

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

**HOSPITAL SERVICES AGREEMENT**

This Agreement (the "Agreement"), by and between University Health Care, Inc., d/b/a Passport Health Plan ("HMO"), and Norton Hospitals, Inc., for and on behalf of the employed and otherwise contracted Hospital Facilities, Providers and associated health services staff identified on the Appendices hereto (collectively referred to herein as "Hospital/Provider").

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

**WHEREAS**, Hospital/Provider and their staff are duly licensed in the Commonwealth of Kentucky without restriction or limitation.

**WHEREAS**, HMO and Hospital/Provider mutually desire to enter into this Agreement whereby the Hospital/Provider shall provide the services (as defined herein) to HMO Members and seek reimbursement from HMO for such services.

**NOW, THEREFORE**, in consideration of the promises and the mutual covenants herein set forth, the parties hereto agree as follows:

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**1. DEFINITIONS**

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

- 1.1. **AGREEMENT.** This Agreement between HMO and Hospital/Provider, including all attachments, addenda and amendments hereto.
- 1.2. **BEHAVIORAL HEALTH CARE PROVIDER.** A psychiatrist, psychologist or other behavioral health services provider who has been successfully credentialed by HMO and who is entering into this Agreement to provide behavioral health care services.
- 1.3. **COMPLAINTS AND APPEALS PROCEDURES.** The procedure describing HMO's compliance with the Department's standards for the prompt resolution of Member's and Provider's complaints/grievances and appeals, as described in the Provider Manual.
- 1.4. **COMMONWEALTH.** References to Commonwealth herein mean the Commonwealth of Kentucky.
- 1.5. **COVERED SERVICES.** Those Medically Necessary medical and health services to which a Member is entitled as set forth in the Provider Manual and in accordance with Kentucky Medicaid laws and regulations.
- 1.6. **DISCLOSURE FORM.** The Annual Disclosure Form required by state and federal laws as a condition of participation in this Agreement, attached hereto and incorporated by reference herein as if fully set forth herein.
- 1.7. **EFFECTIVE DATE.** The Effective Date of this Agreement shall be the 15 day of Dec, 2014.
- 1.8. **EMERGENCY SERVICES.** Services defined as (1) A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in (a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (b) Serious impairment to bodily functions; or (c) Serious dysfunction of any bodily organ or part; or (2) With respect to a pregnant woman who is having contractions: (a) A situation in which there is inadequate time to effect a safe transfer to another Hospital/Provider before delivery; or (b) A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.



- 1.9. **GROUP PROVIDER.** A physician or nurse practitioner, who practices with a Provider subject to this Agreement, as an employee, partner, shareholder, or contractor.
- 1.10. **HOSPITAL/PROVIDER SERVICES.** Those Medically Necessary Covered Services that Hospital/Provider normally furnishes to patients within the scope of its license and as indicated in Appendix A.
- 1.11. **MEDICAL DIRECTOR.** A physician licensed to practice medicine or osteopathy under the laws of the Commonwealth, who is appointed by HMO to coordinate and monitor the Quality Management and Utilization Management Programs of HMO.
- 1.12. **MEDICALLY NECESSARY.** A Covered Service, and which is determined by HMO's Medical Director, to be (a) Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy; (b) Clinically appropriate in terms of the service, amount, scope, and duration based on generally accepted standards of good medical practice; (c) 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; (d) 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; (e) Needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; (f) Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 USC 1396r and 42 CFR part 441 Subpart B for individuals under twenty-one (21) years of age; and (g) Provided in accordance with 42 CFR 440.230.
- 1.13. **MEMBER.** An individual who is an eligible Medicaid recipient and has been assigned to the HMO by the Department.
- 1.14. **PARTICIPATING HOSPITAL.** A Hospital that is entering into this Agreement with HMO to provide Hospital Services to Members.
- 1.15. **PARTICIPATING PROVIDER.** A duly licensed provider who has been successfully credentialed by HMO and who has entered into, or who is recognized by HMO as member of or employed by a group, that is entering into this Agreement with HMO to provide Covered Services to Members.
- 1.16. **PRIMARY CARE PROVIDER.** A duly licensed pediatrician, internist, family practitioner, doctor of general medicine or osteopathy, nurse practitioner, or group thereof, or provider associated with a Rural Health Clinic or Primary Care Center, or specialist, including obstetrician or gynecologist , approved as a primary care provider by HMO's Medical Director, who has been successfully credentialed by, and is a Participating Provider with HMO, and who will be responsible for the supervision, coordination, and provision of Basic Health Services to Members who have selected, or have been assigned to that provider. The Primary Care Provider will also initiate referrals for specialty care needed by a Member and maintain overall continuity of a Member's care.
- 1.17. **PROVIDER MANUAL.** The manual created by HMO, which explains HMO's policies, and procedures that are referenced in this Agreement and to which Hospital/Provider has agreed to adhere.
- 1.18. **QUALITY MANAGEMENT PROGRAM.** An ongoing review process and plan which functions to define, monitor, review, and recommend corrective action for managing and improving the quality of Covered Services rendered to Members.
- 1.19. **SPECIALTY CARE PROVIDER.** A duly licensed physician who has been successfully credentialed by HMO and who is entering this Agreement with HMO to provide specialty care services to Members referred to such Provider.
- 1.20. **URGENT CARE SERVICES.** Medically Necessary Covered Services for the treatment of a condition which requires prompt medical attention, but does not pose an immediate, serious health threat.
- 1.21. **UTILIZATION MANAGEMENT PROGRAM.** A process of review of the appropriateness and necessity of health care services rendered to Members.

