreement is terminated for any reason or Contracted Provider goes out of business, ceases operations or becomes insolvent, then Subcontracted Provider: (a) for at least six months, shall continue to provide Covered Services to Members, subject to and in accordance with the terms and conditions of this Agreement, (b) shall accept compensation from Health Plan for such Covered Services at the fee for service rates set forth in this Agreement for the applicable Benefit Plans or, if this Agreement does not include fee for service rates, at 100

percent of Health Plan's then current fee for service rates for the applicable Benefit Plans, and (c) after six months, may terminate its continuing participation under this Agreement upon 90 days prior notice to Health Plan.

(k) Any dispute with respect to Subcontracted Provider's performance under this Agreement shall be subject to and resolved in accordance with the dispute resolution procedures in this Agreement.

4.2.3 Credentialing. All Providers must meet the Credentialing Criteria prior to participating in Health Plan's contracted provider networks under this Agreement. Subject to Laws and Program Requirements, (a) Health Plan conducts credentialing of providers before they begin providing Covered Services and re-credentialing from time to time thereafter as required for Health Plan's compliance with Laws, Program Requirements and accreditation standards, and Providers shall consent to and cooperate with such credentialing/re-credentialing, which may include site reviews, and (b) until successful completion of credentialing of a provider by Health Plan, (i) the provider shall not be added as a Participating Provider under this Agreement, and (ii) the provision of, and payment for, Health Plan authorized Covered Services to Members by the provider shall be subject to Health Plan's policies and procedures for non-participating providers.

4.3 Covered Services. Providers shall provide Covered Services to Members, subject to and in accordance with the terms of this Agreement.

4.3.1 Standards. Providers shall provide Covered Services in accordance with Laws and generally accepted standards of medical practice, including nationally recognized clinical protocols and guidelines where available. Providers shall ensure that Covered Services are available to Members on a 24 hour/day, 7 day/week basis, except Providers who do not provide Emergency Services shall ensure that Covered Services are available to Members in accordance with standard operating hours for each Provider location and shall maintain an after-hours phone service for individuals to seek instructions in the event of an emergency.

4.3.2 Eligibility. Except for Emergency Services, Providers shall verify Member eligibility in accordance with the Provider Manual before providing Covered Services to a Member. Health Plan provides member eligibility information through Health Plan's provider website and other means. For Emergency Services, Providers shall verify Member eligibility no later than the next business day after the Member is stabilized or the Provider learning the individual may be a Member, whichever is later. Members' eligibility status is subject to retroactive disenrollment, and Health Plan may, unless prohibited by Laws and Program Requirements, recoup payments for items or services provided to such individuals after the effective date of disenrollment even if such items and services were authorized by Health Plan.

4.3.3 Prior Authorization. Except for Emergency Services or where prior authorization is not required by the Provider Manual, Providers shall obtain prior authorization for Covered Services in accordance with the Provider Manual. Except where not permitted by Laws or Program Requirements, Health Plan may deny payment for Covered Services where a Provider fails to meet Health Plan's requirements for prior authorization.

4.3.4 Referrals. Providers shall not refer Members to other health care providers, including other Participating Providers, for Covered Services without the approval of Health Plan, except (a) in case of Emergency Services, (b) when Member self-referral is permitted by the Benefit Plan, or (c) as permitted by the Provider Manual. When making a referral to another health care provider, a Provider

shall furnish the other provider complete information on treatment procedures and diagnostic tests performed prior to such referral, which may include providing copies of the medical records.

4.3.5 Non-Covered Services. Before a Provider provides items or services to a Member that are not Covered Services, Provider shall (a) inform the Member of the specific items or services that are not Covered Services and that they will not be paid for by Health Plan, and (b) obtain the Member's written agreement to pay for such specific items or services after being so advised. Provider may contact Health Plan to determine if an item or service is a Covered Service.

4.3.6 Carve Out Agreements. While a Carve Out Agreement is in effect, Covered Services subject to the Carve Out Agreement shall be Non-Contracted Services and are not within the scope of this Agreement, except for (a) Emergency Services, or (b) Covered Services authorized by Health Plan in advance in accordance with the Provider Manual, in which cases the terms and conditions of this Agreement, including compensation, shall apply. Health Plan shall notify Contracted Provider of Carve Out Agreements through the Provider Manual or other notice. Upon expiration or termination of a Carve Out Agreement, Provider shall provide the Covered Services to Members that were subject to the Carve Out Agreement, subject to and in accordance with the terms of this Agreement, including compensation.

4.4 Claims and Encounter Data / EDI.

4.4.1 Clean Claims. Providers shall prepare and submit Clean Claims to Health Plan within 365 days or such other time period required by Laws or Program Requirements, of the date of a Covered Service or the date of discharge from an inpatient facility, as the case may be. Unless prohibited by Laws and Program Requirements, Health Plan may deny payment for any claims that fail to meet Health Plan's submission requirements for Clean Claims or that are received after the time limit in this Agreement for filing Clean Claims.

4.4.2 Additional Reports. If Health Plan requests additional information, data, or reports from a Provider regarding Covered Services provided to Members for risk adjustment data validation or other administrative purposes, even if Health Plan has paid claims or accepted Encounter Data related to the Covered Services, the Provider shall provide the information, data or reports as requested by Health Plan.

4.4.3 NPI Numbers / Taxonomy Codes. Payment of compensation for Covered Services is conditioned on Providers including their NPI numbers and Provider taxonomy codes on claims or encounter data submitted under this Agreement, and Health Plan may deny payment for Covered Services where a Provider fails to meet these requirements.

4.4.4 Electronic Transaction Requirements. Provider may submit claims and encounter data to Health Plan electronically. Providers shall (a) follow the requirements for electronic data interchange in accordance with the current HIPAA Administrative Simplification transaction standards and WellCare Companion Guide, and (b) submit all claims and encounter data either through a clearinghouse used by Health Plan or directly to Health Plan in accordance with the WellCare Companion Guide.

4.4.5 EFT / Remittance Advice. If a Provider is able to accept payments and remittance advice electronically, (a) the Provider shall register and complete the forms for electronic funds transfer and electronic remittance advice no later than 60 days following Health Plan's confirmation of Provider's status as participating, and (b) Health Plan shall make all payments and remittance advice to the Provider electronically. If a Provider is not able to accept payments and remittance advice electronically, the Provider shall make good faith efforts to be able to accept electronic funds transfer and electronic remittance within 24 months of the Effective Date.

4.4.6 Coordination of Benefits. Health Plan shall coordinate payment for Covered Services in accordance with the terms of a Member's Benefit Plan and Laws. Providers shall provide Health Plan with explanations of benefits and other documents and information in their possession regarding insurance covering a Member that is primary to the Member's Benefit Plan. Providers shall bill primary insurers for items and services they provide to a Member before they submit claims for the same items or services to Health Plan. If Health Plan is not the primary payor for Covered Services provided to a Member, then when not prohibited by Laws or Program Requirements, Health Plan's payment to Provider for such services shall not exceed the compensation in this Agreement less amounts payable by the primary payor or payors, less Member Expenses. Unless prohibited by Laws and Program Requirements, Health Plan may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services.

4.4.7 Subrogation. Providers shall cooperate and assist Health Plan with its subrogation efforts.

4.4.8 No payment made by Health Plan under this Agreement is intended as a financial incentive or inducement to reduce, limit or withhold Covered Services required by Members.

4.5 Member Protections.

4.5.1 Providers shall not discriminate in their treatment of Members based on Members' health status, source of payment, cost of treatment, participation in Benefit Plans, race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, or genetic information.

4.5.2 In no event including nonpayment by Health Plan, Health Plan's insolvency or breach of this Agreement, shall a Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons (other than Health Plan) acting on the Member's behalf, for amounts that are the legal obligation of Health Plan. This provision (a) shall survive termination or expiration of this Agreement regardless of the cause giving rise to termination or expiration, (b) shall be construed for the benefit of Members, (c) does not prohibit collection of Member Expenses where lawfully permitted or required, and (d) supersedes any oral or written agreement to the contrary now existing or hereafter entered into between a Provider and Members or persons acting on their behalf.

4.5.3 Regardless of any denial of a claim or reduction in payment to a Provider by Health Plan, in no event will a Member be responsible for payment for any Covered Services other than Member Expenses. However, Members shall not be responsible for Member Expenses where collection of Member Expenses is prohibited by Laws, Program Requirements, or this Agreement. If payment of an amount sought in a claim is denied or reduced by Health Plan, the Provider shall adjust Member Expenses accordingly.

4.5.4 Except where collection of Member Expenses is prohibited by Laws, Program Requirements, or this Agreement, a Provider shall (a) collect Member Expenses directly from the Member, and (b) not waive, discount or rebate any such amounts except as permitted by and in accordance with Laws and Program Requirements regarding prohibited inducements to Federal Health Care Program beneficiaries.

4.5.5 Providers shall not bill Members for any items or services, such as missed appointments or administrative fees, where such billing is prohibited by Laws or Program Requirements.

4.6 Provider Manual. The Provider Manual supplements and is made a part of and incorporated into this Agreement, and Providers shall comply with the Provider Manual. Health Plan may amend the Provider Manual from time to time upon notice to Provider by posting to Health Plan's provider website, email or other means of notice permitted by this Agreement, provided that in the case of material revisions to the Provider Manual, Health Plan shall provide notice in accordance with the provisions of this Agreement regarding written notice. Changes to the Provider Manual shall become effective 15 days after such posting or notice, or such other time period required for Health Plan to comply with Laws, Program Requirements or accreditation standards. Providers shall have and maintain systems necessary for access to Health Plan's provider website, and check for revisions to the Provider Manual from time to time.

4.7 Quality Improvement. Providers shall comply with Health Plan's quality improvement programs, including those designed to improve quality measure outcomes in the then current Healthcare Effectiveness Data and Information Set (HEDIS) or other quality or outcome measures. Health Plan may audit Providers periodically and upon request Providers shall provide Records to Health Plan for HEDIS or other quality reasons and risk management purposes, including Records that will enable Health Plan to perform a thorough assessment of the overall care being provided to Members.

4.8 Utilization Management. Providers shall cooperate and participate in Health Plan's utilization review and case management programs. Health Plan's utilization review/case management programs may include provisions for (a) verification of eligibility and prior authorization for Covered Services, (b) concurrent and retrospective reviews, (c) requirements regarding referrals to third party Participating Providers, and (d) corrective action plans.

4.9 Member Grievances / Appeals. Providers shall comply with the Provider Manual, Laws and Program Requirements regarding Member grievances and appeals, including by providing information, records or documents requested by Health Plan and participating in the grievance/appeal process.

4.10 Compliance. In performing this Agreement, Providers shall comply with all Laws and Program Requirements. Providers shall (a) cooperate with Health Plan with respect to Health Plan's compliance with Laws and Program Requirements, including downstream requirements that are inherent to Health Plan's responsibilities under Laws or Program Requirements, and (b) not knowingly take any action contrary to Health Plan's obligations under Laws or Program Requirements.

4.10.1 Privacy / HIPAA. Providers shall maintain Member information and medical records in accordance with Laws, including Federal and State Laws related to privacy and confidentiality of Member information and medical records, including HIPAA, and shall use and disclose such information or records only in accordance with Laws and Program Requirements.

4.10.2 Fraud, Waste and Abuse. Providers shall comply with Laws designed to prevent or ameliorate fraud, waste, and abuse, including applicable provisions of Federal criminal law, the False Claims Act (31 USC §§ 3729 et. seq.), and the anti-kickback statute (section 1128B(b) of the Social Security Act).

4.10.3 Compliance / Program Reporting. OIG publishes compliance program guidance for health care firms available at <http://oig.hhs.gov/fraud/complianceguidance.asp>. Contracted Provider shall, and shall require its employees and its subcontractors and their employees to, comply with Health Plan compliance program requirements, including Health Plan's compliance training requirements, and to report to Health Plan any suspected fraud, waste, or abuse or criminal acts by Health Plan, Contracted Provider, other Providers, their respective employees or subcontractors, or by Members. Reports may be made anonymously through the WellCare fraud hotline at (866) 678-8355. Also, if DHHS publishes compliance program requirements that providers must follow as a condition of participation in Federal

Health Care Programs, Contracted Provider shall, and shall require its subcontractors to, comply with such requirements.

4.10.4 Accreditation. Providers shall comply with policies and procedures required for Health Plan to obtain or maintain its accreditation from accreditation bodies, including the National Committee for Quality Assurance or Utilization Review Accreditation Commission.

4.10.5 Acknowledgement of Federal Funding. Claims, data and other information submitted to Health Plan pursuant to this Agreement may be used, directly or indirectly, for purposes of obtaining payments from Federal or State governments under Federal Health Care Programs, and payments that Providers receive under this Agreement may be, in whole or in part, from Federal funds.

(a) Providers shall, upon request of Health Plan, certify, based on its best knowledge, information and belief, that all data and other information directly or indirectly reported or submitted to Health Plan pursuant to this Agreement is accurate, complete and truthful.

(b) Providers shall not claim payment in any form, directly or indirectly, from a Federal Health Care Program for items or services covered under this Agreement, except for wrap around payments made directly by Governmental Authorities to certain qualified providers, such as Federally qualified health centers (“**FQHCs**”) or rural health clinics (“**RHCs**”) where applicable.

(c) If a Governmental Authority imposes a reduction to the Federal or State funds Health Plan receives under a Government Contract, Health Plan may adjust its payments to Provider by an equivalent or comparable amount. Such adjustment shall be effective concurrent with the effective dates such reductions are imposed upon Health Plan.

4.10.6 Ineligible Persons. Contracted Provider warrants and represents as of the Effective Date and throughout the term of the Agreement and the duration of post expiration or termination transition activities described in this Agreement, that none of it, its Principals or any individual or entity it employs or has contracted with to carry out its part of this Agreement is an Ineligible Person.

4.10.7 Compliance Audit. Health Plan shall be entitled to audit Providers with respect to compliance issues, including their compliance programs, and require them to address compliance issues through education, counseling or corrective action plans. Providers shall cooperate with Health Plan with respect to any such audit, including by providing Health Plan with Records and site access within such time frames as requested by Health Plan.

4.10.8 Fines / Penalties. The following applies if Provider is capitated or Health Plan has delegated activities to Provider pursuant to a separate delegation addendum: Provider shall reimburse Health Plan for any fines, penalties or costs of corrective actions required of Health Plan by Governmental Authorities caused by Provider’s failure to comply with Laws or Program Requirements, including failure to submit accurate encounters on a timely basis or to properly perform delegated functions.

4.11 Licensure. Providers shall secure and maintain all necessary licenses, certificates, permits, registrations, consents, approvals and authorizations that must be obtained by them to perform their obligations under this Agreement. As required by Program Requirements, Providers shall meet the conditions of participation and be enrolled in applicable Federal Health Care Programs (including for dual eligible special needs plan Members, both Medicare and Medicaid) and have all accreditations necessary to meet such conditions of participation.

4.12 Insurance. Contracted Provider and its subcontracted Providers shall secure and maintain for themselves and their employees, commercial general liability and professional liability (malpractice) insurance or self-insurance coverage for claims arising out of events occurring during the term of this Agreement and any post expiration or termination activities under this Agreement, in amounts required to meet Credentialing Criteria, and worker's compensation insurance as required by State Laws. Contracted Provider and its subcontracted Providers shall, upon request of Health Plan, provide Health Plan with certificates of insurance or other evidence of coverage reflecting satisfaction of the foregoing requirements of this paragraph. Contracted Provider and the subcontracted Providers shall provide at least 30 days prior notice to Health Plan in advance of any material modification, cancellation or termination of their insurance.

4.13 Proprietary Information. In connection with this Agreement, Health Plan or its Affiliates may disclose to Providers, directly or indirectly, certain information that Health Plan or its Affiliate have taken reasonable measures to maintain as confidential and which derives independent economic value from not being generally known or readily ascertainable by the public (“**Proprietary Information**”). Proprietary Information includes Member lists, the compensation provisions of this Agreement, and other information relating to Health Plan's or its Affiliates' business that is not generally available to the public. Contracted Provider shall, and shall require its subcontractors to, hold in confidence and not disclose any Proprietary Information and not use Proprietary Information except (a) as expressly permitted under this Agreement, or (b) as required by Laws or legal or regulatory process. Contracted Provider shall, and shall require its subcontractors to, provide Health Plan with prior notice of any such disclosure required by Laws or legal or regulatory process so that Health Plan can seek an appropriate protective order. Contracted Provider shall, and shall require its subcontractors to, disclose Proprietary Information only in order to perform their obligations under this Agreement, and only to persons who have agreed to maintain the confidentiality of the Proprietary Information. The requirements of this Agreement regarding Proprietary Information shall survive expiration or termination of this Agreement.

