AMENDMENT
UNIVERSITY HEALTH CARE, INC.
dba PASSPORT HEALTH PLAN
PROVIDER SERVICES AGREEMENT

This Amendment to the University Health Care, Inc., Provider Services Agreement ("the Agreement"), is made and entered into as of the effective date set forth below (the "Effective Date") by and among the provider(s) identified on the signature page ("Provider") and University Health Care, Inc. ("HMO").

WHEREAS, HMO and PROVIDER entered into the University Health Care, Inc. Provider Services Agreement.

WHEREAS, HMO and PROVIDER desire to amend the Agreement as set forth herein.

NOW, THEREFORE, in consideration of the premises and the mutual promises contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, HMO and PROVIDER intending to be legally bound, agree as follows:

1. Capitalized Terms. All capitalized terms not otherwise defined herein shall have the meanings ascribed to such terms in the Agreement.

2. Effective Date. This Amendment shall be effective for inpatient discharges occurring on or after October 1, 2015.

3. Appendix A. Appendix A to the Agreement shall remain as set forth in the Agreement, as amended, except reimbursement for Acute-Care Hospital inpatient services shall be deleted and replaced with the attached.

4. Governing Law. This Amendment shall be construed and enforced in accordance with the laws of the Commonwealth of Kentucky.

5. Reaffirmation of Other Terms and Conditions. Except as expressly modified by this Amendment, all other terms and provisions of the Agreement, as amended, shall remain in full force and effect, unmodified and unrevoked, and the same are hereby reaffirmed and ratified by HMO and Provider as if fully set forth herein.

IN WITNESS WHEREOF, HMO and PROVIDER have signed and executed this Amendment as of the date written below, but effective as of the Effective Date.

"HMO"

UNIVERSITY HEALTH CARE, INC.

By: _____

Title: Vice President of Operations

Date: 11/30/15

"PROVIDER"

NORTON HOSPITALS, INC.

By (Signature): _____

Print Name: Shelley Gast

Title: System VP Managed Care & Payer Strategy

Date: 11/24/15

Tax ID # (s): 61-0703799

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APPENDIX A

ACUTE-CARE HOSPITAL SERVICES AND COMPENSATION

For inpatient Covered Services rendered to a Covered Person during a single admission, and billed under the Hospital/Provider's tax identification number ("TIN"), HMO shall pay Hospital/Provider based on the DRG methodology as defined below.

Effective October 1, 2015, the HMO shall pay Hospital/Provider on a fully-prospective per discharge basis using the Medicare Severity DRG (MS-DRG) version 32 grouping software released by the Centers for Medicare and Medicaid Services (CMS). The HMO will establish DRG relative weights obtained from the Medicare IPPS Final Rule Data Files and Tables corresponding to the grouper version in effect. When CMS releases subsequent versions of the DRG grouper, the HMO shall implement changes to the DRG relative weights and the geometric length-of-stay values within one hundred and twenty (120) days of the CMS release date. There will be no retroactive adjustment to claims for discharge dates occurring after the CMS effective date of such changes. All changes to the DRG grouper will be implemented on a prospective basis.

Payment Rates

Payment rates shall approximate one hundred and eight percent (108%) for Kosair Children's Hospital downtown campus and ninety-seven and one half (97.5%) of all other Norton Hospital's Medicare reimbursement excluding the following Medicare reimbursement components:

1. A Medicare low-volume hospital payment;
2. A Medicare end stage renal disease payment;
3. A Medicare new technology add-on payment;
4. A Medicare routine pass-through payment;
5. A Medicare ancillary pass-through payment;
6. A Medicare value-based purchasing payment or penalty;
7. A Medicare readmission penalty;
8. A Medicare hospital-acquired condition penalty;
9. Any type of payment implemented by Medicare after October 1, 2015; or
10. Any type of Medicare payment not described in this Amendment.

When CMS releases periodic updates to payment rates, the HMO shall implement the changes within one hundred and twenty (120) days of the CMS release date. Within sixty (60) days after CMS publishes the Medicare IPPS Final Rule Data Files and Tables for a given year, the HMO will send a written notice to the Provider containing the hospital's data and calculation of the DRG base rate and operating and capital cost to charge ratios. The Provider will have thirty (30) days from the date of the letter to appeal these calculations.

There will be no retroactive adjustment to claims for discharge dates occurring after the CMS effective date of such changes. All changes to payment rates will be implemented on a prospective basis.

The total hospital-specific per discharge payment shall be the sum of:

1. A DRG base payment; and
2. If applicable, a cost outlier payment; and
3. If applicable, a transplant acquisition payment.

The resulting payment shall be limited to one hundred and eight percent (108%) for Kosair Children's Hospital and ninety-seven and one half (97.5%) for all other Norton Hospitals of the calculated value.