## **2. HMO'S OBLIGATIONS**

- 2.1. HMO shall perform administrative, claims processing, Member services, Provider services, quality management and utilization management functions.
- 2.2. HMO shall assure that each Member has the option to select, or is assigned a Participating Primary Care Provider.
- 2.3. HMO shall provide or arrange for Member's to receive identification cards or other materials that will enable Hospital/Providers to identify Members who are eligible to receive Covered Services.
- 2.4. HMO shall compensate Hospital/Provider in accordance with Appendices of this Agreement. In addition, HMO shall comply with the Kentucky's Prompt-Pay statute, codified in KRS 304.17A-700-730.
- 2.5. HMO shall monitor the quality of health care provided to Members in accordance with the Provider Manual and all applicable legal and regulatory requirements.
- 2.6. Except as otherwise mandated by federal and Commonwealth governmental entities, HMO shall provide thirty (30) days written notice to Hospital/Provider of all changes to HMO's operational policies with which Hospital/Provider must comply as a condition of participation.
- 2.7. This Agreement only allows HMO to market Hospital/Provider's services to the Commonwealth for the purpose of providing Hospital/Provider Services to eligible Medicaid recipients who have been assigned as Members in the HMO by the Department.

## **3. HOSPITAL/PROVIDER OBLIGATIONS**

- 3.1. Hospital/Provider shall maintain all licenses required by law to operate its facilities and all certifications necessary for Hospital/Provider to participate in Medicaid.
- 3.2. Hospital/Provider shall ensure that all employees (including physicians and allied health professionals employed by or under contract with Hospital/Provider) shall be appropriately licensed or certified as required by applicable Commonwealth law and that such employees have met and continue to meet all applicable Commonwealth and federal laws, regulations and HMO policies and procedures. Hospital/Provider shall provide evidence of such licensure or compliance to HMO upon request. If Hospital/Provider performs laboratory services; all applicable requirements of the Clinical Laboratory Improvement Act of 1988 ("CLIA") must be met.
- 3.3. Hospital/Provider shall be in compliance with the credentialing criteria established by HMO.
- 3.4. Participating Providers shall maintain appropriate privileges on the medical staff of at least one Participating Hospital or have an HMO approved affiliation with a Participating Provider who has appropriate privileges on the medical staff of at least one Participating Hospital.
- 3.5. Participating Provider shall accept those Members who select participating Provider as their primary care provider on the same basis that participating Provider accepts any other patient.
- 3.6. Hospital/Provider shall notify HMO in writing three (3) days, whenever there is any change to the requirements enumerated in Sections 3.1 through 3.4 of this Agreement.
- 3.7. Hospital/Provider shall provide or arrange for the provision of the staff, personnel, equipment and facilities necessary for Members to obtain the Hospital/Provider Services described in the Appendices hereto, in accordance with the terms and conditions of this Agreement and the Provider Manual.
- 3.8. Hospital/Provider shall comply with all administrative policies and procedures (as described in the Provider Manual), as well as with all applicable state and federal laws and regulations relating to the delivery of Hospital/Provider Services. Hospital/Provider may appeal adverse actions in accordance with the procedures established by HMO and set out in the Provider Manual. HMO may revise the Provider Manual as it deems necessary and will provide Hospital/Provider with any revised or new material to be made part of the Provider Manual with thirty (30) days prior

notice unless otherwise required by the Commonwealth. The parties agree to comply with the provisions of KRS 304.17A-578 concerning material changes, (as defined by KRS 304.17A-578) to the Provider Manual.