4.14 Required Notices. In addition to any other notices required under this Agreement, Contracted Provider shall notify Health Plan within five business days of Contracted Provider's knowledge, or when Contracted Provider should have known, of any event that could reasonably be expected to impair the ability of a Provider to comply with the obligations of this Agreement, including any of the following: (a) an occurrence that causes any of the representations and warranties in this Agreement made by or on behalf of a Provider to be inaccurate, (b) a Provider fails to maintain insurance as required by this Agreement, (c) a Provider's license, certification or accreditation expires or is suspended, revoked, conditioned or otherwise restricted, (d) a Provider is excluded, suspended or debarred from, or sanctioned under a Federal Health Care Program, (e) a disciplinary action is initiated by a Governmental Authority against a Provider, (f) where applicable, a Provider's hospital privileges are suspended, limited, revoked or terminated, (g) a Provider is under investigation for fraud or a felony, or (h) a Provider enters into a settlement related to any of the foregoing.

5. Health Plan Responsibilities.

5.1 ID Cards. Health Plan shall issue identification cards to Members and instruct them to present their cards to providers when seeking health care items and services.

5.2 Claims Processing. Health Plan shall pay or deny Clean Claims within the time period set forth in Attachment C. Health Plan uses claims editing software programs to assist it in determining proper coding for provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative and the National Physician Fee Schedule Database, the AMA and Specialty Society correct coding guidelines, and state specific regulations. These software programs may result in claim edits for specific procedure code and diagnosis code combinations.

5.3 Compensation. Compensation shall be as set forth in Attachment C. Providers shall accept such compensation (plus wrap around payments from Governmental Authorities to qualified providers such as FQHCs or RHCs where applicable) as payment in full for Covered Services rendered to Members and all other activities of Providers under this Agreement. Items and services constituting “**never events**” as described in the Provider Manual shall not be paid. Health Plan shall not pay for Non-Contracted Services.

5.4 Medical Record Review. Health Plan shall be entitled to perform concurrent or retrospective reviews of medical records for utilization management purposes or to verify that items and services billed to or paid for by Health Plan were provided and billed correctly in accordance with this Agreement and the Provider Manual, or were Covered Services (including that such items and services were Medically Necessary).

5.5 Overpayments. Overpayment recovery shall be in accordance with Health Plan’s Provider Manual and Providers shall refund Overpayments to Health Plan within 30 days (or such other timeframe as required by Laws or Program Requirements) of the Provider’s receipt of notice from Health Plan of such Overpayments (“Notice Period”) or Provider’s knowledge of such Overpayment. This section regarding Overpayments shall survive expiration or termination of this Agreement. Health Plan shall not seek repayment of an Overpayment from a Provider beyond the time period set forth in Health Plan’s Provider Manual, unless a longer time is required or permitted by Laws or Program Requirements. Notwithstanding anything to the contrary herein, there shall be no deadline within which Health Plan may seek recovery of an Overpayment in a case of fraud.

5.5.1 Unless prohibited by Laws or Program Requirements, Contracted Provider, for itself and the Providers, authorizes Health Plan to offset Overpayments against any future payments due to Provider.

5.5.2 Except for offsets related to changes in Member eligibility, which shall not require notice prior to deducting Overpayments, Health Plan shall notify Providers that an offset against future payments will occur unless the Provider (a) refunds such amounts within the Notice Period, or (b) provides Health Plan with a written explanation of why the Overpayments should not be refunded along with any supporting documentation. If the Provider does not respond within the Notice Period, Health Plan shall deduct Overpayments from future payments.

5.5.3 If Provider disputes Overpayments within the Notice Period, Health Plan shall review the Provider’s explanation and supporting documentation. Health Plan shall notify Provider of its decision to either uphold or overturn its initial determination that the payment at issue was an Overpayment. If Health Plan upholds its decision, the Overpayment will be offset against future payments unless prohibited by Law or Program Requirements.

5.6 Suspension of Payment. If DHHS suspends payments to a Provider while Governmental Authorities investigate a credible allegation of fraud (as determined by DHHS), then Health Plan may suspend the Provider and payments for Covered Services provided by the Provider during the period of the DHHS suspension of payments.

5.7 Health Plan Designees. With regard to administering Benefit Plans, Health Plan may delegate administrative functions to third parties, and Provider shall cooperate with such third parties to the same extent Provider is required to cooperate with Health Plan.

6. Records, Access & Audits.

6.1 Maintenance. Contracted Provider shall, and shall cause its Providers and subcontractors to, maintain operational, financial and administrative records, contracts, books, files, data, information, and other documentation related to the Covered Services provided to Members, claims filed, quality and cost outcomes, quality measurements and initiatives, and other services and activities conducted under this Agreement (collectively, “**Records**”). Contracted Provider shall ensure that such Records are kept in accordance with Laws, Program Requirements, generally accepted accounting principles (as applicable), and prudent record keeping practices and are sufficient to enable Health Plan to enforce its rights under this Agreement, including this section, and to determine whether Contracted Provider and its subcontractors and their respective employees are performing or have performed Contracted Provider’s obligations in accordance with this Agreement, Laws and Program Requirements. Contracted Provider shall, and shall cause its subcontractors to, maintain such Records for the time period set forth in the applicable Program Attachment governing the Benefit Plan. Records that are under review or audit shall be retained until the completion of such review or audit if that date is later than the time frame indicated above.

6.2 Access & Audit. Health Plan shall have the right to monitor, inspect, evaluate and audit Contracted Provider, Providers, and their subcontractors. In connection with any monitoring, inspection, evaluation or audit, Contracted Provider shall, and shall cause Providers and its subcontractors to, provide Health Plan with access to all Records, personnel, physical facilities, equipment and other information necessary for Health Plan or its auditors to conduct the audit. Within three business days of Health Plan’s written request for Records, or such shorter time period required for Health Plan to comply with requests of Governmental Authorities, Contracted Provider shall, and shall cause its subcontractors to, collect, compile, and prepare all such Records and furnish such Records to Health Plan in a format reasonably requested by Health Plan. Copies of such Records shall be at no cost to Health Plan. If Provider participates in any health information exchange (“HIE”), Provider hereby consents to the release of any Records contained in such an HIE to Health Plan.

6.3 The requirements of this Agreement regarding Records, access and audit shall survive expiration or termination of this Agreement.

7. Term and Termination.

7.1 Term. The term of this Agreement shall begin on the Effective Date and continue for a period of one year, and thereafter shall renew for successive periods of one year each unless a Party provides notice of nonrenewal to the other at least 90 days before the end of the then current (initial or renewal) term, unless and until the Agreement is terminated in accordance with the terms and conditions of the Agreement, including those in a Program Attachment.

7.2 Termination.

7.2.1 Termination for Convenience. Either Party may terminate this Agreement, in whole or with respect to any particular Program, Benefit Plan, or Covered Service, at any time for any reason or no reason upon 90 days prior notice to the other. Health Plan may terminate this Agreement as to any particular Provider at any time for any reason or no reason upon 90 days prior notice to Contracted Provider.

7.2.2 Termination for Cause.

(a) A Party may terminate this Agreement for material breach by the other Party of any of the terms or provisions of this Agreement by providing the other Party at least 90 days prior notice specifying the nature of the material breach. During the first 60 days of the notice

period, the breaching Party may cure the breach to the reasonable satisfaction of the non-breaching Party.

(b) Health Plan may terminate this Agreement as to a particular Provider for a material failure by the Provider to comply with any of the terms or provisions of this Agreement by providing Contracted Provider at least 90 days prior notice specifying the nature of the material failure. During the first 60 days of the notice period, the affected Provider may cure the material failure to the reasonable satisfaction of Health Plan.

7.2.3 Immediate Termination. Health Plan may terminate this Agreement in its entirety, or with respect to a particular Provider, upon immediate notice to Contracted Provider upon the occurrence of any of the following: (a) termination is necessary for health and safety of Members, (b) a Provider suffers the loss, suspension or restriction of a license from a Governmental Authority or accreditation from an accreditation body required to carry out its obligations under this Agreement, including meeting the conditions of participation in applicable Programs, (c)(1) Contracted Provider becomes an Ineligible Person or voluntarily withdraws from participation in applicable Programs, or (2) another Provider becomes an Ineligible Person or voluntarily withdraws from participation in applicable Programs, and is not immediately terminated by Contracted Provider, (d) a Governmental Authority orders Health Plan to terminate the Agreement, (e) Health Plan reasonably determines or a Governmental Authority determines or advises that a Provider is engaging or has engaged in fraud or abuse, or has submitted a false claim, (f) a Provider fails to meet Credentialing Criteria, (g) a Provider fails to maintain insurance as required by this Agreement, (h) a Provider undergoes a change of control that is not acceptable to Health Plan, or (i) a Provider becomes insolvent, is adjudicated as bankrupt, has its business come into possession or control of any trustee in bankruptcy, has a receiver appointed for it, or makes a general assignment for the benefit of its creditors.

7.2.4 Transition of Care. To ensure that a transition is undertaken in an orderly manner that maximizes Member safety and continuity of care, upon expiration or termination of this Agreement for any reason except for immediate termination, Providers shall (a) continue providing Covered Services to Members through (1) the lesser of the period of active treatment for a chronic or acute medical condition or up to 90 days, (2) the postpartum period for Members in their second or third trimester of pregnancy, or (3) such longer period required by Laws or Program Requirements, and (b) cooperate with Health Plan for the transition of Members to other Participating Providers. The terms and conditions of this Agreement shall apply to any such post expiration or termination activities, provided that if a Provider is capitulated, Health Plan shall pay the Provider for such Covered Services at 100 percent of Health Plan's then current rate schedule for the applicable Benefit Plans. The transition of care provisions in this Agreement shall survive expiration or termination of this Agreement.

7.2.5 Notification to Members. Upon expiration or termination of this Agreement, Health Plan will communicate such expiration or termination to Members as required by and in accordance with Laws and Program Requirements. Providers shall obtain Health Plan's prior written approval of Provider communications to Members regarding the expiration or termination of this Agreement. The foregoing sentence shall not prevent a Provider from engaging in communications with his patient regarding the patient's health.

8. Dispute Resolution.

8.1 Provider Administrative Review and Appeals. Where applicable, a Provider shall exhaust all Health Plan's review and appeal rights in accordance with the Provider Manual before seeking any other remedy. Where required by Laws or Program Requirements, administrative reviews and appeals shall be subject to and resolved in accordance with administrative law.

8.2 Except as prohibited by State Laws, all claims and disputes between Health Plan and a Provider related to this Agreement must be submitted to arbitration within one year of the act or omission giving rise to the claim or dispute, except for claims based on fraud, which must be brought within the State statute of limitation governing fraud claims. The failure to initiate arbitration within the foregoing time period will constitute waiver of such claims and disputes.

8.3 Negotiation. Before a Party initiates arbitration regarding a claim or dispute under this Agreement, the Parties shall meet and confer in good faith to seek resolution of the claim or dispute. If a Party desires to initiate the procedures under this section, the Party shall give notice (a “**Dispute Initiation Notice**”) to the other providing a brief description of the nature of the dispute, explaining the initiating Party’s claim or position in connection with the dispute, including relevant documentation, and naming an individual with authority to settle the dispute on such Party’s behalf. Within 20 days after receipt of a Dispute Initiation Notice, the receiving Party shall give a written reply (a “**Dispute Reply**”) to the initiating Party providing a brief description of the receiving Party’s position in connection with the dispute, including relevant documentation, and naming an individual with the authority to settle the dispute on behalf of the receiving Party. The Parties shall promptly make an investigation of the dispute, and commence discussions concerning resolution of the dispute within 20 days after the date of the Dispute Reply. If a dispute has not been resolved within 30 days after the Parties have commenced discussions regarding the dispute, either Party may submit the dispute to arbitration subject to the terms and conditions herein.

8.4 Arbitration. Except as barred or excepted by this Agreement, all claims and disputes between the Parties shall be resolved by binding arbitration in Louisville, Kentucky. The arbitration shall be conducted through the American Arbitration Association (“**AAA**”) pursuant to the AAA Commercial Arbitration Rules then in effect, subject to the following: Arbitration shall be commenced by completing and filing with AAA a Demand for Arbitration form in accordance with the Commercial Arbitration Rules setting forth a description of the dispute, the amount involved and the remedy sought, and sending notice of the demand to the opposing Party. The arbitration shall be held before a single arbitrator, unless the amount in dispute is more than \$10 million, in which case it will be held before a panel of three arbitrators. In a case with a single arbitrator, the Parties shall select the arbitrator by agreement within 30 days of the date the Demand for Arbitration is filed, and if the Parties are unable to agree on the selection of an arbitrator within such time, AAA shall select an independent arbitrator. In the case of a panel, within 30 days of the date the Demand for Arbitration is filed each Party shall select an arbitrator, and the two arbitrators shall select the third arbitrator, and if the two arbitrators are unable to agree on the selection of a third arbitrator within such time, AAA shall select an independent third arbitrator. If either Party disputes the arbitrability of a claim or dispute, the arbitrator or panel will decide if this arbitration agreement applies to the claim or dispute. The arbitrator or panel may not certify a class or conduct class based arbitration. The decision of the arbitrator or panel shall be final and binding on the Parties. The award of the arbitrator or panel may be confirmed or enforced in any court having jurisdiction. Each Party shall assume its own costs related to the arbitration, including costs of subpoenas, depositions, transcripts, witness fees, and attorneys’ fees. The compensation and expenses of the arbitrator and administrative fees or costs of the arbitration shall be borne equally by the Parties.

9. Miscellaneous.

9.1 Governing Law / Venue. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of Kentucky except where Federal law applies, without regard to principles of conflict of laws. Each of the Parties hereby agrees and consents to be subject to the exclusive jurisdiction and venue of the appropriate State or Federal court located in Jefferson County, Kentucky in any suit, action, or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Agreement.

9.2 Waiver of Jury Trial. Each Party hereby irrevocably and unconditionally waives, to the fullest extent it may legally and effectively do so, trial by jury in any suit, action or proceeding arising hereunder.

9.3 Equitable Relief. Notwithstanding anything in this Agreement, either Party may bring court proceedings to seek an injunction or other equitable relief to enforce any right, duty or obligation under this Agreement.

9.4 Independent Contractors. The Parties are independent contractors. This Agreement shall not be deemed to create a partnership or joint venture, or an employment or agency relationship between the Parties. Neither Party has the right or authority to assume or create any obligation or responsibility on behalf of the other. Neither Party is liable for the acts of the other.

9.5 No Steering. For the term of this Agreement and for one year thereafter, Providers shall not engage in steering or otherwise directly or indirectly solicit any Member to join a competing health plan or induce any Member to cease doing business with Health Plan.

9.6 No Offshore Contracting. No work related to this Agreement may be performed outside of the United States without Health Plan's prior written consent.

9.7 The following applies to State plans: Contracted Provider shall not, and shall require Providers and their subcontractors not to, make any payments for items or services provided under a State plan to financial institutions or entities such as provider bank accounts or business agents located outside of the States. Further Contracted Provider shall not, and shall require its Providers and their subcontractors not to, make payments to telemedicine providers located outside of the States, or payments to pharmacies located outside of the States. Any such funds paid may be recovered by Health Plan or a State Governmental Authority with applicable jurisdiction over a plan.

9.8 Notices. Except for non-material revisions to the Provider Manual, all notices required or permitted under this Agreement must be in writing and sent by (a) hand delivery, (b) U.S. certified mail, postage prepaid, return receipt requested, (c) overnight delivery service providing proof of receipt, (d) facsimile, or (e) regular U.S. mail, first-class postage prepaid, to the addresses of the Parties as set forth on the signature page. Each Party may designate by notice any future or different addresses to which notices will be sent. Notices will be deemed delivered upon receipt or refusal to accept delivery, except for regular U.S. mail, which shall be deemed delivered seven days after the date of mailing. Notice to Contracted Provider shall constitute notice to all Providers. Routine day to day operational communications between the Parties are not notices in accordance with this section.

9.9 Incorporation of Laws / Program Requirements / Accreditation Standards. All terms and conditions of this Agreement are subject to Laws, Program Requirements, and accreditation standards. Any term, condition or provision now or hereafter required to be included in the Agreement by Laws, Program Requirements, or accreditation standards shall be deemed incorporated herein and binding upon and enforceable against the Parties, regardless of whether or not the term, condition or provision is expressly stated in this Agreement. Health Plan may amend this Agreement upon notice to Contracted Provider to comply with Laws, Program Requirements, or accreditation standards, and such amendment shall be effective upon receipt.

9.10 Amendment. Except as otherwise set forth in this Agreement, any amendments to this Agreement shall be in writing and signed by both Parties. However, Health Plan may amend this Agreement upon 30 days prior notice to Contracted Provider, and if Contracted Provider objects to the

amendment, Contracted Provider shall notify Health Plan of the objection within the 30 day notice period, and Health Plan may terminate this Agreement for convenience in accordance with this Agreement.