The DRG base payment shall be one hundred and eight percent (108%) for Kosair Children's Hospital and ninety-seven and one half (97.5%) for all other Norton Hospitals of the sum of the operating base payment and the capital base payment calculated as described below:

1. The DRG base payment shall be determined by multiplying the hospital-specific rate by the DRG relative weight.
2. If applicable, the hospital-specific indirect medical education (IME) factor will also be included in the base rate.
3. The hospital-specific operating rate, IME rate and capital rate referenced in this Amendment shall be calculated using inputs from the Federal Fiscal Year 2016 Medicare Inpatient Prospective Payment System (IPPS) Final Rule Data Files and Tables published by CMS.

4. The Medicare IPPS standard amount established for operating labor costs shall be multiplied by the wage index associated with the final Core Based Statistical Area (CBSA) assigned to the hospital by Medicare, inclusive of any Section 505 adjustments applied by Medicare.
5. The operating labor costs as defined in item 3 above shall be added to the Medicare IPPS standard amount for non-labor operating costs.
6. The Medicare IPPS standard amount established for capital costs shall be multiplied by the geographic adjustment factor (GAF) associated with the final CBSA assigned to the hospital by Medicare.

The HMO shall make a cost outlier payment per discharge as described below:

1. A discharge is eligible for outlier payment if its estimated cost exceeds the DRG's outlier threshold.
2. The estimated cost of the discharge shall be computed by multiplying the sum of the hospital-specific Medicare operating and capital-related cost-to-charge ratios by the HMO allowed charges. The Medicare operating and capital-related cost-to-charge ratio shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables published by CMS.
3. The DRG's outlier threshold shall be calculated as the sum of a hospital's DRG base payment or transfer payment and the fixed loss cost threshold. The fixed loss cost threshold shall be the Medicare fixed loss cost threshold established for Federal Fiscal Year 2016.
4. For specialized burn DRGs as established by Medicare, a cost outlier payment shall equal ninety percent (90%) of the amount by which estimated costs exceed a discharge's outlier threshold
5. For all other DRGs, a cost outlier payment shall equal eighty percent (80%) of the amount by which estimated costs exceed a discharge's outlier threshold.

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

Transfer Payments

If a patient is transferred to or from another hospital, the HMO shall make a transfer payment to the transferring hospital if the initial admission and the transfer are determined to be medically necessary. Transfer payments shall be calculated as described below:

1. For a service reimbursed on a prospective discharge basis, the HMO shall calculate the transfer payment amount based on the average daily rate of the transferring hospital's payment for each covered day the patient remains in that hospital, plus one (1) day up to 100 percent of the allowable per discharge reimbursement amount.
2. The average daily discharge rate shall be calculated by dividing the DRG base payment by the Medicare geometric mean length-of-stay for a patient's DRG classification.
3. The Medicare geometric length-of-stay shall be obtained from the Medicare IPPS Final Rule Data Files and Tables corresponding to the grouper version in effect.
4. Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a cost outlier payment amount, limited to one hundred and eight percent (108%) for Kosair Children's Hospital and ninety-seven and one half (97.5%) for all other Norton Hospitals of the amount calculated for each.
5. For a hospital receiving a transferred patient, the HMO shall reimburse the standard DRG payment.

The HMO shall reimburse a transferring hospital for a transfer from an acute care hospital to a qualifying post-acute care facility for selected DRGs as described below:

1. The following shall qualify as a post-acute care facility:
    a. Skilled nursing facility;
    b. Cancer or children's hospital;
    c. Home health agency;
    d. Rehabilitation hospital or rehabilitation distinct part unit located within an acute care hospital;
    e. Long-term acute care hospital; or
    f. Psychiatric hospital or psychiatric distinct part unit located within an acute care hospital.
2. The HMO shall pay each transferring hospital an average daily rate for each day of a stay.
3. A transfer related payment shall not exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.
4. A DRG identified by CMS as being eligible for special payment shall receive fifty percent (50%) of the full DRG payment plus the average daily rate for the first day of the stay and fifty percent (50%) of the average daily rate for the remaining days of the stay up to the full DRG base payment.

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5. A DRG identified by CMS as being eligible for the post-acute payment shall receive twice the average daily rate for the first day of the stay and the average daily rate for each following day of the stay prior to the transfer.
6. Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a cost outlier payment amount, limited to one hundred and eight percent (108%) for Kosair Children's Hospital and ninety-seven and one half (97.5%) for all other Norton Hospitals of the amount calculated for each.

The HMO shall reimburse a receiving hospital for a transfer to a rehabilitation or psychiatric distinct part unit the facility-specific distinct part unit per diem rate for each day the patient remains in the distinct part unit.