- 3.9. Hospital/Provider shall not differentiate or discriminate in the treatment of any Member because of the Member's race, color, national origin, sex, age, disability, political beliefs or religion, marital status, political beliefs, or source of payment.
- 3.10. Provider shall complete the Annual Disclosure Form (ADO) as required by the Department, deliver a copy to HMO and notify HMO in writing of any update or other changes to information required by the Disclosure Form throughout the term of this Agreement. Provider acknowledges that the certifications, representations and warranties contained in the Annual Disclosure Form (and any addendum thereto) constitute a material part of this Agreement, the breach of which shall constitute a material breach of this Agreement.
- 3.11. Hospital/Provider shall be responsible for submitting claims/encounter data and such other data as may be required by the DMS or Commonwealth in accordance with the requirements described in the Provider Manual. Hospital/Provider agrees to submit such data to HMO within the time frame established by HMO and the DMS.
- 3.12. Hospital/Provider authorizes HMO to include Hospital/Provider's name, address, telephone number, accreditations, and other similar information in its Hospital/Provider directory, which may be included in various marketing materials. Hospital/Provider agrees to afford HMO the same opportunity to display brochures, signs, or advertisements in Hospital/Provider's facilities as Hospital/Provider affords any other insurance company or third party payor. Hospital/Provider may, with the prior written consent of HMO and the Commonwealth, engage in Hospital/Provider's own marketing activities designed to promote Hospital/Provider as a Participating Hospital/Provider with HMO.
- 3.13. Hospital/Provider shall provide, and make readily available and accessible, Hospital/Provider Services to Members during normal business hours. Emergency Services shall be available and accessible on a twenty-four (24) hours a day, seven (7) days a week basis.
- 3.14. Hospital/Provider agrees to notify HMO in writing within three (3) days in the event that Hospital/Provider has filed a petition for protection under the Federal bankruptcy laws. Such notice shall include information stating the district and state in which such bankruptcy petition was filed as well as the case number for such filing. Additionally, Hospital/Provider agrees to provide written notice to HMO within three (3) days of any legal action, proposed action, suit or counterclaim filed against Hospital/Provider or any administrative or regulatory action affecting this Agreement or the services to be provided under this Agreement.
- 3.15. Hospital/Provider and HMO agree that (i) Hospital/Provider may freely communicate with Members regarding the treatment options available to Members, including medication treatment options, regardless of the coverage limitations of the Plan and (ii) nothing included within this Agreement shall be construed so as to limit or prohibit the communication described in (i) above or to otherwise limit or prohibit open clinical dialogue between the Hospital/Provider and Members.
- 3.14. Hospital/Provider agrees to cooperate with HMO's Quality Management Program and all other quality improvement activities of HMO. Hospital/Provider agrees to allow the HMO reasonable access to all Member medical records.
- 3.15. Hospital/Provider agrees to comply with KRS 30417A.714 concerning the collection of overpayments.
- 3.16. Hospital/Provider acknowledges that it is Hospital/Provider's responsibility to obtain the Member's written consent for the purpose of sharing Member health information, including mental health, substance abuse, human immunodeficiency, and auto-immune deficiency syndrome information.
- 3.17. Hospital/Provider agrees that in accordance with 908 KAR 3:040, when Members are transferred between Hospital/Providers, between Hospital/Providers and forensic psychiatric facilities, between Hospital/Providers and residential treatment centers or between residential treatment centers upon the mutual agreement of the administrative officer, his designated representative or an authorized staff physician of each facility, provided such agreement is based upon one (1) of the following findings by the officers, representatives or physicians: (1) That the transfer will improve the opportunities of the patient to receive care and treatment most likely to be of benefit to him; or (2) That the transfer will permit the patient to receive care and treatment in the least restrictive alternative mode of treatment, considering the degree of danger or threat of danger to self or others which the patient presents; or (3) That the transfer is part of an individual treatment plan which has been reviewed and approved by a court.
- 3.18. Hospital/Provider shall schedule outpatient follow-up and/or continuing treatment within fourteen (14) days from date of discharge for Members receiving inpatient psychiatric services.