9.11 Third Parties. Except as otherwise provided in this Agreement, this Agreement is not a third party beneficiary contract and no provision of this Agreement is intended to create or may be construed to create any third party beneficiary rights in any third party, including any Member.

9.12 Assignment. Contracted Provider may not assign, delegate or transfer this Agreement, in whole or in part, without the prior written consent of Health Plan. Health Plan may assign this Agreement, in whole or in part, including any Benefit Plan or Program hereunder, to an Affiliate or any purchaser of the assets or successor to the operations of Health Plan. As used in this section, the term “**assign**” or “**assignment**” includes a change of control of a Party by merger, consolidation, transfer, or the sale of the majority or controlling stock or other ownership interest in such Party.

9.13 Name, Symbol and Service Mark. The Parties shall not use each other’s name, symbol, logo, or service mark for any purpose without the prior written approval of the other. However, (a) Providers may include Health Plan’s or Benefit Plan names in listings of health plans the providers participate in, and (b) Health Plan may use information about Providers in information or publications identifying Participating Providers or as required by Laws or Program Requirements. Providers shall provide comparable treatment to Health Plan as provided to other managed care organizations with respect to marketing or the display of cards, plaques or other logos provided by Health Plan to identify Participating Providers to Members.

9.14 Other Agreements. If a Provider participates as a Participating Provider under more than one agreement with Health Plan for a particular Program, Health Plan will compensate the Provider for Covered Services it provides to Members of Benefit Plans in that Program under the agreement selected by Health Plan.

9.15 Health Plan Affiliates. If a Provider renders covered services to a member of a benefit plan issued or administered by a Health Plan Affiliate, the Health Plan Affiliate may pay for such covered services, and the Provider shall accept, the applicable out of network rates paid by the Health Plan Affiliate for the member’s benefit plan. A list of Health Plan Affiliates is available in the Provider Manual or on Health Plan’s provider website. There shall be no joint liability between or among Health Plan and its Affiliates.

9.16 Force Majeure. The Parties shall have and maintain disaster recovery plans in accordance with high industry standards. However, if either Party’s performance under this Agreement is prevented, hindered or delayed by reason of any cause beyond the Party’s reasonable control that cannot be overcome by reasonable diligence, including war, acts of terrorism, civil disorders, labor disputes (other than strikes within such Party’s own labor force), governmental acts, epidemics, quarantines, embargoes, fires, earthquakes, storms, or acts of God, such Party shall be excused from performance to the extent that it is prevented, hindered or delayed thereby, during the continuances of such cause; and such Party’s obligations hereunder shall be excused so long as and to the extent that such cause prevents or delays performance. If a Provider is unable to perform under this Agreement due to an event as described in this paragraph, Health Plan may take whatever action is reasonable and necessary under the circumstances to ensure its compliance with Laws and Program Requirements and equitably adjust payments to the Provider until the Provider resumes its performance under this Agreement.

9.17 Severability. When possible, each provision of this Agreement shall be interpreted in such manner as to be effective, valid and enforceable under Laws. If any provision of this Agreement is held to be prohibited by, or invalid or unenforceable under Laws, such provision shall be ineffective only to the

express extent of such prohibition, unenforceability or invalidity, without invalidating the remainder of this Agreement.

9.18 Waiver. No waiver shall be effective unless in writing and signed by the waiving Party. A waiver by a Party of a breach or failure to perform this Agreement shall not constitute a waiver of any subsequent breach or failure.

9.19 Entire Agreement. This Agreement, including the Attachments each of which are made a part of and incorporated into this Agreement, the Provider Manual and any addenda or amendments comprises the complete agreement between the Parties and supersedes all previous agreements and understandings (whether verbal or in writing) related to the subject matter of this Agreement.

9.20 Headings. The various headings of this Agreement are provided for convenience only and shall not affect the meaning or interpretation of this Agreement or any provision of it.

9.21 Interpretation. Both Parties have had the opportunity to review this Agreement with legal counsel, and any ambiguity found in this Agreement shall not be construed in a Party's favor on the basis that the other Party drafted the provision containing the ambiguity.

9.22 Survival. Any provision of this Agreement, including an Attachment, that requires or reasonably contemplates the performance or existence of obligations by a Party after expiration or termination of this Agreement shall survive such expiration or termination regardless of the reason for expiration or termination.

9.23 Rights Cumulative. Except as set forth herein, all rights and remedies of a Party in this Agreement are cumulative, and in addition to all legal rights and remedies available to such Party.

9.24 Counterparts / Electronic Signature. This Agreement may be executed in any number of counterparts. The exchange of copies of this Agreement and of signature pages by facsimile transmission or electronic mail shall constitute effective execution and delivery of this Agreement as to the parties and may be used in lieu of the original Agreement for all purposes.

9.25 Warranties and Representations. Each Party warrants and represents, as of the Effective Date and continuously thereafter throughout the entire term of this Agreement and during the post expiration or termination transition period described herein, as follows:

9.25.1 The Party is a corporation or other legally recognized entity duly incorporated or organized, validly existing and in good standing under the laws of the State in which it is incorporated, organized or operating and it has the authority to transact business in each State in which it operates.

9.25.2 The Party has the corporate or company power and legal authority to, and has taken all necessary corporate or other action on its part to, authorize the execution and delivery of this Agreement and the performance of its obligations hereunder.

9.25.3 This Agreement has been duly executed and delivered by the Party, and constitutes a legal, valid, and binding agreement that is enforceable against such Party in accordance with its terms, except as limited by applicable bankruptcy, reorganization, moratorium and similar Laws affecting the enforcement of creditors' rights.

9.25.4 The execution and delivery of this Agreement and the performance of the Party's obligations hereunder do not (a) conflict with or violate any provision of the Party's organizational

documents or Laws, or (b) conflict with, or constitute a default under, any contractual obligation of the Party.

The following Attachments are incorporated into and made a part of this Agreement:

Attachment A - Provider Specific Requirements/Covered Services/Information

Attachment B - Program Attachments

Attachment C - Compensation

SIGNATURE PAGE FOLLOWS

SIGNATURE PAGE

IN WITNESS WHEREOF, the undersigned, with the intent to be legally bound, have caused this Agreement to be duly executed and effective as of the Effective Date.

WellCare of Kentucky, Inc. _____

By: _____ By: _____

Print Name: _____ Print Name: _____

Title: _____ Title: _____

Date: _____ Date: _____

TIN: _____

Health Plan Notice Address:

Contracted Provider Notice Address:

13551 Triton Park Blvd., Suite 1800 _____

Louisville, KY 40223 _____

ATTN: Network Development ATTN: _____

Fax: _____ Fax: _____

Revision # 2015.1

FOR HEALTH PLAN USE ONLY

ATTACHMENT A
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES / INFORMATION

(See following attachments)

ATTACHMENT A-1
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES
PROFESSIONAL

1. Additional Definitions.
 - a. **“Assigned Member”** means a Member who selects or is assigned by Health Plan to a Primary Care Provider or (if required by Laws or Program Requirements) an allied health care practitioner supervised by a Physician, as the Member’s primary care provider.
 - b. **“Covering Provider”** means a Provider who provides health care items and services to another Provider’s patients when the other Provider is not available.
 - c. **“Nurse Practitioner”** means a Provider who is licensed as a nurse practitioner and certified in advanced or specialized nursing practice, in accordance with applicable state Laws.
 - d. **“Physician”** means a Provider who is a doctor of medicine or osteopathy.
 - e. **“Primary Care Provider”** means a Physician, Nurse Practitioner, certified nurse midwife, physician assistant, or other duly licensed Provider who spends the majority of his/her clinical time providing Primary Care Services to patients, and may include a Provider in the practice of family medicine, general medicine, internal medicine or pediatrics, or obstetrics and gynecology.
 - f. **“Primary Care Services”** means health care items or services available from Primary Care Provider within the scope of their medical or professional licenses or certifications, and shall include primary care items and services required by the Provider Manual or Program Requirements, which may include (i) assuring the timeliness of urgent, emergent, sick and preventive care to Members; (ii) conducting initial health assessments of new Members when such assessments are Covered Services under the applicable Benefit Plan; (iii) informing Members of specific health care needs that require follow up; (iv) instructing Members on measures they may take to promote their own health; (v) providing the coordination necessary for the referral of Members to specialists; or (vi) monitoring and follow-up of care provided by other providers for diagnosis and treatment.
 - g. **“Specialty Provider”** means a Provider who provides Specialty Services.
 - h. **“Specialty Services”** means health care items and services within the scope of a particular medical specialty.
2. Subject to and in accordance with the terms of this Agreement, applicable Laws, and Program Requirements, Contracted Provider shall provide or arrange for the provision of all Covered Services available from Providers that are within the scope of their medical or professional licenses or certifications.
3. If Contracted Provider employs or subcontracts with Providers to provide Covered Services, Contracted Provider shall be responsible to ensure that (a) Primary Care Providers render Primary Care Services to Members, including their Assigned Members, and (b) Specialty Providers provide Specialty Services to Members upon appropriate referral. If a Provider provides Covered Services that are subject to a Carve-Out Agreement, such services shall be Non-Contracted Services.
4. If a Provider provides or arranges for the provision of Primary Care Services to Assigned Members:

- a. The Provider shall have primary responsibility for arranging and coordinating the overall health care of Assigned Members, including (i) the provision of Primary Care Services from Primary Care Provider and appropriate referral to other Participating Providers, or if a Participating Provider is unavailable to any health care provider upon authorization of Health Plan, and (ii) managing and coordinating the performance of administrative functions relating to the delivery of Covered Services to Assigned Members.
 - b. The Provider shall ensure Primary Care Provider make all reasonable efforts to (i) establish satisfactory provider-patient relationships with their Assigned Members and (ii) instruct their Assigned Members on measures they may take to promote their own health.
5. If a Provider provides or arranges for the provision of Specialty Services, the Provider shall ensure that Specialty Provider (i) care for common medical conditions in their medical specialty, (ii) provide consultation summaries or appropriate periodic progress notes to the Member's Primary Care Provider on a timely basis, after a referral or routinely scheduled consultative visit, and (iii) notify the Member's Primary Care Provider when scheduling a hospital admission or other procedure requiring the Primary Care Provider's approval.
 6. Except for Emergency Services, when a Member requires a hospital admission by a Primary Care Provider or other Provider that the Primary Care Provider has referred a Member to, the Primary Care Provider shall, or shall arrange for the other Provider to, secure authorization for such admission from Health Plan prior to the admission. Providers shall seek further authorization for any extension of the initial length of stay approved for the Member in accordance with the Provider Manual.
 7. Subject to Laws and Program Requirements regarding provider to patient ratios, a Provider shall accept Members as patients as long as the Provider is accepting new patients. Contracted Provider shall give Health Plan 60 days' prior notice in advance of any circumstance where a Provider is not available to accept Members as patients.

**ATTACHMENT A-2
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES
(EPSDT PROVIDER)**

1. Subject to and in accordance with the terms and conditions of this Agreement, Contracted Provider shall provide or arrange for the provision of all Covered Services that are EPSDT health care items or services as defined by 907 KAR 11:034 that available from the Providers and within the scope of their medical or professional licenses or certifications.

**ATTACHMENT A-3
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES
(HOSPITAL)**

1. Subject to and in accordance with the terms of this Agreement, applicable Laws, and Program Requirements, Contracted Provider shall provide or arrange for the provision of all Covered Services that are hospital based health care items or services available from the Providers that are within the scope of their medical or professional licenses or certifications.
2. Covered Services include professional services of hospital based physicians and their physician extenders.

ATTACHMENT A-4
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES

1. Additional Definitions.
 - a. **“Assigned Member”** means a Member who selects or is assigned by Health Plan to a Primary Care Provider or (if required by Laws or Program Requirements) an allied health care practitioner supervised by a Physician, as the Member’s primary care provider.
 - b. **“Covering Provider”** means a Provider who provides health care items and services to another Provider’s patients when the other Provider is not available.
 - c. **“Nurse Practitioner”** means a Provider who is licensed as a nurse practitioner and certified in advanced or specialized nursing practice, in accordance with applicable state Laws.
 - d. **“Physician”** means a Provider who is a doctor of medicine or osteopathy.
 - e. **“Primary Care Provider”** means a Physician, Nurse Practitioner, certified nurse midwife, physician assistant, or other duly licensed Provider who spends the majority of his/her clinical time providing Primary Care Services to patients, and may include a Provider in the practice of family medicine, general medicine, internal medicine or pediatrics, or obstetrics and gynecology.
 - f. **“Primary Care Services”** means health care items or services available from Primary Care Provider within the scope of their medical or professional licenses or certifications, and shall include primary care items and services required by the Provider Manual or Program Requirements, which may include (i) assuring the timeliness of urgent, emergent, sick and preventive care to Members; (ii) conducting initial health assessments of new Members when such assessments are Covered Services under the applicable Benefit Plan; (iii) informing Members of specific health care needs that require follow up; (iv) instructing Members on measures they may take to promote their own health; (v) providing the coordination necessary for the referral of Members to specialists; or (vi) monitoring and follow-up of care provided by other providers for diagnosis and treatment.
 - g. **“Specialty Provider”** means a Provider who provides Specialty Services.
 - h. **“Specialty Services”** means health care items and services within the scope of a particular medical specialty.
2. Subject to and in accordance with the terms of this Agreement, applicable Laws, and Program Requirements, Contracted Provider shall provide or arrange for the provision of all Covered Services available from Providers that are within the scope of their medical or professional licenses or certifications, which may include Primary Care Services, Specialty Services and hospital based Covered Services.
3. If Contracted Provider employs or subcontracts with Providers to provide Covered Services, Contracted Provider shall be responsible to ensure that (a) Primary Care Providers render Primary Care Services to Members, including their Assigned Members, and (b) Specialty Providers provide Specialty Services to Members upon appropriate referral. If a Provider provides Covered Services that are subject to a Carve-Out Agreement, such services shall be Non-Contracted Services.
4. If a Provider provides or arranges for the provision of Primary Care Services to Assigned Members:

- a. The Provider shall have primary responsibility for arranging and coordinating the overall health care of Assigned Members, including (i) the provision of Primary Care Services from Primary Care Provider and appropriate referral to other Participating Providers, or if a Participating Provider is unavailable to any health care provider upon authorization of Health Plan, and (ii) managing and coordinating the performance of administrative functions relating to the delivery of Covered Services to Assigned Members.
 - b. The Provider shall ensure Primary Care Provider make all reasonable efforts to (i) establish satisfactory provider-patient relationships with their Assigned Members and (ii) instruct their Assigned Members on measures they may take to promote their own health.
5. If a Provider provides or arranges for the provision of Specialty Services, the Provider shall ensure that Specialty Provider (i) care for common medical conditions in their medical specialty, (ii) provide consultation summaries or appropriate periodic progress notes to the Member's Primary Care Provider on a timely basis, after a referral or routinely scheduled consultative visit, and (iii) notify the Member's Primary Care Provider when scheduling a hospital admission or other procedure requiring the Primary Care Provider's approval.
 6. Except for Emergency Services, when a Member requires a hospital admission by a Primary Care Provider or other Provider that the Primary Care Provider has referred a Member to, the Primary Care Provider shall, or shall arrange for the other Provider to, secure authorization for such admission from Health Plan prior to the admission. Providers shall seek further authorization for any extension of the initial length of stay approved for the Member in accordance with the Provider Manual.
 7. Subject to Laws and Program Requirements regarding provider to patient ratios, a Provider shall accept Members as patients as long as the Provider is accepting new patients. Contracted Provider shall give Health Plan 60 days' prior notice in advance of any circumstance where a Provider is not available to accept Members as patients.
 8. For hospital Providers, Covered Services include professional services of hospital based Physicians and their physician extenders.

ATTACHMENT A-5
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES
(MEDICAL FACILITY)

1. Subject to and in accordance with the terms of this Agreement, applicable Laws, and Program Requirements, Contracted Provider shall provide or arrange for the provision of all Covered Services that are facility based health care items or services available from the Providers that are within the scope of their medical or professional licenses or certifications.

ATTACHMENT A-6
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES
(ANCILLARY PROVIDER)

1. Subject to and in accordance with the terms of this Agreement, applicable Laws, and Program Requirements, Contracted Provider shall provide or arrange for the provision of all Covered Services that are ancillary health care items or services available from the Providers that are within the scope of their medical or professional licenses or certifications.