Organ Transplants

The HMO shall reimburse for an organ transplant on a prospective per discharge method according to the recipient's DRG classification.

The organ acquisition reimbursement shall include an interim reimbursement followed by a final reimbursement. Final reimbursement shall:

1. Include a cost settlement process based on the Medicare 2552 cost report form; and
2. Be designed to reimburse hospitals for one hundred and eight percent (108%) for Kosair Children's Hospital and ninety-seven and one half (97.5%) for all other Norton Hospitals of organ acquisition costs.
3. An interim organ acquisition payment shall be made using a fixed-rate add-on to the standard DRG payment using the following rates:
    a. Kidney Acquisition - $65,000
    b. Liver Acquisition - $55,000
    c. Heart Acquisition - $70,000
    d. Lung Acquisition - $65,000; or
    e. Pancreas Acquisition - $40,000.

Upon receipt of a hospital's finalized Medicare cost report, the HMO shall calculate a final settlement at one hundred and eight percent (108%) for Kosair Children's Hospital and ninety-seven and one half (97.5%) for all other Norton Hospitals of costs for organ acquisition costs utilizing worksheet D-4 of the CMS 2552 cost report for each organ specified above.

Hospital-Acquired Conditions and Never Events

For each diagnosis on a claim, a hospital shall specify on the claim whether the diagnosis was present upon the individual's admission to the hospital. In assigning a DRG for a claim, the HMO shall exclude from the DRG assignment consideration of any secondary diagnosis code associated with a hospital-acquired condition.

Neither the HMO nor the member shall be liable for treatment for or related to a never event.

Readmissions

An unplanned inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a readmission and shall not be billed separately. Reimbursement for an unplanned readmission with the same diagnosis shall be included in the initial admission payment.

Pre-Admission Services

A pre-admission service provided within three (3) calendar days immediately preceding an inpatient admission reimbursable under the prospective per discharge reimbursement methodology shall:

1. Be included with the related inpatient billing and shall not be billed separately as an outpatient service; and
2. Exclude a service furnished by a home health agency, a skilled nursing facility, or hospice, unless it is a diagnostic service related to an inpatient admission or an outpatient maintenance dialysis service.

Sole Community Hospitals

The operating rate for sole community hospitals shall be calculated as described below:

1. The HMO shall utilize the hospital's hospital-specific (HSP) rate calculated by Medicare.
2. The HSP rate shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables.
3. The HMO shall compare the HSP rate with the operating rate described above in the Payment Rates section of the Amendment, or the standard Medicare IPPS rate. The higher of the two rates shall be utilized as the operating rate for sole community hospitals.

Medicare Dependent Hospitals

The operating rate for a Medicare dependent rate shall be calculated as described below:

1. The HMO shall utilize the hospital's hospital-specific (HSP) rate calculated by Medicare.
2. The HSP rate shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables.
3. The HMO shall compare the HSP rate with the operating rate described above in the Payment Rates section, or the standard Medicare IPPS rate. If the standard Medicare IPPS rate is higher, it shall be utilized as the operating rate for Medicare dependent hospitals. If the HSP rate is higher, the HMO shall calculate the arithmetic difference between the two rates. The difference shall be multiplied by seventy-five percent (75%). The resulting product shall be added to the standard Medicare IPPS rate to determine the hospital's operating rate.
4. If CMS terminates the Medicare dependent hospital program, a hospital that is a Medicare dependent hospital at the time of termination shall receive the standard Medicare IPPS rate as described above in the Payment Rates section of this Amendment.

Direct Graduate Medical Education Costs

If federal financial participation for direct graduate medical education costs is not provided to DMS and the HMO, the HMO shall not reimburse for direct graduate medical education costs.

The HMO shall reimburse for the direct cost of a graduate medical education (GME) program approved by Medicare separately from the per discharge and per diem payment methodologies, on an annual basis corresponding to the hospital's fiscal year. GME shall be calculated as described below:

1. Total direct graduate medical education costs shall be obtained from a facility's as-filed CMS 2552 cost report, worksheet E-4, line 25.
2. HMO utilization shall be calculated by dividing HMO inpatient paid days during the cost report period by total inpatient hospital days, as reported on worksheet E-4, line 27 of the CMS 2552 cost report. The resulting Medicaid utilization factor shall be rounded to six (6) decimals.
3. The total graduate medical education costs shall by multiplied by the utilization factor to determine the total graduate medical education costs related to the HMO.
4. HMO program graduate medical education costs shall then be multiplied by ninety-five (95) percent to determine the annual payment amount.

Intensity Operating Allowance

An Intensity Operating Allowance (IOA) will only be paid to Hospital if received by HMO from the Commonwealth of Kentucky. The HMO will make monthly supplemental payments to the Provider on or before the last business day of the month of service for which capitation is paid. HMO will transmit all such funds within the timeframe required by the Department of Medicaid Services but no later than the last business day of the month in which HMO received the funds.