#### 4. COMPENSATION

- 4.1. Hospital/Provider shall bill and be paid for Hospital/Provider Services rendered in accordance with the Appendices hereto.
- 4.2. Hospital/Provider shall provide HMO with itemized and accurate statements of all Hospital/Provider Services provided to Members using the appropriate forms and the most recent, applicable ICD-CM Codes, CPT-4 Codes and HCFA Common Procedure Coding System (HCPCS) or their successors. Hospital/Provider will use best efforts to submit bills for Plan Benefits to HMO within thirty (30) days after the date of service in the case of an outpatient or the date of discharge in the case of an inpatient.
- 4.3. Original bills must be submitted by Hospital/Provider to the HMO by Hospital/Provider within 180 calendar days from the date services were rendered, date of discharge or compensable items were provided. Resubmission of previously processed claims with corrections and/or requests for adjustments must be submitted within two years of the last process date. Claims originally rejected for missing or invalid data elements must be corrected and resubmitted within 180 calendar days from the date of service. Submission of claims for members retroactively enrolled in HMO by DMS must be submitted to HMO within 180 days from the date of notification from DMS to HMO of enrollment.
- 4.4. Hospital/Provider shall accept HMO compensation as provided in this Agreement as payment in full for Hospital/Provider Services. Under no circumstances will Hospital/Provider make any charges or claims against any Member directly or indirectly for specified services authorized by HMO. Hospital/Provider shall look only to HMO for compensation for Hospital/Provider Services as set out in Appendices hereto. Hospital/Provider agrees that in no event, including, but not limited to, non-payment by HMO, insolvency or breach of this Agreement, shall Hospital/Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons acting on a Member's behalf (other than HMO) for Covered Services, except as provided in Appendices hereto. Hospital/Provider further agrees that (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and that (ii) this provision supersedes any oral or written contrary agreement now existing, or hereafter entered into between Hospital/Provider, a Member, or persons acting on their behalf. This paragraph is to be interpreted for the benefit of Members and does not diminish the obligation of HMO to make payments to Hospital/Provider according to the terms of this Agreement.
- 4.5. Hospital/Provider may directly bill the Member for Non-Covered Services if the Member is advised before the services are rendered (i) the nature of the service(s) to be rendered, (ii) that HMO does not cover the services, (iii) the cost of the Non-Covered Services and (iv) that the Member will be financially responsible for the services. The Member must agree in writing to be financially responsible for the service after receiving the required information before the Member may be charged. Furthermore, Hospital/Provider shall hold HMO harmless for any claim or expense arising from such services.
- 4.6. Hospital/Provider agrees that in the event of HMO's insolvency, or other cessation of operations, or if this Agreement is terminated for any reason, other than a quality of care issue, fraud, or breach of the Agreement by Hospital/Provider, the Hospital/Provider shall continue to provide services and be reimbursed in accordance with this Agreement until 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 postpartum period if the pregnant woman is in her fourth or later month of pregnancy. Hospital/Providers that have a valid contract with the Commonwealth to provide care under the Medicaid Program shall revert to such status in the event of insolvency or cessation of operations of HMO and shall be paid according to the terms of such contract.
- 4.7. Hospital/Provider will cooperate with HMO in coordinating benefits with other payors as follows. Hospital/Provider will make a reasonable attempt to determine whether any other payor has primary responsibility for the payment of a claim for services that Hospital/Provider rendered to an HMO member. If another payor is primarily responsible, Hospital/Provider will bill that payor before billing HMO, and Hospital/Provider will bill HMO only for the difference, if any, between the payment made, or to be made, by the primary carrier and the payment rate stated in this Agreement. If, after Hospital/Provider submits a claim to HMO, HMO determines that another payor is primarily responsible for payment of the claim, HMO will deny the claim for Hospital/Provider to bill primary carrier. HMO will provide known information to Hospital/Provider regarding primary carrier. If, after HMO pays a claim Hospital/Provider has submitted, HMO determines that another payor is primarily responsible for all or a portion of the claim, HMO will recover payment from Hospital/Provider until Hospital/Provider bills and receives payment or final denial from primary carrier. Hospital/Provider agrees to cooperate with HMO in all coordination of benefits activities.
- 4.8. No changes to the compensation schedule are to be made without the written consent of both parties, except for reimbursement changes by DMS and/or those due to National coding requirements.