**ATTACHMENT A-7
INFORMATION FOR PROVIDERS**

Contracted Provider shall provide the following information for (1) Contracted Provider, (2) each other Provider and (3) each of their respective medical facilities:

- Name
- Address
- E-mail address
- Telephone and facsimile numbers
- Professional license numbers
- Medicare/Medicaid ID numbers
- Federal tax ID numbers
- Completed W-9 form
- National Provider Identifier (NPI) numbers
- Provider Taxonomy Codes
- Area of medical specialty
- Age restrictions (if any)
- Area hospitals with admitting privileges (where applicable)
- Whether Providers are employed or subcontracted with Contracted Provider using the designation “E” for employed or “C” for subcontracted.
- For a subcontracted Provider, whether its Providers are employed or contracted with the subcontracted Provider using the designation “E” for employed or “C” for contracted.
- Office contact person
- Office hours
- Billing office
- Billing office address
- Billing office telephone and facsimile numbers
- Billing office email address
- Billing office contact person
- Ownership Disclosure Form, as required to comply with Laws, Program Requirements, and Government Contract

**ATTACHMENT B
PROGRAM ATTACHMENTS**

(See following attachments)

**ATTACHMENT B-1
KENTUCKY MEDICAID AND CHIP
PROGRAM ATTACHMENT**

1. Participation in Kentucky Contracts. Subject to and in accordance with the terms and conditions of the Agreement, including this Attachment, Contracted Provider shall participate in Benefit Plans offered or administered by Health Plan under Kentucky Contracts (as defined below).
2. Compensation for Covered Services provided to Members of Benefit Plans under Kentucky Contracts is set forth in Attachment C.
3. Additional Definitions.
 - a. “**Cabinet**” means the Kentucky Cabinet for Health and Family Services.
 - b. “**Commonwealth**” or “**State**” means the Commonwealth of Kentucky.
 - c. “**Department**” means Cabinet’s Department for Medicaid Services.
 - d. “**Emergency Medical Condition**” is defined in 42 USC 1395dd(e) and 42 CFR 438.114 and means (i) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention 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 of bodily functions, or (C) serious dysfunction of any bodily organ or part; or (ii) with respect to a pregnant woman having contractions (A) that there is an inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child. [Kentucky Medicaid Contract, § 1]
 - e. “**Emergency Services**” or “**Emergency Care**” means care for a condition as defined in 42 USC 1395dd and 42 CFR 438.114. [Kentucky Medicaid Contract, § 1]
 - f. “**Finance**” means the Kentucky Cabinet for Finance and Administration.
 - g. “**Kentucky Contract**” means a contract between the Commonwealth and Health Plan for Health Plan to provide or arrange for the provision of health care items and services to enrollees in the Kentucky managed care programs for Medicaid or CHIP, and Kentucky SKY, as amended from time to time, including any requests for proposal issued by the Commonwealth and incorporated into such a contract, including RFP 758 1500000283 and RFP 758 1900000093 (each a “**RFP**”), as amended from time to time. A Kentucky Contract is a Government Contract as defined in the Agreement.
 - h. Items and services that are “**Medically Necessary**” or a “**Medical Necessity**” are those that are (i) reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy; (ii) appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice; (iii) provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care provider, or for cosmetic reasons; (iv) provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;

- (v) needed, if used in reference to an emergency medical service, to exist using the prudent layperson standard; (vi) provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in Federal laws and regulations for individuals under 21 years of age; and (vii) sufficient in amount, duration, and scope to reasonably achieve its purpose, subject to appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. [907 KAR 3:130(2)(1)(b); 907 KAR 1:320(13)] They meet national standards, if applicable, and are provided in accordance with 42 C.F.R. §440.230, including children's services pursuant to 42 U.S.C. 1396d(r). [RFP Attachment F, Definitions]
- i. **“Member”** means an individual enrolled in a Benefit Plan issued by Health Plan pursuant to a Kentucky Contract.
4. All provisions of the Agreement and this Attachment are cumulative. All provisions shall be given effect when possible. If there is inconsistent or contrary language between this Attachment and any other part of the Agreement, the provisions of this Attachment shall prevail with respect to the Program described in this Attachment except to the extent a provision of the Agreement exceeds the minimum requirements of the Attachment. Any obligation of Contracted Provider in this Attachment shall apply to Providers to the same extent that it applies to Contracted Provider.
 5. Emergency Services. Providers shall not be required to seek prior authorization for Emergency Care before the Member has been stabilized. Once a Member who receives Emergency Care is stabilized, Providers shall seek prior authorization for post-stabilization care services for the Member in accordance with the Provider Manual.
 6. Kentucky Statutory Requirements.
 - a. Member Hold Harmless. Provider may not, under any circumstance, including: (i) nonpayment of moneys due the Provider by Health Plan, (ii) insolvency of Health Plan, or (iii) breach of the provider agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member, dependent of a Member, or any persons acting on their behalf, for services provided in accordance with the provider agreement. This provision shall not prohibit collection of deductible amounts, copayment amounts, coinsurance amounts, and amounts for noncovered services. [KRS § 304.17A-527(1)(a)]
 - b. Continuity of Care. If an agreement between Provider and Health Plan is terminated for any reason, other than a quality of care issue or fraud, Provider shall continue to provide services and Health Plan shall continue to reimburse Provider in accordance with the agreement until the Member or dependent of the Member is discharged from an inpatient facility, or the active course of treatment is completed, whichever time is greater, and 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 the agreement is terminated. [KRS § 304.17A-527(1)(b)]
 - c. Survivorship. The foregoing hold harmless clause and continuity of care clause shall survive the termination of the Agreement. [KRS § 304.17A-527(1)(c)]
 - d. Health Plan will, upon request of Provider, provide or make available to Provider, when contracting or renewing an existing contract with Provider, the payment or fee schedules or other information sufficient to enable Provider to determine the manner and amount of payments under the contract for Provider's services prior to the final execution or renewal of the contract and shall provide any

change in such schedules at least 90 days prior to the effective date of the amendment pursuant to KRS § 304.17A-577. [KRS § 304.17A-527(1)(d)]

- e. If Provider enters into any subcontract agreement with another Provider to provide their licensed health care services to a Member or dependent of the Member of Health Plan where the subcontracted Provider will bill Health Plan or Member directly for the subcontracted services, the subcontract agreement must meet all requirements of KRS subtitle 304.17A and all such subcontract agreements shall be filed with the commissioner in accordance with this paragraph. [KRS § 304.17A-527(1)(e)]
- f. As used in this section, unless the context requires otherwise: (1) “material change” means a change to a contract, the occurrence and timing of which is not otherwise clearly identified in the contract, that decreases the health care provider’s payment or compensation or changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider’s administrative expense, and includes any changes to provider network requirements, or inclusion in any new or modified insurance products; and (2) “participating provider” means a provider that has entered into an agreement with an insurer to provide health care services.
 - i. If Health Plan makes a material change to an agreement it has entered into with a participating provider for the provision of health care services, Health Plan shall provide the participating provider with at least 90 days’ written notice of the material change. The notice shall:
 - A. Provide the proposed effective date of the change;
 - B. Include a description of the material change;
 - C. Include a statement that the participating provider has the option to either accept or reject the proposed material change in accordance with this Attachment;
 - D. Provide the name, business address, telephone number, and electronic mail address of a representative of Health Plan to discuss the material change, if requested by the participating provider;
 - E. Provide notice of the opportunity for a meeting using real-time communication to discuss the proposed changes if requested by the participating provider. For purposes of this paragraph, “real-time communication” means any mode of telecommunications in which all users can exchange information instantly or with negligible latency and includes the use of traditional telephone, mobile telephone, teleconferencing, and videoconferencing. If requested by the provider, the opportunity to communicate to discuss the proposed changes may occur via electronic mail instead of real-time communication; and
 - F. Provide notice that upon three material changes in a 12 month period, the provider may request a copy of the contract with material changes consolidated into it. Provision of the copy of the contract by Health Plan shall be for informational purposes only and shall have no effect on the terms and conditions of the Agreement.
 - ii. If a material change relates to the participating provider’s inclusion in any new or modified insurance products, or proposes changes to the participating provider’s membership networks:
 - A. The material change shall only take effect upon the acceptance of the participating provider, evidenced by a written signature; and

- B. The notice of the proposed material change shall be sent by certified mail, return receipt requested.
- iii. Except for inclusion in any new or modified insurance products, or proposes changes to the participating provider's membership networks any other material change shall be subject to the following:
 - A. The material change shall take effect on the date provided in the notice unless the participating provider objects to the change as set forth herein.
 - B. A participating provider who objects under this paragraph shall do so in writing and the written protest shall be delivered to Health Plan within 30 days of the participating provider's receipt of notice of the proposed material change.
 - C. Within 30 days following Health Plan's receipt of the written objection, Health Plan and the participating provider shall confer in an effort to reach an agreement on the proposed change or any counter-proposals offered by the participating provider.
 - D. If Health Plan and participating provider fail to reach an agreement during the 30 day negotiation period described herein, then 30 days shall be allowed for the parties to unwind their relationship, provide notice to patients and other affected parties, and terminate the Agreement pursuant to its original terms; and
 - E. The notice of proposed material change shall be sent in an orange-colored envelope with the phrase "ATTENTION! CONTRACT AMENDMENT ENCLOSED!" in no less than 14 point boldface Times New Roman font printed on the front of the envelope. This color of envelope shall be used for the sole purpose of communicating proposed material changes and shall not be used for other types of communication from Health Plan.
- iv. If Health Plan makes a change to an agreement that changes an existing prior authorization, precertification, notification, or referral program, or changes an edit program or specific edits, Health Plan shall provide notice of the change to the participating provider at least 15 days prior to the change.
- v. Any notice required to be mailed pursuant to this section shall be sent to the participating provider's point of contact, as set forth in the Agreement. If no point of contact is set forth in the Agreement, Health Plan shall send the requisite notice to the provider's place of business addressed to the provider. [KRS § 304.17A-235]

7. Kentucky Contract Requirements.

- a. Neither Provider, nor any individual who has a direct or indirect ownership or controlling interest of 5% or more of the Provider, nor any officer, director, agent or managing employee (i.e., general manager, business manager, administrator, director or like individual who exercises operational or managerial control over the Provider or who directly or indirectly conducts the day-to-day operation of Provider) is an entity or individual (1) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. §1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)-(3) of the Social Security Act (42 U.S.C. §1320a-7(b)(1)-(3)); or (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (3) who has been excluded from participation in a program

under Title XVIII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the Balanced Budget Act or under a Commonwealth health care program. [KY Medicaid Contract § 3.6]

- b. Provider shall comply with the requirements of 42 CFR 438, as applicable. [KY Medicaid Contract § 4.3F]
- c. During the term of this Agreement, Provider agrees as follows:
 - i. Provider shall not discriminate against any employee or applicant for employment because of race, religion, color, national origin, sex, sexual orientation, gender identity or age. Provider further agrees to comply with the provision of the Americans with Disabilities Act of 1990 (Public Law 101- 336), 42 USC 12101, and applicable federal regulations relating thereto prohibiting discrimination against otherwise qualified disabled individuals under any program or activity. Provider agrees to provide, upon request, needed reasonable accommodations. Provider will take affirmative action to ensure that applicants are employed and that employees are treated during employment without regard to their race, religion, color, national origin, sex, age or disability. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Provider agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause or its nondiscriminatory practices. [KY Medicaid Contract § 5.3 A.]
 - ii. Provider shall, in all solicitations or advertisements for employees placed by or on behalf of Provider; state that all qualified applicants will receive consideration for employment without regard to race, religion, color, national origin, sex, sexual orientation, gender identity, age or disability. [KY Medicaid Contract § 5.3 B.]
 - iii. Provider shall send to each labor union or representative of workers with which they have a collective bargaining agreement or other contract understanding, a notice advising the said labor union or workers' representative of Provider's commitments under this section, and shall post copies of the notice in conspicuous places available to employees and applicants for employment. [KY Medicaid Contract § 5.3 C.]
 - iv. Provider will comply with all applicable provisions of Executive Order No. 11246 of Sept. 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.
 - v. Provider will furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, as amended, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to their books, records, and accounts by the administering agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders. [KY Medicaid Contract § 5.3 D.]
 - vi. In the event of Provider's noncompliance with the nondiscrimination clauses of this Agreement or with any of such rules, regulations, or orders, this Agreement may be cancelled, terminated, or suspended in whole or in part and Provider may be declared ineligible for further Government contracts in accordance with procedures authorized in Executive Order No. 11246 of Sept. 24, 1965, as amended, and such other sanctions may be imposed and remedies invoked as provided in Executive Order No. 11246 of September 24, 1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law. [KY Medicaid Contract § 5.3 E.]

- vii. Provider will include the provisions of this section 7(c) in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. Provider will take such action with respect to any subcontract or purchase order as may be directed by the Secretary of Labor as a means of enforcing such provisions including sanctions for noncompliance: Provided, however, that in the event Provider becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction, Provider may request the United States to enter into such litigation to protect the interests of the United States. [KY Medicaid Contract § 5.3 F.]
- d. The Equal Employment Opportunity Act of 1978, KRS 45.560 – 45.640 applies to all State government projects with an estimated value exceeding \$500,000. Provider shall comply with all terms and conditions of the Act. [KY Medicaid Contract § IV., Terms and Conditions]
- e. Provider shall comply with the following laws:
 - i. Title VI of the Civil Rights Act of 1964 (Public Law 88-352);
 - ii. Title IX of the Education Amendments of 1972 (regarding education, programs and activities);
 - iii. The Age Discrimination Act of 1975;
 - iv. The Rehabilitation Act of 1973;
 - v. Rules and regulations prescribed by the United States Department of Labor in accordance with 41 CFR Part 60-741; and
 - vi. Regulations of the United States Department of Labor recited in 20 CFR Part 741, and Section 504 of the Federal Rehabilitation Act of 1973 (Public Law 93-112).

[KY Medicaid Contract § 5.4]

- f. Access to Premises.
 - i. If Health Plan delegates the payment of claims or the provision of customer service to Provider then Provider shall provide to the Department or the Department of Insurance (“DOI”) computer access in the event the Department or DOI conducts an audit or other on-site visit. Provider shall provide the Department and the DOI with log-in credentials in order to access Provider’s claims and customer service systems on a read-only basis. During the course of the on-site visit, Provider shall provide the Department or DOI access to a locked space and office security credentials for use during business hours. All access under this provision shall comply with HIPAA’s minimum necessary standards and any other applicable Commonwealth or Federal Law.
 - ii. Upon reasonable notice, Provider shall allow duly authorized agents or representatives of the Commonwealth or federal government or the independent external quality review organization required by Section 1902(a)(30)(c) of the Social Security Act, 42 U.S. Code Section 1396a(a)(30), access to the Provider’s premises during normal business hours to inspect, audit, investigate, monitor or otherwise evaluate the performance of the Provider and/or its subcontractors. Provider and/or its subcontractors shall forthwith produce all records, documents, or other data requested as part of such review, investigation, or audit.

- iii. In the event right of access is requested under this section, the Provider or subcontractor shall provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the Commonwealth, federal, or external quality review personnel conducting the audit, investigation, or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of the Provider's or its subcontractors' activities. Provider will be given 20 business days to respond to any findings of an audit made by Finance, the Department or their agent before the findings are finalized. Provider shall cooperate with Finance, the Department or their agent as necessary to resolve audit findings. All information obtained will be accorded confidential treatment as provided under applicable laws, rules and regulations.

[KY Medicaid Contract § 5.6]

g. Hold Harmless Provisions.

- i. Provider will indemnify, defend 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 the Provider.
- ii. Provider further covenants and agrees that in the event of a breach of this Agreement by the Health Plan, termination of this Agreement, or insolvency of the Health Plan, Provider shall provide all services and fulfill all of its obligations pursuant to this Agreement for the remainder of any month for which the Department has made payments to the Health Plan, and shall fulfill all of its obligations respecting the transfer of Members to other providers, including record maintenance, access and reporting requirements all such covenants, agreements, and obligations of which shall survive the termination of the Kentucky Contract and this Agreement.

[KY Medicaid Contract § 6.1]

h. Behavioral Health Provider and Primary Care Providers.

- i. The following applies if Provider is a primary care provider: Provider shall have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavior health problems and disorders. Primary care providers may provide any clinically appropriate behavioral health services within the scope of their practice. [KY Medicaid Contract § 34.7]
- ii. The following applies if Provider provides behavioral health services: Provider shall ensure that all Members receiving inpatient behavioral health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. Provider will contact Members who have missed appointments within 24 hours to reschedule appointments. [KY Medicaid Contract § 34.8]

i. General Requirements.