If the State's IOA calculation is not based on the most recent fiscal year, the DRG base rate for Kosair Children's Hospital downtown facility shall be updated annually each September 1 to reflect cost estimates for the Hospital's most recent fiscal year.

A hospital that qualifies as an in-state non-state owned pediatric teaching hospital will be paid an amount equal to its cost.

Cost estimates will be based on the CMS 2552-10 cost report, or successor forms, and paid claims data for HMO members during Hospital's fiscal year. Cost reports will be due annually one month after the due date of the Medicare cost report. Cost reports and supporting accounting records may be subject to audit upon request by the HMO. Cost reports will be used to compute the difference between actual cost and HMO's inpatient payments made to Kosair Children's Hospital downtown facility plus the IOA supplemental payments. The difference will be due to or from the HMO within three months of the date the cost report is filed with the HMO.

DRG Transition Neutrality

Either party may request an audit no sooner than six (6) months from the effective date of the amendment to verify rate neutrality on an individual DRG basis was achieved compared to the December 15, 2014 contract. The audit will be conducted by both parties and will be final when both provide approval in writing.

The audit process will be as follows:

- All inpatient claims, excluding Kosair Children's Hospital downtown facility, for dates of service October 1, 2015 through March 31, 2016. Audits in subsequent years will be based on a minimum of six (6) months of claims data.

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- The comparison will be based on the top ten DRG's, whose ranking is determined based on the number of paid claims for the period under audit. Payment rates will be multiplied by claim volumes to assess total reimbursement impact of DRG change.
- The total of the top ten DRG payments will be compared to the per case payment rates in effect as of December 15, 2014. An illustrative calculation is shown in the table provided below.
- The DRG payment rates will include the operating base payment, indirect medical education, capital payment and capital IME. The following payments will not be included in this audit: IOA interim or settlement payments, GME payments, organ acquisition interim and settlement payments, transfer payments and outlier payments.
- If the change in the total DRG payments has a variance greater than 4.0% (400 bps), the impact shall be considered material and subject to renegotiation on a prospective basis.
- Rates will be adjusted on a prospective basis and there will be no retroactive reprocessing of claims.
- Either party may initiate the audit and must notify the other party in writing if a material impact exists. If there is no notification, then both parties agree that rates will not be adjusted based on this neutrality clause.
- This clause will not preclude future updates to DRG weights based on Medicare Severity DRGs (MS-DRG) and rates as published in the Medicare IPPS Final Rule Data Files.

The following table illustrates the top 10 DRGs as of this date and how the analysis will be completed per the bulleted description above.

	MS-DRG v24					MS-DRG v33				
Claims*	DRG	Weight	Base Rate	Payment Rate	Total	DRG	Weight	Base Rate @ 97.5%	Payment Rate	Total
446	373	0.6354	5959.79	$ 3,786.85	$1,688,935	775	0.5865	5599.07	$ 3,283.85	$1,464,599
367	391	0.1913	5959.79	$ 1,140.11	$ 418,420	795	0.1758	5599.07	$ 984.32	$ 361,244
184	371	1.0032	5959.79	$ 5,978.86	$1,100,110	794	0.7807	5599.07	$ 4,371.19	$ 804,300
155	370	1.2362	5959.79	$ 7,367.49	$1,141,961	766	1.1442	5599.07	$ 6,406.46	$ 993,001
138	372	0.7173	5959.79	$ 4,274.96	$ 589,944	765	0.7509	5599.07	$ 4,204.34	$ 580,199
103	690	0.3313	5959.79	$ 1,974.48	$ 203,371	774	1.2987	5599.07	$ 7,271.51	$ 748,966
93	383	0.575	5959.79	$ 3,426.88	$ 318,700	781	0.8182	5599.07	$ 4,581.16	$ 426,048
72	183	0.5558	5959.79	$ 3,312.45	$ 238,496	392	0.74	5599.07	$ 4,143.31	$ 298,318
41	88	1.3653	5959.79	$ 8,136.90	$ 333,613	190	1.1578	5599.07	$ 6,482.60	$ 265,787
41	523	3.0752	1843.22	$ 5,668.27	$ 232,399	897	0.7231	5599.07	$ 4,048.69	$ 165,996
				$ 45,067.25	**$6,265,950**				$ 45,777.44	**$6,108,458**

**Claims from 12-15-14 through 4-30-15*

Total Difference	-2.51%

This illustration indicates the total reimbursement under time period 2 is **2.51% less** than in time period 1. However, that falls inside the 4.00% material clause and therefore, no change to the rate is needed.

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