## 5. PROFESSIONAL LIABILITY INSURANCE AND INDEMNITY

- 5.1. Hospital/Provider shall maintain such professional liability, comprehensive general liability, and other insurance as agreed to by the parties, to insure against any claim or claims for damages arising by reason of personal injuries or death occasioned, directly or indirectly, in connection with the performance of any service pursuant to this Agreement. Hospital/Provider, at its sole cost and expense, shall maintain policies of comprehensive general liability, including contractually assumed liability, directors' and officers' liability and other insurance of the type and in the amount customarily carried by similar type entities. Upon written request, Hospital/Provider shall provide proof of such coverage to HMO. Hospital/Provider shall require that each of its subcontractors performing services pursuant to this Agreement, if any, shall maintain such policies of professional liability, comprehensive general liability, and other insurance as shall be deemed necessary by HMO. This obligation shall survive the expiration or termination of this Agreement for any reason.
- 5.2. Hospital/Provider agrees to defend, indemnify and hold harmless HMO, its officers, directors and employees from and against any and all actions, liabilities, claims for damages and demands, and against all costs, expenses and attorneys' fees for or by reason of Hospital/Provider's breach of this Agreement, any actual or alleged death or injury to person or property arising from, or as a consequence of the negligence or willful misconduct of Hospital/Provider and/or Hospital/Provider's employees in connection with the terms and conditions of this Agreement. This section shall survive termination or expiration of this Agreement for any reason.
- 5.3. Hospital/Provider agrees to defend, indemnify and hold harmless the Commonwealth, its officers, agents, and employees, and each and every member from any liability whatsoever arising in connection with this Agreement for the payment of any debt of or the fulfillment of any obligation of Hospital/Provider.
- 5.4. HMO agrees to defend, indemnify and hold harmless Hospital/Provider, its officers, directors and employees from and against any and all actions, liabilities, claims for damages and demands, and against all costs, expenses and attorneys' fees for or by reason of HMO's breach of this Agreement and the negligence or willful misconduct of HMO and/or HMO's employees in connection with the terms and conditions of this Agreement. This section shall survive termination or expiration of this Agreement for any reason.

## 6. RECORDS

- 6.1. Hospital/Provider shall maintain adequate medical records relating to the provision of Hospital/Provider Services to Members, in such form and containing such information as required by applicable state and federal law and regulations and in accordance with usual and customary practices and the State contract. Upon reasonable, timely request received by Hospital/Provider from HMO and subject to applicable legal restrictions, Hospital/Provider shall forward to HMO in a prompt manner, any clinical information pertaining to Members necessary for HMO to conduct any functions specified by this Agreement. Hospital/Provider shall maintain all medical records relating to Members for the greater of five (5) years or the period required under applicable Commonwealth or federal law to maintain patient records and the State contract. These obligations shall survive the expiration or termination of this Agreement for any reason.
- 6.2. The Parties agree that all Members' medical records shall be treated as confidential so as to comply with all federal and Commonwealth laws regarding the confidentiality of medical records. Hospital/Provider specifically agrees to abide by the applicable statutes, regulations and rules regarding the confidentiality of Protected Health Information, including medical records, as mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d), as may be promulgated or amended. Hospital/Provider specifically agrees to protect the privacy and security of member information shared in the Patient Clinical Summary. To the extent permitted by the law and to the extent that it does not conflict with the provision of patient care, Hospital/Provider shall permit HMO and appropriate federal and Commonwealth regulatory agencies to (1) have reasonable access to Members' medical records, and (2) upon request, to inspect and copy at reasonable times any accounting, administrative and medical records maintained by Hospital/Provider relating to claims by and payments made to Hospital/Provider under this Agreement. Hospital/Provider shall permit HMO access to all Members' appeals and complaints/grievances, and/or relating to coordination of benefits. These obligations shall survive termination or expiration of this Agreement for any reason.
- 6.3. Hospital/Provider agrees to permit appropriate Commonwealth and/or federal regulatory agencies, or their authorized representatives or agents, access at all reasonable times upon demand to books, records, and other papers relating to the provision of Hospital/Provider Services rendered by or through Hospital/Provider under this Agreement, to the cost thereof, to the amount of any payments received therefore from Members, or from others on Members' behalf, and to the financial condition of Hospital/Provider. Hospital/Provider agrees to retain the books, records, and other papers

provided for in this Agreement, for at least five (5) years from the date of their creation and that such obligation shall not terminate upon termination or expiration of this Agreement for any reason.