- i. The Commonwealth is the intended third-party beneficiary of this Agreement and, as such, the Commonwealth is entitled to all remedies entitled to third-party beneficiaries under law. [KY Medicaid Contract § 6.2.I]

- ii. Provider shall timely submit encounter records in the format specified by the Department so that Health Plan can meet the Department's specifications required by the Kentucky Contract. [KY Medicaid Contract § 6.2.J]
- iii. This Agreement incorporates all provisions of the Kentucky Contract to the fullest extent applicable to the service or activity to be performed under the Agreement, including without limitation, the obligation to comply with all applicable federal and Commonwealth law and regulations, including but not limited to, KRS 205.8451-8483, all rules, policies and procedures of Finance and the Department, and all standards governing the provision of Covered Services and information to Members, all QAPI requirements, all record keeping and reporting requirements, all obligations to maintain the confidentiality of information, all rights of Finance, the Department, the Office of the Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations, all indemnification and insurance requirements, and all obligations upon termination. [KY Medicaid Contract § 6.2.K]
- iv. In no event shall the Commonwealth, Finance, the Department or Member be liable for the payment of any debt or fulfillment of any obligation of Health Plan or any Provider to any subcontractor, supplier, out-of-network provider or any other party, for any reason whatsoever, including the insolvency of Health Plan or any Provider. Provider agrees that any subcontract will contain a hold harmless provision. [KY Medicaid Contract § 13.2]
- v. Provider is prohibited from directly receiving payment or any type of compensation from the Member, except for Member co-pays or deductibles from Members for providing Covered Services. Member co-pay, co-insurance or deductible amounts cannot exceed amounts specified in 907 KAR 1:604. [KY Medicaid Contract § 14.2]
- vi. Provider will report/submit all encounter records in an accurate and timely fashion. [KY Medicaid Contract § 16.1]
- vii. Health Plan encourages Provider to establish connectivity with the Kentucky Health Information Exchange. [KY Medicaid Contract § 17]
- viii. Quality Assessment/Performance Improvement ("QAPI") program activities of Provider, if separate from Health Plan's QAPI activities, shall be integrated into the overall QAPI program. Requirements to participate in QAPI activities, including submission of complete encounter record, are incorporated into this Agreement and Provider subcontracts and employment agreements. Health Plan shall provide feedback regarding the integration of, operation of, and corrective actions necessary in Provider's QAPI activities. [KY Medicaid Contract § 19.3]
- ix. Consistent with 42 CFR sections 438.6(h) and 422.208, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to a Member. [KY Medicaid Contract § 21.2]
- x. Provider's service locations shall meet all requirements of the Americans with Disabilities Act, and all Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures which are applicable to health care facilities. [KY Medicaid Contract § 23.1]

- xi. A provider cannot enroll in Health Plan's Participating Provider network if the provider has active sanctions imposed by Medicare or Medicaid or CHIP, if required licenses and certifications are not current, if money is owed to the Medicaid program, or if the Office of the Attorney General has an active fraud investigation involving the provider or the provider otherwise fails to satisfactorily complete the credentialing process. Health Plan shall obtain access to the National Practitioner Database as part of their credentialing process in order to verify the provider's eligibility for network participation. [KY Medicaid Contract § 29.3]
- xii. Provider is not required to participate in the Kentucky Medicaid fee-for-service program as a condition of participation in Health Plan's network but must enroll in the program and receive a Medicaid provider number in order to participate in Health Plan's network. If Provider has not had a Medicaid number assigned, Provider shall apply for enrollment with the Department and meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. [KY Medicaid Contract § 29.5]
- xiii. Health Plan shall terminate from participation any provider who (i) engages in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare or Medicaid program; (ii) has a license, certification, or accreditation terminated, revoked or suspended; (iii) has medical staff privileges at any hospital terminated, revoked or suspended; or (iv) engages in behavior that is a danger to the health, safety or welfare of Members. [KY Medicaid Contract § 29.6]
- xiv. If coverage of any Medicaid service provided by Provider requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be properly completed according to the appropriate Kentucky Administrative Regulation. Provider shall retain the form in the event of audit and a copy shall be submitted to the Department upon request. [KY Medicaid Contract § 31.1]
- xv. Provider shall maintain its accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted system of accounting. The accounting system shall clearly document all financial transactions between Health Plan and Provider. These transactions shall include, but not be limited to, claims payment, refunds and adjustment of payments. [KY Medicaid Contract § 38.14]
- xvi. Provider shall provide access to the medical record of Members to Health Plan, the Department, the Office of the Inspector General and other authorized Commonwealth and federal agents thereof, for purposes of auditing. Additionally, when a Member changes primary care providers, the medical records or copies of medical records shall be forwarded by Provider to the new primary care provider or Health Plan within 10 days from receipt of request. Primary care Providers shall have Members sign a release of medical records before a medical record transfer occurs. [KY Medicaid Contract § 39.1]
- xvii. Provider shall provide written notice to Health Plan, so that Health Plan may meet its obligation to notify Finance pursuant to the terms of the Kentucky Contract, of any legal action or notice listed below, within two days following the date Provider becomes aware of:
 - A. Any action, proposed action, lawsuit or counterclaim filed against Provider, related in any way to the Kentucky Contract;

- B. Any administrative or regulatory action, or proposed action, respecting the business or operations of Provider, related in any way to the Kentucky Contract;
- C. Any notice received from the Department of Insurance or the Cabinet for Health and Family Services;
- D. Any claim made against Provider by a Member having the potential to result in litigation related in any way to the Kentucky Contract;
- E. The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider; and
- F. The payment of a civil fine or conviction of any person who has an ownership or controlling interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person's involvement in a program under Medicare, Medicaid, or Title XX of the Social Security Act, or of fraud, or unlawful manufacture, distribution, prescription or dispensing of a controlled substance, as specified in 42 USC 1320a-7.

A complete copy of all documents, filings or notices shall accompany the notice to Health Plan. A complete copy of all further filings and other documents generated in connection with any such legal action shall be provided to Health Plan within five days following the date Provider receives such documents. [KY Medicaid Contract § 41.4]

- xviii. Provider shall abide by the rules and regulations regarding the confidentiality of protected health information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164. [KY Medicaid Contract § 41.15]

8. Kentucky RFP Requirements.

- a. Provider shall adhere to applicable Commonwealth policies and standards related to technology use and security. [KY Medicaid RFP 758 1500000283 § 30.1]
- b. Provider shall comply with the provisions of the Privacy Act of 1974 and instruct its employees to use the same degree of care as it uses with its own data to keep confidential information concerning client data, the business of the Commonwealth, its financial affairs, its relations with its citizens and its employees, as well as any other information which may be specifically classified as confidential by the Commonwealth in writing to Health Plan. All Federal and State regulations and statutes related to confidentiality shall be applicable to Provider. Provider shall have an appropriate agreement with its employees to that effect, provided however, that the foregoing will not apply to: (i) information which the Commonwealth has released in writing from being maintained in confidence; (ii) information which at the time of disclosure is in the public domain by having been printed and published and available to the public in libraries or other public places where such data is usually collected; or (iii) information, which, after disclosure, becomes part of the public domain as defined above, through no act of Provider.

Provider shall have an appropriate agreement with its subcontractors extending these confidentiality requirements to all subcontractors' employees. [KY Medicaid RFP 758 1500000283 § 40.17]

- c. Provider is not a third party beneficiary of the Kentucky Contract and is performing Covered Services as agreed upon with Health Plan pursuant to this Agreement and as outlined in the Kentucky Contract. [RFP Appendix C, A(4)]
- d. In the event the Department determines that any provision of this Agreement conflicts with the Kentucky Contract, such provision shall be null and void and all other provisions of this Agreement shall remain in full force and effect. [RFP Appendix C, A(5)]
- e. Provider shall adhere to the marketing restrictions and requirements set forth in the Kentucky Contract. [RFP Appendix C, section B]
- f. If Provider renders covered primary care services under this Agreement, Provider shall adhere to the PCP requirements set forth in the Kentucky Contract. [RFP Appendix C, subsection C(3).]
- g. If Provider renders covered laboratory services under this Agreement, Provider shall meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988. [RFP Appendix C, subsection C(4)]
- h. Provider shall meet appointment waiting time standards set forth in the Kentucky Contract and further described in the Provider Manual. [RFP Appendix C, subsection C(5)]
- i. Provider shall comply with Member rights and responsibilities as outlined in the Kentucky Contract. [RFP Appendix C, subsection D(2)]
- j. Provider shall comply with all applicable cultural competency requirements of the Kentucky Contract. [RFP Appendix C, subsection D(3)]
- k. Provider shall display notices in a public area of its office or facility, in accordance with Department rules and regulations as amended, of Member's right to appeal adverse action affecting Covered Services. [RFP Appendix C, subsection D(5)]
- l. Provider shall submit timely to Health Plan any information, including reports and clinical information, necessary for Health Plan to perform its obligations under the Kentucky Contract. [RFP Appendix C, subsection H(1)]
- m. Health Plan shall monitor Provider's performance on an ongoing basis and Provider shall be subject to formal periodic review. [RFP Appendix C, subsection H(2)]
- n. Health Plan shall monitor Provider's performance and the quality of services delivered by Provider pursuant to this Agreement. [RFP Appendix C, subsection H(3)]
- o. Provider shall comply with any corrective action plans required by Health Plan related to this Agreement. [RFP Appendix C, subsection H(4)]
- p. Provider shall, as a condition of receiving payment under this Agreement, comply with the Program Integrity requirements of the Kentucky Contract, as applicable. [RFP Appendix C, subsection I(1)]
- q. Consistent with the termination provisions of this Agreement and in accordance with the Kentucky Contract, Provider shall be terminated for any violation of applicable State or federal statutes, rules, or regulations. [RFP Appendix C, subsection K(1)]

- r. The Department shall reserve the right to direct Health Plan to terminate or modify this Agreement when the Department has determined such termination or modification is in the best interest of the Commonwealth. [RFP Appendix C, subsection K(2)]

**ATTACHMENT C
COMPENSATION**

(See following attachments

ATTACHMENT C-1
KENTUCKY MEDICAID AND CHIP COMPENSATION
(HOSPITAL)

1. The compensation rates set forth in this Attachment apply for Benefit Plans under Kentucky Contracts. Compensation shall be subject to and in accordance with the terms and conditions of the Agreement, including this Attachment.
2. Compensation. Fee for service compensation for Covered Services provided to Members shall be the lesser of the Provider's usual and customary billed charges or the following, less Member Expenses:
 - a. Inpatient Covered Services:

_____ of the applicable Kentucky Medicaid inpatient prospective payment system rates of Diagnosis Related Groups (DRG) published on the Department's website on the date of the Member's discharge.
 - b. Outpatient Covered Services:

_____ percent of the applicable Kentucky Medicaid payment system published on the Department's website on the date the Covered Services are rendered.
3. Laboratory Compensation. Notwithstanding the above, fee for service compensation for laboratory Covered Services provided to Members shall be the lesser of the Provider's usual and customary billed charges or the following, less Member Expenses:

_____ percent of the applicable Kentucky Medicaid fee schedule published on the Department's website on the date the Covered Services are rendered, provided that Health Plan has previously received verification of the Provider's current and appropriate CLIA Certificate or Certificate of Waiver.
4. Health Plan will make no payment in addition to the applicable inpatient rate for Covered Services set forth above for (i) outpatient services rendered in the emergency room of the hospital prior to an inpatient admission, (ii) outpatient observation services rendered prior to an inpatient admission, or (iii) outpatient services or procedures rendered to Members by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), in the three days preceding and day of an inpatient admission to the hospital for the same illness or injury. The terms "wholly owned" and "wholly operated" shall be as defined by CMS.
5. Upon a Member's discharge from a Provider's facility, Health Plan shall not pay the Provider for additional Covered Services rendered to the Member by the Provider if the Member is readmitted to the same facility within 30 days for the same diagnosis.
6. If a Member is transferred (i) from a Provider facility to another medical facility, or (ii) to a Provider facility from another medical facility, Health Plan shall adjust its payments for Covered Services rendered at the Provider facility and other medical facility in a manner consistent with the Department's payment rules and guidelines for traditional Medicaid.
7. Health Plan may request an itemized statement or copies of medical records for outlier claims and may deny any such claim where Provider fails to provide a complete and accurate itemized statement or medical record as requested.
8. Health Plan shall process claims and pay or deny a Clean Claim within 30 days of its receipt of the

Clean Claim. The date of receipt of a Clean Claim shall be the date Health Plan receives the Clean Claim electronically, or for paper claims as indicated by Health Plan's date stamp on the Clean Claim. The date of payment shall be the date of the electronic funds transfer, check or other form of payment.

9. Health Plan will implement and prospectively apply changes to the Department's Kentucky Medicaid fee schedules and payment systems on the later of (a) the effective date of the change, (b) 45 days from the date the Department publishes the change on its website, or (c) 45 days after the proposed change has received all necessary regulatory approvals. With respect to hospital compensation, Health Plan shall make all reasonable good faith efforts to obtain rate factors from the Department; however, if the Department does not provide such rate factors to Health Plan, Health Plan may request Contracted Provider to provide such rate factors and Contracted Provider shall do so as soon as reasonably practicable. In such a case, Health Plan shall have 45 days from its receipt of the rate factors to load the rate factors into its rate schedule. Health Plan will not reprocess claims that were adjudicated prior to the date Health Plan implemented such changes.
10. Health Plan may implement successor codes for deleted or retired codes as codes are revised or implemented by the Governmental Authorities or coding authorities. Health Plan will, to the extent reasonably possible, tie existing compensation rates for the Covered Services to the successor codes. When applicable, such as for value added benefits covered by a Benefit Plan, Health Plan will determine rates for Covered Services that are not included in the Department's Kentucky Medicaid fee schedules and payment systems published on its website.

ATTACHMENT C-2
KENTUCKY MEDICAID AND CHIP COMPENSATION
(PROFESSIONAL)
(FEE FOR SERVICE)

1. The compensation rates set forth in this Attachment apply for Benefit Plans under Kentucky Contracts. Compensation shall be subject to and in accordance with the terms and conditions of the Agreement, including this Attachment.
2. Compensation. Fee for service compensation for Covered Services provided to Members shall be the lesser of the Provider's usual and customary billed charges or the following, less Member Expenses:
 - a. Primary Care Services:
____ percent of the Kentucky Medicaid physician fee schedule published on the Department's website on the date the Covered Services are rendered.
 - b. Specialty Services:
____ percent of the Kentucky Medicaid physician fee schedule published on the Department's website on the date the Covered Services are rendered.
3. Laboratory Services. Notwithstanding the above, fee for service compensation for laboratory Covered Services provided to Members shall be the lesser of the Provider's usual and customary billed charges or the following, less Member Expenses:
____ percent of the applicable Kentucky Medicaid fee schedule published on the Department's website on the date the Covered Services are rendered, provided that Health Plan has previously received verification of the Provider's current and appropriate CLIA Certificate or Certificate of Waiver.
4. Health Plan shall process claims and pay or deny a Clean Claim within 30 days of its receipt of the Clean Claim. The date of receipt of a Clean Claim shall be the date Health Plan receives the Clean Claim electronically, or for paper claims as indicated by Health Plan's date stamp on the Clean Claim. The date of payment shall be the date of the electronic funds transfer, check or other form of payment.
5. Health Plan will implement and prospectively apply changes to the Department's Kentucky Medicaid fee schedules on the later of (a) the effective date of the change, (b) 45 days from the date the Department publishes the change on its website, or (c) 45 days after a proposed fee schedule change has received all necessary regulatory approvals. Health Plan will not reprocess claims that were adjudicated prior to the date Health Plan implemented such changes.
6. Health Plan may implement successor codes for deleted or retired codes as codes are revised or implemented by the Governmental Authorities or coding authorities. Health Plan will, to the extent reasonably possible, tie existing compensation rates for the Covered Services to the successor codes. When applicable, such as for value added benefits covered by a Benefit Plan, Health Plan will determine rates for Covered Services that are not included in the Department's Kentucky Medicaid fee schedules published on its website.
7. The amount of compensation paid is based on the treating Provider's licensure and Health Plan's credentialing requirements for that discipline, not on the Provider's academic credentials.

**ATTACHMENT C-3
KENTUCKY MEDICAID AND CHIP COMPENSATION
(PROFESSIONAL)
(CAPITATION)**

1. The compensation rates set forth in this Attachment apply for Benefit Plans under Kentucky Contracts. Compensation shall be subject to and in accordance with the terms and conditions of the Agreement, including this Attachment.
2. Capitation Payments.
 - a. Health Plan shall make capitation payments to Contracted Provider for Primary Care Services provided to Assigned Members on or about the 20th day of each month in the following amount and subject to the terms of this Attachment:

_____ per Assigned Member per month.
 - b. With respect to capitated Primary Care Services, Health Plan reserves the right to deduct from capitation paid to the Provider any amounts paid to other providers for capitated Primary Care Services when provided to Assigned Members by such other providers.
 - c. Each month, Health Plan will review its total capitation payments for Assigned Members for preceding months and reconcile such payments against the Department's member enrollment data. If Health Plan determines there were enrollment changes in any preceding months, Health Plan may adjust capitation payments to Provider in any subsequent months by the amount of any underpayment or overpayment due to changes in enrollment to reflect the actual number of Assigned Members.
 - d. Capitation payments are subject to Health Plan's receipt of timely, accurate, true, and complete Encounter Data. Contracted Provider shall, and shall require the other Providers to, electronically submit Encounter Data to Health Plan within 30 days of the last day of the month in which Covered Services were provided, or such shorter period necessary for Health Plan to comply with Laws or Program Requirements.
3. Fee for Service Compensation.
 - a. For Covered Services not covered by the capitation payments described above, fee for service compensation for Covered Services provided to Members shall be the lesser of the Provider's billed charges or the following, less Member Expenses:
 - i. Primary Care Services:

_____ percent of the Kentucky Medicaid physician fee schedule published on the Department's website on the date the Covered Services are rendered.
 - ii. Specialty Services:

_____ percent of the Kentucky Medicaid physician fee schedule published on the Department's website on the date the Covered Services are rendered.
 - b. Health Plan shall process claims and pay or deny a Clean Claim within 30 days of its receipt of the

Clean Claim. The date of receipt of a Clean Claim shall be the date Health Plan receives the Clean Claim electronically, or for paper claims as indicated by Health Plan's date stamp on the Clean Claim. The date of payment shall be the date of the electronic funds transfer, check or other form of payment.

- c. Health Plan will implement and prospectively apply changes to the Department's Kentucky Medicaid fee schedules on the later of (i) the effective date of the change, (ii) 45 days from the date the Department publishes the change on its website, or (iii) 45 days after a proposed fee schedule change has received all necessary regulatory approvals. Health Plan will not reprocess claims that were adjudicated prior to the date Health Plan implemented such changes.
- d. Health Plan may implement successor codes for deleted or retired codes as codes are revised or implemented by the Governmental Authorities or coding authorities. Health Plan will, to the extent reasonably possible, tie existing compensation rates for the Covered Services to the successor codes. When applicable, such as for value added benefits covered by a Benefit Plan, Health Plan will determine rates for Covered Services that are not included in the Department's Kentucky Medicaid fee schedules published on its website.
- e. The amount of compensation paid is based on the treating Provider's licensure and Health Plan's credentialing requirements for that discipline, not on the Provider's academic credentials.

ATTACHMENT C-4
KENTUCKY MEDICAID AND CHIP COMPENSATION
(EPSDT SERVICES)
(FEE FOR SERVICE)

1. The compensation rates set forth in this Attachment apply for Benefit Plans under Kentucky Contracts. Compensation shall be subject to and in accordance with the terms and conditions of the Agreement, including this Attachment.
2. Compensation. Fee for service compensation for Covered Services provided to Members shall be the lesser of the Provider's usual and customary billed charges or the following, less Member Expenses:

____ percent of the Department's applicable Kentucky Medicaid fee schedule published on the Department's website on the date the Covered Services are rendered, in accordance with 907 KAR 11:035.
3. Laboratory Compensation. Notwithstanding the above, fee for service compensation for laboratory Covered Services provided to Members shall be the lesser of the Provider's usual and customary billed charges or the following, less Member Expenses:

____ percent of the applicable Kentucky Medicaid fee schedule published on the Department's website on the date the Covered Services are rendered, provided that Health Plan has previously received verification of the Provider's current and appropriate CLIA Certificate or Certificate of Waiver.
4. Health Plan shall process claims and pay or deny a Clean Claim within 30 days of its receipt of the Clean Claim. The date of receipt of a Clean Claim shall be the date Health Plan receives the Clean Claim electronically, or for paper claims as indicated by Health Plan's date stamp on the Clean Claim. The date of payment shall be the date of the electronic funds transfer, check or other form of payment.
5. Health Plan will implement and prospectively apply changes to the Department's Kentucky Medicaid fee schedules on the later of (a) the effective date of the change, (b) 45 days from the date the Department publishes the change on its website, or (c) 45 days after a proposed fee schedule change has received all necessary regulatory approvals. Health Plan will not reprocess claims that were adjudicated prior to the date Health Plan implemented such changes.
6. Health Plan may implement successor codes for deleted or retired codes as codes are revised or implemented by the Governmental Authorities or coding authorities. Health Plan will, to the extent reasonably possible, tie existing compensation rates for the Covered Services to the successor codes. When applicable, such as for value added benefits covered by a Benefit Plan, Health Plan will determine rates for Covered Services that are not included in the Department's Kentucky Medicaid fee schedules published on its website.
7. The amount of compensation paid is based on the treating Provider's licensure and Health Plan's credentialing requirements for that discipline, not on the Provider's academic credentials.

**ATTACHMENT C-5
KENTUCKY MEDICAID AND CHIP COMPENSATION
(BEHAVIORAL HEALTH FACILITY)
(FEE FOR SERVICE)**

- The compensation rates set forth in this Attachment apply for Benefit Plans under Kentucky Contracts. Compensation shall be subject to and in accordance with the terms and conditions of the Agreement, including this Attachment.
- Compensation. Fee for service compensation for Covered Services provided to Members shall be the lesser of the Provider's usual and customary billed charges, or Health Plan's applicable fee schedule for behavioral health Covered Services, less Member Expenses. As of the Effective Date, Health Plan's current fee schedules for behavioral health inpatient and outpatient Covered Services are as follows:

Health Plan's Kentucky Medicaid Fee Schedule for Inpatient Behavioral Health			
Revenue Codes	Description	Rate	Unit
114, 124, 134, 144, 154	Psych Revenue Codes	\$ _____	Per Diem
116, 118, 126, 128, 136, 138, 146, 156, 158	Detox Revenue Codes/Rehab	\$ _____	Per Diem
901*	Electroshock Treatment (ECT)	\$ _____	Per Treatment
1001, 1002, 1003, 1004, 1005	Residential Treatment	\$ _____	Per Diem

*Note: when ECT is performed during an inpatient stay, Health Plan will pay for ECT at the above rate in addition to the inpatient per diem rate.

Health Plan's Kentucky Medicaid Fee Schedule for Outpatient Behavioral Health			
Revenue Codes	Description	Rate	Unit
513	Psychiatric Clinic	\$ _____	Per Visit
900	Psychiatric/Psychological Treatment	\$ _____	Per Diem
901	Electroshock Treatment	\$ _____	Per Treatment
905	Intensive Outpatient - Mental Health	\$ _____	Per Diem
906	Intensive Outpatient - Substance Abuse	\$ _____	Per Diem
911, 944, 945	Rehabilitation	\$ _____	Per Diem
912, 913	Partial Hospitalization	\$ _____	Per Diem
914	Individual Therapy	\$ _____	Per Visit
915	Group Therapy	\$ _____	Per Visit

916	Family Therapy	\$_____	Per Visit
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3. The rates set forth in Health Plan’s fee schedule for behavioral health Covered Services are inclusive of all additional services performed on the same date, including without limitation labs, pharmacy, infusion, and x-ray.
4. Health Plan shall process claims and pay or deny a Clean Claim within 30 days of its receipt of the Clean Claim. The date of receipt of a Clean Claim shall be the date Health Plan receives the Clean Claim electronically, or for paper claims as indicated by Health Plan’s date stamp on the Clean Claim. The date of payment shall be the date of the electronic funds transfer, check or other form of payment.
5. With respect to billing codes listed in Health Plan’s fee schedules for behavioral health inpatient and outpatient Covered Services:
 - a. Health Plan may update its fee schedules without notice to account for changes in billing codes as implemented by the Governmental Authorities and coding authorities. In such a case, Health Plan will, to the extent reasonably possible, tie existing compensation rates for the Covered Services to the changed codes. If Health Plan is unable to tie existing rates to changed codes or if there is a code applicable to behavioral health Covered Services that is not on Health Plan’s fee schedule, Health Plan will determine rates for such items and services, in its sole discretion, and update its fee schedule accordingly.
 - b. Upon Contracted Provider’s request, Health Plan will provide its current fee schedule for behavioral health Covered Services to Contracted Provider.

**ATTACHMENT C-6
KENTUCKY MEDICAID AND CHIP COMPENSATION
(SKILLED NURSING FACILITY)
(PER DIEM)**

1. The compensation rates set forth in this Attachment apply for Benefit Plans under Kentucky Contracts. Compensation shall be subject to and in accordance with the terms and conditions of the Agreement, including this Attachment.
2. Compensation. Fee for service compensation for Covered Services provided to Members shall be the lesser of the Provider's usual and customary billed charges or the following, less Member Expenses:
 - a. Inpatient Covered Services:

Health Plan’s Medicaid SNF Per Diem Rate Table					
Level of Care*	Level 1	Level 2	Level 3	Level 4	Level 5 for Medically Complex/Other
Per Diem Amount	\$___	\$___	\$___	\$___	\$___
Revenue Code	191	192	193	194	199
*The Level of Care is based on nationally accepted clinical care guidelines and Health Plan’s clinical coverage guidelines, which are available on Health Plan’s website.					
The Per Diem Amount set forth above is reimbursement in full for all Covered Services rendered by Providers, including rehabilitation, pharmacy, laboratory, diagnostics, and durable medical equipment.					

- b. Outpatient Physical, Occupation and Speech Therapy Covered Services:

\$___ per visit

3. Health Plan shall process claims and pay or deny a Clean Claim within 30 days of its receipt of the Clean Claim. The date of receipt of a Clean Claim shall be the date Health Plan receives the Clean Claim electronically, or for paper claims as indicated by Health Plan’s date stamp on the Clean Claim. The date of payment shall be the date of the electronic funds transfer, check or other form of payment.
4. Health Plan may, without notice to Contracted Provider or amendment to the Agreement, update its Medicaid SNF Per Diem Rate Table to include successor code numbers for the same services or delete retired codes, as such are revised or implemented by Governmental Authorities or coding authorities from time to time. Health Plan may modify its rate tables for new codes, services, or otherwise upon providing 90 days prior written notice to Contracted Provider.

**ATTACHMENT C-7
KENTUCKY MEDICAID AND CHIP COMPENSATION
(DME)
(FEE FOR SERVICE)**

1. The compensation rates set forth in this Attachment apply for Benefit Plans under Kentucky Contracts. Compensation shall be subject to and in accordance with the terms and conditions of the Agreement, including this Attachment.
2. Compensation. Fee for service compensation for Covered Services provided to Members shall be the lesser of the Provider's usual and customary billed charges or the lesser of the following, less Member Expenses:
 - a. ____ percent of the Health Plan's then current Kentucky Medicaid Home Health and Durable Medical Equipment Supplemental Fee Schedule, a copy of which is annexed to this Agreement. Health Plan will include in its Kentucky Home Health and Durable Medical Equipment Supplemental Fee Schedule those Covered Services and corresponding reimbursement rates that are not included in the Department's Medicaid fee schedule.
 - b. ____ percent of the Department's applicable Kentucky Medicaid fee schedule published on the Department's website on the date the Covered Services are rendered.
3. Laboratory Compensation. Notwithstanding the above, fee for service compensation for laboratory Covered Services provided to Members shall be the lesser of the Provider's usual and customary billed charges or the following, less Member Expenses:

____ percent of the applicable Kentucky Medicaid fee schedule published on the Department's website on the date the Covered Services are rendered, provided that Health Plan has previously received verification of the Provider's current and appropriate CLIA Certificate or Certificate of Waiver.
4. Health Plan shall process claims and pay or deny a Clean Claim within 30 days of its receipt of the Clean Claim. The date of receipt of a Clean Claim shall be the date Health Plan receives the Clean Claim electronically, or for paper claims as indicated by Health Plan's date stamp on the Clean Claim. The date of payment shall be the date of the electronic funds transfer, check or other form of payment.
5. Health Plan will implement and prospectively apply changes to the Department's Kentucky Medicaid fee schedules on the later of (i) the effective date of the change, (ii) 45 days from the date the Department publishes the change on its website, or (iii) 45 days after a proposed fee schedule change has received all necessary regulatory approvals. Health Plan will not reprocess claims that were adjudicated prior to the date Health Plan implemented such changes.
6. Health Plan may implement successor codes for deleted or retired codes as codes are revised or implemented by the Governmental Authorities or coding authorities. Health Plan will, to the extent reasonably possible, tie existing compensation rates for the Covered Services to the successor codes. When applicable, such as for value added benefits covered by a Benefit Plan, Health Plan will determine rates for Covered Services that are not included in the Department's Kentucky Medicaid fee schedules published on its website.
7. If Health Plan changes its Home Health and Durable Medical Equipment Supplemental Fee Schedule or its Medicaid rate schedules for reasons other than described above it will provide notice to Provider at least ninety (90) days prior to the effective date of the change.

ATTACHMENT C-8
KENTUCKY MEDICAID AND CHIP COMPENSATION
(CRITICAL ACCESS HOSPITAL)

1. The compensation rates set forth in this Attachment apply for Benefit Plans under Kentucky Contracts for licensed and certified Critical Access Hospital (CAH) Providers covered under this Agreement. Compensation shall be subject to and in accordance with the terms and conditions of the Agreement, including this Attachment.
2. CAH Compensation. Fee for service compensation for Covered Services provided to Members by CAH Providers shall be the lesser of the Provider's usual and customary billed charges or the following, less Member Expenses:
 - a. Inpatient Covered Services:

____ percent of the applicable per diem amount paid by the Department in accordance with 907 KAR 10:815.
 - b. Outpatient Covered Services:

____ percent of the applicable Kentucky Medicaid payment system published on the Department's website on the date the Covered Services are rendered.
 - c. In addition to the foregoing outpatient compensation, the Parties shall conduct an annual outpatient settlement in accordance with 907 KAR 10:015. Health Plan payments hereunder shall be conditioned on Provider submitting cost reports and documentation required by the regulation to Health Plan.
3. If a Member is transferred (i) from a Provider facility to another medical facility, or (ii) to a Provider facility from another medical facility, Health Plan shall adjust its payments for Covered Services rendered at the Provider facility and other medical facility in a manner consistent with the Department's payment rules and guidelines for traditional Medicaid.
4. Health Plan may request an itemized statement or copies of medical records for outlier claims and may deny any such claim where Provider fails to provide a complete and accurate itemized statement or medical record as requested.
5. Health Plan shall process claims and pay or deny a Clean Claim within 30 days of its receipt of the Clean Claim. The date of receipt of a Clean Claim shall be the date Health Plan receives the Clean Claim electronically, or for paper claims as indicated by Health Plan's date stamp on the Clean Claim. The date of payment shall be the date of the electronic funds transfer, check or other form of payment.
6. Health Plan will implement and prospectively apply changes to the Department's Kentucky Medicaid fee schedules and payment systems on the later of: (a) the effective date of the change, (b) 45 days from the date the Department publishes the change on its website, or (c) 45 days after the proposed change has received all necessary regulatory approvals. With respect to hospital compensation, Health Plan shall make all reasonable good faith efforts to obtain rate factors from the Department; however, if the Department does not provide such rate factors to Health Plan, Health Plan may request Contracted Provider to provide such rate factors and Contracted Provider shall do so as soon as reasonably practicable. In such a case, Health Plan shall have 45 days from its receipt of the rate factors to load the rate factors into its rate schedule. Health Plan will not reprocess claims that were adjudicated prior

to the date Health Plan implemented such changes.

7. Health Plan may implement successor codes for deleted or retired codes as codes are revised or implemented by the Governmental Authorities or coding authorities. Health Plan will, to the extent reasonably possible, tie existing compensation rates for the Covered Services to the successor codes. When applicable, such as for value added benefits covered by a Benefit Plan, Health Plan will determine rates for Covered Services that are not included in the Department's Kentucky Medicaid fee schedules and payment systems published on its website.

**ATTACHMENT C-9
KENTUCKY MEDICAID AND CHIP COMPENSATION
(UPSIDE BONUS - QUALITY)**

1. Additional Definitions.

- a. **“Compliance Percentage”** means the number of Assigned Members who are compliant with the Program Measures divided by the total number of Assigned Members eligible for the applicable Program Measure. Health Plan shall determine such percentage using administrative data methodologies outlined in the current year HEDIS® Technical Specifications. Health Plan shall accept claims and encounter data for Covered Services rendered during the applicable HEDIS Measurement Year until March 31st of the HEDIS Reporting Year.
- b. **“Deficit”** means a negative balance in the Net Operating Fund.
- c. **“HEDIS®”** means Healthcare Effectiveness Data and Information Set. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
- d. **“HEDIS® Measure Percentile”** means the percentile for a particular HEDIS® measure based on the most recent NCQA Quality Compass HEDIS Measures for Medicaid managed care plans.
- e. **“HEDIS Measurement Year”** is the first calendar year (and each calendar year thereafter) for which Health Plan has a full year of claims and encounter data for Covered Services rendered by Contracted Provider and its Providers.
- f. **“HEDIS Reporting Year”** is the calendar year immediately following the HEDIS Measurement Year.
- g. **“HEDIS® Technical Specifications”** means the HEDIS® 2014 Volume 2, Technical Specifications as published by NCQA, or any relevant successor HEDIS® Technical Specifications published during the term of this Agreement.
- h. **“Net Operating Fund”** means the Operating Fund funding less the Operating Fund deductions.
- i. **“Operating Fund”** means a separate Contracted Provider specific fund created in Health Plan ledgers for purposes of accounting for Health Plan’s payments for Covered Services, including covered medical and related health care items and services and any value added items and services covered under the applicable Benefit Plans, provided to Assigned Members, and other associated administrative or insurance payments made by Health Plan.
- j. **“Other Risk Agreement”** means an agreement between Health Plan or its Affiliate and Contracted Provider or its Affiliate that includes compensation to Contracted Provider or its Affiliate based in any part, on potential upside bonuses or risk sharing.
- k. **“Physician Incentive Plan”** or **“PIP”** shall have the meaning set forth in 42 CFR §§ 422.208 and 417.479.
- l. **“Program Measure(s)”** means the HEDIS® measures or other measures used by Health Plan to calculate Contracted Provider’s Quality Rating Score. Program Measures are based on HEDIS® Technical Specifications and other measures used by a Governmental Authority to evaluate Health Plan’s quality. Health Plan will disclose the Program Measures for the HEDIS Measurement Year

to Contracted Provider annually during the HEDIS Reporting Year. Health Plan may exclude any measure that cannot be calculated using claims or encounter data or that Health Plan cannot otherwise reasonably determine at the Contracted Provider level.

- m. **“Quality Rating Score”** means the average of each HEDIS® Measure Percentile achieved by Contracted Provider. Health Plan will determine Contracted Provider’s Quality Rating Score by using the Compliance Percentage for each of the Program Measures. Health Plan shall determine Contracted Provider’s Quality Rating Score annually each HEDIS Reporting Year.
 - n. **“Quality Rating Target”** means a Quality Rating Score that meets or exceeds the 75th percentile.
 - o. **“Referral Services”** means all Covered Services rendered to Assigned Members by any provider other than a Provider, including Participating Providers who are not Providers and non-Participating Providers, including Emergency Services, and specialty, physician, inpatient, outpatient, institutional, ancillary, mental health and substance abuse, home health care, laboratory, other traditional institutional and professional services, whether on an in-network or out-of-network basis, and other services or value added services covered under such Assigned Members’ Benefit Plans.
 - p. **“Reporting Period”** means a calendar month.
 - q. **“Service Fund Report”** means the monthly report of the Operating Fund revenue, deductions and any adjustments thereto distributed or made available electronically by Health Plan.
 - r. **“Stop Loss Program”** means the stop loss program implemented and maintained by Health Plan to cover ____ percent of the amounts paid for Referral Services above the applicable identified deductible.
 - s. **“Surplus”** means a positive balance in the Net Operating Fund.
2. Upside Bonus Arrangement.
- a. Commencement of Upside Bonus Arrangement. The upside bonus arrangement will commence on the first day of the month following four full months from the Effective Date of this Agreement. As of the commencement of the upside bonus arrangement, Contracted Provider shall be eligible for upside bonus payments based on Covered Services rendered to Assigned Members, subject to and in accordance with this Agreement. If Contracted Provider was in a bonus or shared risk arrangement for any program or insurance product with Health Plan or a Health Plan Affiliate before the Effective Date (**“Prior Risk Arrangement”**), then for any activity, including funding, claims and capitation payments for dates of service prior to the Effective Date, the funds in the Prior Risk Arrangement shall be credited and deducted in accordance with the Prior Risk Arrangement to initially determine any surplus or deficit, and the initial surplus or deficit determined under the Prior Risk Arrangement will be reconciled (such reconciliation to also include the retroactive Operating Fund adjustments described in this Attachment) and netted under this Agreement to arrive at an aggregate Surplus or Deficit.
 - b. Fund Risk Allocations. The allocation of the upside bonus percentages and associated Surplus resulting from the various funds as between Health Plan and Contracted Provider shall be as set out in Table 1.

Table 1

Fund	Bonus Limited	Contracted Provider Surplus	Health Plan Surplus
Operating Fund	___% of total primary care physician services payments	____%	____%

c. Aggregate Surplus in Operating Fund. For each Reporting Period any potential bonus payments from any aggregate Surplus attributed to Contracted Provider or Providers for which Contracted Provider may be eligible: (i) are limited to the amounts set out in Table 1 above; (ii) may be withheld by Health Plan if Health Plan projects a Deficit allocation to the Operating Fund in any upcoming Reporting Period based on claims received by Health Plan; and (iii) will not be paid if Contracted Provider is in breach of this Agreement, including due to failure to timely submit accurate and appropriate Encounter Data and Clean Claims, or failure to perform an administrative function that may be delegated to Contracted Provider under this Agreement.

d. Summary of Calculation of the Potential Bonus Payment.

- (Net Operating Fund * Table 1 Percent) = Net All Funds
- (PCP capitation payment + Contracted Provider claims) * ___% = Bonus Limit
- Lesser of Net All Funds or Bonus Limit = Available Bonus Amount
- Available Bonus Amount – Prior Payments = Potential Bonus Due

The Bonus Limit is based on the requirements found in 42 CFR §§ 422.208 and 417.479. Prior Payments means the bonus payments made to Contracted Provider in prior months. No Bonus will be due or payable for any Reporting Period in which Contracted Provider is in a Deficit.

e. Aggregate Deficit in Operating Fund. If there is an aggregate Deficit attributed to Contracted Provider from the reconciliation for the Net Operating Funds or its Affiliate from reconciliation of other service funds for more than three consecutive Reporting Periods, Health Plan may (i) immediately discontinue the upside bonus arrangement hereunder upon notice to Contracted Provider, or (ii) terminate the Agreement upon 60 days notice to Contracted Provider. In no event will Contracted Provider be paid a bonus if it is in a Deficit under this Agreement or any Other Risk Agreement. If Contracted Provider or its Affiliate is in an Other Risk Agreement for which it is responsible for payment of the Deficit, then that Deficit will be payable under such arrangement by Contracted Provider or its Affiliate.

3. Determination of Funds.

a. Funding for the Operating Fund and any and all deductions to the Operating Fund shall be calculated as follows to arrive at the Net Operating Fund.

i. Funding of Operating Fund.

A. Funding for the Operating Fund shall be a percent of the net monthly payment to Health Plan received from a Governmental Authority or Assigned Member, applicable to Assigned Members for items and services covered under Kentucky Contracts, which is reduced for any excise or premium tax, fee or cost imposed by any Governmental Authority on Health Plan (“Funding Level”).

- B. On the Effective Date of this Agreement, the baseline Funding Level shall be 84 percent (“Baseline Funding Level”), subject to the Quality Adjustment as set forth below.
- C. During the term of this Agreement any retroactive adjustments in premium, claims or expenses affecting any year shall be added to or deducted from the Operating Fund, regardless of whether such adjustments are specific to Assigned Members, as appropriate, including any retroactive changes to the premium amounts paid by the Department to Health Plan, any Department audit recovery or any working aged plan level adjustments.
- ii. Quality Adjustments. The Baseline Funding Level shall be adjusted annually as follows (the “Quality Adjustment”):
- A. On or about September of each year, after Health Plan determines Contracted Provider’s Quality Rating Score for the HEDIS Reporting Year, if Contracted Provider meets or exceeds the Quality Rating Target, the Funding Level shall be increased to _____ percent and applied retroactively to January 1st of that calendar year. Such increase shall remain in effect through December 31st of that calendar year and shall reset to the Baseline Funding Level beginning January 1st of the next calendar year.
- iii. Operating Fund Deductions. The following amounts will be deducted from (or credited to, if applicable) the Operating Fund:
- All payments for Covered Services rendered to Assigned Members, including Referral Services, prescription drug costs and dispensing fees, claims, capitation or other payments, including any average amounts paid in lieu of actual claims or capitation amounts or amounts paid in settlement of disputes regarding amounts alleged to be owing for Covered Services provided to Assigned Members regardless of whether such Covered Services were rendered by providers pursuant to a contract with Health Plan.
 - Amounts paid for disease/care/case management programs in which Assigned Members are enrolled.
 - Estimated amounts for incurred but not reported claims based on incurred expenses associated with providing medical care for Members that have been actuarially determined to have occurred but not yet reported to Health Plan.
 - Any Deficit amounts.
 - Monthly Stop Loss Program costs or financial benefit described in provisions regarding stop loss protection, when applicable.
 - If applicable, amounts paid for delegation of administrative services by Health Plan covered under this Agreement.
- b. Stop Loss Protection.
- i. Contracted Provider agrees (A) to participate in Health Plan’s Stop Loss Program made available to Participating Providers under bonus or risk sharing arrangements with Health Plan, (B) that Contracted Provider remains financially responsible for amounts paid for Covered Services rendered by Providers and Referral Services up to and including the identified deductible, as well as the remaining ten percent of amounts paid for Covered Services rendered by Providers and any Referral Services in excess of the identified deductible, (C) that the monthly payment for such participation shall be deducted from the Operating Fund, (D) that the monthly financial benefit for such participation shall be credited to the Operating Fund, and (E) the amount of monthly payments for participation in the Stop Loss Program are set annually by Health Plan and based in part on the aggregate patient panel size of all Primary Care

Providers in or around January of each year during the term of this Agreement as reported to Health Plan by Contracted Provider.

- ii. Prior to implementation of any bonus or shared risk arrangement and each year thereafter during the term of the Agreement in which it applies, Health Plan will provide notice to Contracted Provider of the set Stop Loss Program monthly payments for that calendar year.
 - iii. Contracted Provider represents and warrants that with respect to the aggregate patient panel size of all Primary Care Providers reported prior to execution of the Agreement and each January thereafter during the term of this Agreement, Contracted Provider meets the five pooling requirements set out in 42 CFR §§ 422.208 and 417.479. Contracted Provider shall submit updated aggregated patient panel sizes as indicated above in January of each year during the term of this Agreement along with such other documentation as may be required by Health Plan to maintain compliance with Laws and Program Requirements regarding Physician Incentive Plans.
 - iv. Contracted Provider shall indemnify and hold harmless Health Plan from any costs, charges, fines, fees or other liabilities incurred, including attorneys' fees, as a result of or arising from Contracted Provider's misrepresentation of compliance with any Laws and Program Requirements regarding Physician Incentive Plans or inaccurate information given to Health Plan hereunder.
 - v. Stop Loss Program Cost. Health Plan will establish the cost of stop loss protection for Contracted Provider, which shall be a monthly per member per month amount deducted from the Operating Fund.
 - vi. Stop Loss Reconciliation. Once the accumulated annual claims expense exceeds the reinsurance threshold amounts, ____ percent of those amounts are returned to the fund.
- c. Compliance. The Parties agree that this upside bonus arrangement shall comply with Laws and Program Requirements, including 42 CFR §§ 422.208, 417.479 and 422.210, and shall not contain provisions that provide incentives for withholding medically necessary care.
4. Fund Reconciliation.
- a. Reconciliation and Netting of Funds. Following the four month period after the Effective Date, and each month thereafter, Health Plan will:
 - i. Determine the Net Operating Fund to arrive at an aggregate Surplus or Deficit for the Reporting Period; and
 - ii. Net the Surplus or Deficit against Other Risk Agreements to arrive at an aggregate Surplus or Deficit for the Reporting Period.
 - b. Surplus. Subject to and in accordance with the terms and conditions of this Agreement, including this Attachment, for each Reporting Period, Health Plan will (i) if there is an aggregate Surplus for the Reporting Period, calculate any potential bonus attributed to Providers and (ii) pay Contracted Provider any payment due, less the amount of all Overpayments and other amounts due and owing Health Plan, within 30 days of Health Plan's completion of reconciliation and settlement activities.

- c. Deficit. Subject to and in accordance with the terms and conditions of this Agreement, including this Attachment, for each Reporting Period Health Plan will, if there is an aggregate Deficit for the Reporting Period, carry such Deficit forward and apply it as an Operating Fund deduction in the next month and Contracted Provider will not be obligated to pay Health Plan directly for such Deficits carried forward. However, if Contracted Provider is also in a shared risk arrangement for any Program or insurance product under this Agreement or Other Risk Agreement with Health Plan or its Affiliate then such Deficit will be netted against funds in such other arrangements, which may result in a payment obligation of Contracted Provider.
 - d. Monthly Service Fund Reports. Each month Health Plan publishes (makes available electronically to Contracted Provider) the Service Fund Report for claims and other payments for the prior month. Contracted Provider must contest information in the Service Fund Report in writing to Health Plan in accordance with Health Plan's policies and procedures within 30 days of the date the Service Fund Report is published or Contracted Provider, for itself and the other Providers, waives (i) any claim for additional compensation, and (ii) any right to contest or dispute information contained or referenced in the Service Fund Report and such report shall be deemed final and approved by Contracted Provider. The foregoing does not negate the requirement for a Provider, where applicable, to notify Health Plan of any dispute regarding payment within the time period provided for in the Agreement, the obligation of Contracted Provider to inform Health Plan of potential overpayments to other providers identified by Contracted Provider in the course of review of Service Fund Reports, or Health Plan's right to make any adjustments as set forth in the Agreement, including this Attachment.
 - e. Effect of Expiration or Termination. On and after the effective date of expiration or termination of the Agreement Health Plan is under no further obligation to provide Contracted Provider any payments or any reports in connection with such arrangement.
5. Additional Requirements. After Health Plan's initial determination of Contracted Provider's Quality Rating Score, and annually thereafter, if Contracted Provider has failed to achieve a Quality Rating Score at the ____th percentile or higher, Health Plan shall withhold payment of Surplus until Contracted Provider achieves a Quality Rating Score at the ____th percentile or higher. If Contracted Provider fails to meet the Quality Rating Target for two consecutive years during the term of this Agreement, Health Plan may terminate the service fund arrangement set forth in this Attachment upon 30 days prior notice to Contracted Provider. If Health Plan is unable to determine a Quality Rating Score for Contracted Provider due to a lack of a full year's claims and encounter data for a HEDIS Measurement Year (whether due to termination of the Agreement during a HEDIS Measurement Year or otherwise), Health Plan will not be obligated to pay any Surplus to Contracted Provider.

**ATTACHMENT C-10
KENTUCKY MEDICAID AND CHIP COMPENSATION
(SHARED RISK - QUALITY)**

1. Additional Definitions.

- a. **“Compliance Percentage”** means the number of Assigned Members who are compliant with the Program Measures divided by the total number of Assigned Members eligible for the applicable Program Measure. Health Plan shall determine such percentage using administrative data methodologies outlined in the current year HEDIS® Technical Specifications. Health Plan shall accept claims and encounter data for Covered Services rendered during the applicable HEDIS Measurement Year until March 31st of the HEDIS Reporting Year.
- b. **“Deficit”** means a negative balance in the Net Operating Fund.
- c. **“Deficit Reserve”** means the cash payment or LOC that Contracted Provider must provide and maintain throughout and after the expiration or termination of the Agreement in an amount equal to the Deficit Reserve Amount, as determined and adjusted annually by Health Plan for each 12 calendar months. The Deficit Reserve shall secure Contracted Provider’s obligations to pay Health Plan part or all of the Deficit.
- d. **“Deficit Reserve Amount”** means two percent of the product of: 12 multiplied by the number of Assigned Members multiplied by the premium amount allocated to Providers, and is subject to adjustment as set forth in this Attachment.
- e. **“HEDIS®”** means Healthcare Effectiveness Data and Information Set. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
- f. **“HEDIS® Measure Percentile”** means the percentile for a particular HEDIS® measure based on the most recent NCQA Quality Compass HEDIS Measures for Medicaid managed care plans.
- g. **“HEDIS Measurement Year”** is the first calendar year (and each calendar year thereafter) for which Health Plan has a full year of claims and encounter data for Covered Services rendered by Contracted Provider and its Providers.
- h. **“HEDIS Reporting Year”** is the calendar year immediately following the HEDIS Measurement Year.
- i. **“HEDIS® Technical Specifications”** means the HEDIS® 2014 Volume 2, Technical Specifications as published by NCQA, or any relevant successor HEDIS® Technical Specifications published during the term of this Agreement.
- j. **“Letter of Credit”** or **“LOC”** means a standby irrevocable letter of credit issued by a financial institution and in a form satisfactory to Health Plan.
- k. **“Net Operating Fund”** means the Operating Fund funding less the Operating Fund deductions.
- l. **“Operating Fund”** means a separate Contracted Provider specific fund created in Health Plan ledgers for purposes of accounting for Health Plan’s payments for Covered Services, including covered medical and related health care items and services and any value added items and services

covered under the applicable Benefit Plan, provided to Assigned Members, and other associated administrative or insurance payments made by Health Plan.

- m. **“Other Risk Agreement”** means an agreement between Health Plan or its Affiliate and Contracted Provider or its Affiliate that includes compensation to Contracted Provider or its Affiliate based in any part, on potential upside bonuses or risk sharing.
 - n. **“Physician Incentive Plan”** or **“PIP”** shall have the meaning set forth in 42 CFR §§ 422.208 and 417.479.
 - o. **“Program Measure(s)”** means the HEDIS[®] measures or other measures used by Health Plan to calculate Contracted Provider’s Quality Rating Score. Program Measures are based on HEDIS[®] Technical Specifications and other measures used by a Governmental Authority to evaluate Health Plan’s quality. Health Plan will disclose the Program Measures for the HEDIS Measurement Year to Contracted Provider annually during the HEDIS Reporting Year. Health Plan may exclude any measure that cannot be calculated using claims or encounter data or that Health Plan cannot otherwise reasonably determine at the Contracted Provider level.
 - p. **“Quality Rating Score”** means the average of each HEDIS[®] Measure Percentile achieved by Contracted Provider. Health Plan will determine Contracted Provider’s Quality Rating Score by using the Compliance Percentage for each of the Program Measures. Health Plan shall determine Contracted Provider’s Quality Rating Score annually each HEDIS Reporting Year.
 - q. **“Quality Rating Target”** means a Quality Rating Score that meets or exceeds the 75th percentile.
 - r. **“Referral Services”** means all Covered Services rendered to Assigned Members by any provider other than a Provider, including Participating Providers who are not Providers and non-Participating Providers, including Emergency Services, and specialty, physician, inpatient, outpatient, institutional, ancillary, mental health and substance abuse, home health care, laboratory, other traditional institutional and professional services, whether on an in-network or out-of-network basis, and other services or value added services covered under such Assigned Members’ Benefit Plans.
 - s. **“Reporting Period”** means a calendar month.
 - t. **“Service Fund Report”** means the monthly report of the Operating Fund revenue, deductions and any adjustments thereto distributed or made available electronically by Health Plan.
 - u. **“Shared Risk Panel Threshold”** means 1,000 or more Assigned Members under this Agreement enrolled in a Benefit Plan under the Kentucky Contract.
 - v. **“Stop Loss Program”** means the stop loss program implemented and maintained by Health Plan to cover ____ percent of the amounts paid for Referral Services above the applicable identified deductible.
 - w. **“Surplus”** means a positive balance in the Net Operating Fund.
2. Shared Risk Arrangement.
- a. Commencement of Shared Risk Arrangement. The shared risk arrangement shall commence when Contracted Provider reaches the Shared Risk Panel Threshold as determined by Health Plan (the

“**Commencement Date**”), which determination may be made effective retroactively for reasons such as retroactive enrollment of Assigned Members. Thereafter, this shared risk arrangement will remain in effect regardless of changes (either prospective or retrospective) in the total number of Assigned Members.

- b. Fund Risk Allocations. The allocation of the shared risk percentages and associated Surplus or Deficit resulting from the Operating Fund as between Health Plan and Contracted Provider shall be as set out in Table 1.

Table 1

Fund	Contracted Provider Surplus/Deficit	Health Plan Surplus/Deficit
Operating Fund	____% / ____%	____% / ____%

- c. Summary of Calculation of the Shared Risk Payment.

- (Net Operating Fund * Table 1 Percent) = Available Shared Risk Amount
- Available Shared Risk Amount – Prior Payments = Potential Shared Risk Payment Due

Prior Payments means all shared risk payments made to Contracted Provider in prior months.

- d. Deficit Reserve. Health Plan will request the Deficit Reserve when it determines that Contracted Provider has reached the Shared Risk Panel Threshold, and Contracted Provider shall provide the Deficit Reserve within 30 days of Health Plan’s request. Once the Deficit Reserve is requested, Health Plan shall not make any payments resulting from a Surplus to Contracted Provider until Health Plan receives the Deficit Reserve Amount. Contracted Provider shall maintain the appropriate Deficit Reserve Amount throughout the term of this Agreement and for 18 months following expiration or termination of this Agreement.

- i. Health Plan may adjust the Deficit Reserve Amount in or about July of each year based on the result of fund settlements, the number of Assigned Members and Operating Fund deductions for the previous 12 months.
- ii. Any time during the term of this Agreement and the ____ month period following expiration or termination of the Agreement, Health Plan may adjust the Deficit Reserve Amount based on sound actuarial principals to directly reflect the actuarial changes due to (A) changes in benefits offered under the Assigned Members’ Benefit Plans; (B) increases or decreases in the number of Assigned Members; (C) adjustments levied by the Department; or (D) if there is a Deficit in the Operating Fund as a result of any reconciliation or settlement conducted by Health Plan for two or more consecutive Reporting Periods. Immediately upon Health Plan’s adjustment of the Deficit Reserve Amount, but not later than 10 business days after the date of Health Plan’s written request, Contracted Provider shall provide an additional cash payment to Health Plan or increase the amount covered under the LOC so that the Deficit Reserve is in an amount equal to the Deficit Reserve Amount requested by Health Plan.
- iii. Health Plan shall be entitled to the payment of funds from the Deficit Reserve upon the occurrence of one or both of the following events in full or any partial amount:

- A. Immediately and without notice if Contracted Provider has a Deficit in the Operating Fund under this Agreement or if there is a deficit in any Other Risk Agreements, regardless of insurance product, or following expiration or termination of the Agreement and Contracted Provider has failed to pay the amount of the Deficit to Health Plan as described in this Attachment.
 - B. Immediately and without notice if the Department or CMS issues a monetary sanction to Health Plan due to a failure of Contracted Provider to properly carry out any functions under this Agreement, and Contracted Provider fails to pay the amount of the sanction to Health Plan within 30 days of receipt of written notice from Health Plan.
- iv. Contracted Provider shall fund the Deficit Reserve to an amount equal to the Deficit Reserve Amount within 10 business days of (A) any adjustment Health Plan makes pursuant to this Attachment, including an adjustment required to meet the Deficit Reserve Amount, or (B) a withdrawal from or draw on the Deficit Reserve whereby the Deficit Reserve is decreased to less than the Deficit Reserve Amount.
3. Determination of Funds.
- a. Funding for the Operating Fund and any and all deductions to the Operating Fund shall be calculated as follows to arrive at the Net Operating Fund.
 - i. Funding of Operating Fund.
 - A. Funding for the Operating Fund shall be a percent of the net monthly payment to Health Plan received from a Governmental Authority or Assigned Member, applicable to Assigned Members for items and services covered under the Kentucky Medicaid program, which is reduced for any excise or premium tax, fee or cost imposed by any Governmental Authority on Health Plan (“Funding Level”).
 - B. On the Effective Date of this Agreement, the baseline Funding Level shall be ____ percent (“Baseline Funding Level”), subject to the Quality Adjustment as set forth below.
 - C. During the term of this Agreement any retroactive adjustments in premium, claims, or expenses affecting any year shall be added to or deducted from the Operating Fund, regardless of whether such adjustments are specific to Assigned Members, as appropriate, including any retroactive changes to the premium amounts paid by the Department to Health Plan, any Department audit recovery or any working aged plan level adjustments.
 - ii. Quality Adjustments. The Baseline Funding Level shall be adjusted annually as follows (the “Quality Adjustment”):
 - A. On or about September of each year, after Health Plan determines Contracted Provider’s Quality Rating Score for the HEDIS Reporting Year, if Contracted Provider meets or exceeds the Quality Rating Target, the Funding Level shall be increased to _____ percent and applied retroactively to January 1st of that calendar year. Such increase shall remain in effect through December 31st of that calendar year and shall reset to the Baseline Funding Level beginning January 1st of the next calendar year.
 - iii. Operating Fund Deductions. The following amounts will be deducted from (or credited to, if applicable) the Operating Fund:

- All payments for Covered Services rendered to Assigned Members, including Referral Services, prescription drug costs and dispensing fees, claims, capitation or other payments, including any average amounts paid in lieu of actual claims or capitation amounts or amounts paid in settlement of disputes regarding amounts alleged to be owing for Covered Services provided to Assigned Members regardless of whether such Covered Services were rendered by providers pursuant to a contract with Health Plan.
- Amounts paid for disease/care/case management programs in which Assigned Members are enrolled.
- Estimated amounts for incurred but not reported claims based on incurred expenses associated with providing medical care for Members that have been actuarially determined to have occurred but not yet reported to Health Plan.
- Any Deficit amounts.
- Monthly Stop Loss Program costs or financial benefit described in provisions regarding stop loss protection, when applicable.
- If applicable, amounts paid for delegation of administrative services by Health Plan covered under this Agreement.

b. Stop Loss Protection.

- i. Contracted Provider agrees (A) to participate in Health Plan's Stop Loss Program made available to Participating Providers under risk sharing arrangements with Health Plan, (B) that Contracted Provider remains financially responsible for amounts paid for Covered Services rendered by Providers and Referral Services up to and including the identified deductible, as well as the remaining ten percent of amounts paid for Covered Services rendered by Providers and any Referral Services in excess of the identified deductible, (C) that the monthly payment for such participation shall be deducted from the Operating Fund, (D) that the monthly financial benefit for such participation shall be credited to the Operating Fund, and (E) the amount of monthly payments for participation in the Stop Loss Program are set annually by Health Plan and based in part on the aggregate patient panel size of all Primary Care Providers in or around January of each year during the term of this Agreement as reported to Health Plan by Contracted Provider.
- ii. Prior to implementation of the shared risk arrangement and each year thereafter during the term of the Agreement in which it applies, Health Plan will provide notice to Contracted Provider of the set Stop Loss Program monthly payments for that calendar year.
- iii. Contracted Provider represents and warrants that with respect to the aggregate patient panel size of all Primary Care Providers reported prior to execution of the Agreement and each January thereafter during the term of this Agreement, Contracted Provider meets the five pooling requirements set out in 42 CFR §§ 422.208 and 417.479. Contracted Provider shall submit updated aggregated patient panel sizes as indicated above in January of each year during the term of this Agreement along with such other documentation as may be required by Health Plan to maintain compliance with Laws and Program Requirements regarding Physician Incentive Plans.
- iv. Contracted Provider shall indemnify and hold harmless Health Plan from any costs, charges, fines, fees or other liabilities incurred, including attorneys' fees, as a result of or arising from Contracted Provider's misrepresentation of compliance with any Laws or Program Requirements regarding Physician Incentive Plans or inaccurate information given to Health Plan hereunder.

- v. Stop Loss Program Cost. Health Plan will establish the cost of stop loss protection for Contracted Provider, which shall be a monthly per member per month amount deducted from the Operating Fund.
 - vi. Stop Loss Reconciliation. Once the accumulated annual claims expense exceeds the reinsurance threshold amounts, ____ percent of those amounts are returned to the fund.
 - c. Compliance. The Parties agree that any bonus or shared risk arrangement shall comply with Laws and Program Requirements, including 42 CFR §§ 422.208, 417.479 and 422.210, and shall not contain provisions that provide incentives for withholding medically necessary care.
4. Fund Reconciliation & Distribution of Surpluses or Collection of Deficits.
- a. Reconciliation and Netting of Funds. Following the four month period after the Commencement Date, and each month thereafter, Health Plan will:
 - i. Determine the Net Operating Fund to arrive at an aggregate Surplus or Deficit for the Reporting Period; and
 - ii. Net the Surplus or Deficit against Other Risk Agreements to arrive at an aggregate Surplus or Deficit for the Reporting Period.
 - b. Surplus. Subject to and in accordance with the terms and conditions of this Agreement, including this Attachment, for each Reporting Period, Health Plan will (i) if there is an aggregate Surplus for the Reporting Period, calculate any shared risk payment attributed to Providers and (ii) pay Contracted Provider any payment due, less the amount of all Overpayments and other amounts due and owing Health Plan, within ____ days of Health Plan's completion of reconciliation and settlement activities.
 - c. Deficit. For each Reporting Period following reconciliation that results in an aggregate Deficit, Health Plan will carry forward the Deficit and apply it as a fund deduction to the Operating Fund in the next Reporting Period until the aggregate reconciliation and fund settlement for the Operating Fund results in a Deficit allocated to Contracted Provider for more than three consecutive Reporting Periods, at which point Health Plan will invoice Contracted Provider for such Deficit. If Contracted Provider does not remit payment of such Deficit to Health Plan within 30 days of the date of the invoice, Health Plan may do any or all of the following: (i) adjust or modify the shared risk arrangement upon notice to Contracted Provider; (ii) immediately collect such payment from the Deficit Reserve or (iii) terminate the Agreement upon ____ days notice to Contracted Provider.
 - d. Monthly Service Fund Reports. Each month Health Plan publishes (makes available electronically to Contracted Provider) the Service Fund Report for claims and other payments for the prior month. Contracted Provider must contest information in the Service Fund Report in writing to Health Plan within 20 days of the date the Service Fund Report is published or Contracted Provider, for itself and its Providers, waives (i) any claim for additional compensation, and (ii) any right to contest or dispute information contained or referenced in the Service Fund Report and such report shall be deemed final and approved by Contracted Provider. The foregoing does not negate the requirement for a Provider, where applicable, to notify Health Plan of any dispute regarding payment within the time period provided for in the Agreement, the obligation of Contracted Provider to inform Health Plan of potential overpayments to other providers identified by Contracted Provider in the course of review of Service Fund Reports, or Health Plan's right to make any adjustments as set forth in the Agreement, including this Attachment.

5. Post Termination Settlement and Distribution of Surpluses or Collection of Deficits.
- a. Upon expiration or termination of this Agreement Health Plan will continue to reconcile funds on a monthly basis and provide Contracted Provider with access to Service Fund Reports for a period of ____ months following the expiration or termination (“**Close Out Period**”). Health Plan may use any Surplus allocated to Contracted Provider under any Program to offset any Deficit attributed to Contracted Provider in the Operating Fund, to maintain the Deficit Reserve Amount, and to deduct all amounts due and owing Health Plan, including for Overpayments. If the amount in the Deficit Reserve becomes less than the Deficit Reserve Amount in effect as of 90 days before the effective date of expiration or termination of the Agreement, then Contracted Provider shall replenish the Deficit Reserve to such Deficit Reserve Amount immediately upon receipt of notice from Health Plan.
 - b. If Health Plan’s reconciliation of the Operating Fund:
 - i. On the effective date of expiration or termination of the Agreement or in any three month period of the Close Out Period results in an aggregate Deficit, Health Plan will invoice Contracted Provider for such Deficit and Contracted Provider shall pay Health Plan 50 percent of the Deficit within 30 days of the date of the invoice. If Contracted Provider fails to pay such amount within such 30 day period, then Health Plan may immediately collect such amount from the Deficit Reserve. The remaining 50 percent of the Deficit shall be carried forward and applied as a deduction to the Operating Fund.
 - ii. Following the first nine months of the Close Out Period results in an aggregate Surplus, Health Plan will pay ____ percent of such aggregate Surplus to Contracted Provider within 30 days of completion of settlement activities by Health Plan.
 - iii. At the conclusion of the Close Out Period results in an aggregate Surplus, Health Plan will pay such remaining Surplus to Contracted Provider within 30 days of completion of settlement activities by Health Plan; provided, however, Health Plan may withhold final payment of the Surplus subject to completion of a final release and settlement acceptable to the Parties.
 - iv. At the conclusion of the Close Out Period results in an aggregate Deficit, Health Plan will invoice Contracted Provider for such Deficit and Contracted Provider shall remit payment of such Deficit to Health Plan within 30 days of the date of the invoice. If Contracted Provider fails to remit payment to Health Plan within such 30 day period then Health Plan may immediately collect the full amount of the Deficit from the Deficit Reserve.
6. Additional Requirements. After Health Plan’s initial determination of Contracted Provider’s Quality Rating Score, and annually thereafter, if Contracted Provider has failed to achieve a Quality Rating Score at the ____th percentile or higher, Health Plan shall withhold payment of Surplus until Contracted Provider achieves a Quality Rating Score at the ____th percentile or higher. If Contracted Provider fails to meet the Quality Rating Target for two consecutive years during the term of this Agreement, Health Plan may terminate the service fund arrangement set forth in this Attachment upon 30 days prior notice to Contracted Provider. If Health Plan is unable to determine a Quality Rating Score for Contracted Provider due to a lack of a full year’s claims and encounter data for a HEDIS Measurement Year (whether due to termination of the Agreement during a HEDIS Measurement Year or otherwise), Health Plan will not be obligated to pay any Surplus to Contracted Provider.