## 7. REGULATORY OVERSIGHT

- 7.1. This Agreement is subject to the requirements of the Commonwealth, the Cabinet for Health and Family Services (CHFS) and the DMS. Hospital/Provider agrees to cooperate with HMO in its efforts to comply with any and all requirements and rules imposed on it by either Commonwealth, the CHFS, the Department and the State Contract. In addition, Hospital/Provider agrees to comply with all applicable federal and state laws, including specifically the provisions of (i) Title VI of the Civil Rights Act of 1973 (Public Law 88-352), (ii) the Federal Rehabilitation Act of 1973 (Public Law 93-112), (iii) the Americans with Disabilities Act of 1990 (Public Law 101-336), (iv) paragraphs (1-7) of Executive Order No. 11246 (the text of which is available upon request from HMO) unless exempted by rules, regulations or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246, (v) Section 6032 of the Deficit Reduction Act of 2005, PL 109-171, False Claims Act, Federal Administrative Remedies for False Claims and Statements Act, and KRS 205.8451, et.seq. (relating to fraud), (vi) 42 U.S.C. 1395nn, as applicable, (vii) comply with the applicable federal and state law regarding health care advance directives addressing the right to accept or reject life-saving medical procedures, and (viii) all amendments to each of the above and all requirements imposed by the regulations issued pursuant to such Acts. Additionally, Hospital/Provider agrees to comply with the rules and regulations prescribed by the United States Department of Labor in accordance with 41 C.F.R. Parts 60-741, including the regulations recited in 20 C.F.R. Part 741. In part, these Acts provide that no person in the United States shall, on the grounds of race, color, national origin, sex, age, disability, political beliefs or religion, be excluded from participation in, or denied, any aid, care, service or other benefits provided by federal and/or Commonwealth funding, or otherwise be subjected to discrimination.
- 7.2. Hospital/Provider agrees to comply with Kentucky's ethic laws and further certifies that no member of or delegate of Congress, the General Accounting Office, Department of Health and Human Services, the Center for Medicare and Medicaid Services or any other federal or Commonwealth agency will benefit financially or materially from any contract(s) Hospital/Provider enters into with HMO.
- 7.3. Hospital/Provider agrees to notify HMO of any action, proposed action, suit or counterclaim filed against Hospital/Provider pertaining to Members, HMO or this Agreement.
- 7.4. Hospital/Provider agrees to permit access to the Commonwealth, Department and/or federal regulatory agencies, or their authorized representatives or agents, at all reasonable times upon demand, to inspect all facilities maintained or utilized by Hospital/Provider in the provision of Hospital/Provider Services under this Agreement.

## 8. RESOLUTION OF DISPUTES

HMO and Hospital/Provider shall both fully cooperate in resolving any and all controversies among or between said parties, their employees, agents, or representatives pertaining to their respective duties under this Agreement. Such disputes shall be submitted for resolution in accordance with the Hospital/Provider grievance and appeal procedures as referenced in the Provider Manual.

## 9. TERM; TERMINATION

- 9.1. The term of this Agreement shall commence as of the Effective Date of this Agreement and, unless earlier terminated in accordance herewith, shall continue for an initial one-(1) year term. The term hereof shall be automatically renewed thereafter for successive one (1) year terms. Notwithstanding the foregoing, either party may terminate this Agreement at any time by providing at least ninety (90) days prior written notice of its intention to terminate the Agreement. If, after the date hereof, HMO revises the Provider Manual pursuant to Section 1.17 herein or otherwise changes its operational policies and Hospital/Provider does not agree with such changes, Hospital/Provider may exercise its right to terminate this Agreement as provided in this Section 9.1. If Hospital/Provider opts to terminate this Agreement because it does not agree with any such new operational policies, during the interim between implementation of such new operational policies and the termination of this Agreement, Hospital/Provider will not be obligated to comply with the new operational policies; provided however, Hospital/Provider must have delivered prior written notice to HMO of its intent to terminate at least ten (10) days prior to implementation of the new operational policies and the new operational policies must not be required by either the Commonwealth or any entity thereof.
- 9.2. Notwithstanding the above, HMO may terminate this Agreement immediately in the event any of the following occur:

- 9.2.1. In the event that Hospital/Provider is expelled, disciplined, barred from participation in, or suspended from receiving payment under any state's Medicaid Program or the Medicare Program;
  - 9.2.2. Upon the loss or suspension of the Hospital/Provider's Professional Liability coverage as set forth under this Agreement;
  - 9.2.3. If a Provider under this Agreement (1) fails to satisfy any or all of the credentialing requirements of HMO, or (2) fails to cooperate with or abide by HMO's Quality Management Program, including data reporting, HMO may immediately terminate this Agreement as to that Provider.
  - 9.2.4. Upon termination of the State Contract for any reason.
- 9.3. In the event that either party commits a material breach of this Agreement, other than those described in Section 9.2, the non-breaching party may terminate this Agreement by giving thirty (30) days' written notice (the "Thirty Day Period") to the breaching party; provided, however, termination shall not be effective if the breach or default is corrected in a manner reasonably satisfactory to the non-breaching party within the Thirty Day Period.

## **10. MISCELLANEOUS**

- 10.1. It is understood that Hospital/Provider is an independent contractor and not an employee, agent, or representative of HMO. It is further understood that Hospital/Provider provides specific services to Members in exchange for an agreed upon compensation. This Agreement shall not create, nor be deemed or construed to create, any relationship between HMO and Hospital/Provider other than that of independent contractors, contracting with each other solely for the purpose of performing this Agreement.
- 10.2. This Agreement shall not be assigned by either party without the advance, express written consent the other party
- 10.3. In the event that any provision under this Agreement is declared null or void, the remaining provisions of this Agreement shall remain in full force and effect.
- 10.4. No alterations, modifications, or amendments of the terms of this Agreement shall be valid unless made in writing and signed by both parties hereto.
- 10.5. This Agreement shall be deemed to have been made and shall be construed and interpreted in accordance with the laws of the Commonwealth of Kentucky.
- 10.6. This Agreement constitutes the entire understanding and Agreement between the parties concerning the subject matter hereof. This Agreement supersedes all prior written or oral Agreements or understandings existing between the parties concerning the subject matter hereof.
- 10.7. Written notices to be given hereunder shall be sent by certified mail, return receipt requested, or by an overnight delivery service which provides a written receipt evidencing delivery to the address set forth by the party. All notices called for hereunder shall be effective upon receipt. Notices shall be sent to HMO at HMO's administrative offices pursuant to the Provider Manual.
- 10.8. Each of the parties hereto agrees to cooperate with the other to carry out the purpose and intent of this Agreement, including without limitation the execution and delivery of any further agreements or other related documents and the taking of any action as may be reasonably required to effectuate the provisions of this Agreement.
- 10.9. The failure of any of the parties to insist upon strict performance of any of the terms of this Agreement shall not be deemed a waiver of any of their respective rights or remedies, and shall not be deemed a waiver of any subsequent breach or default in any of the terms contained in this Agreement.
- 10.10. Any conflict between the terms of this Agreement and any ancillary documents such as the Provider Manual shall be resolved in favor of this Agreement.
- 10.11. Each party recognizes that all material concerning this Agreement or the obligations set forth herein (including this Agreement itself) provided to it by the other party is confidential (the "Confidential Material"). The Confidential Material shall not be disclosed or released by either party for any purpose without the approval of the other party except, and to the extent, as may be required by law.

10.12. The parties agree that the Commonwealth of Kentucky is a third party beneficiary of this Agreement and as such is entitled to all rights and remedies available to a third party beneficiary under the laws of the Commonwealth. No other provision of this Agreement is intended to create any third party rights or status in any person or entity.

10.13 Appendices A through C, are incorporated in full herein.

IN WITNESS WHEREOF, the parties hereto have signed and executed this Agreement as of the date written below.

**"HMO"**

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

By: Christie Spence  
Printed Name: Christie Spence  
Title: Vice President  
Date: 1/15/15

**"HOSPITAL/PROVIDER"**

**NORTON HOSPITALS, INC.**

By: Mike Gough  
Printed Name: Mike Gough  
Title: CFO  
Date: 12.12.14  
KY Medical Assistance I.D. #: \_\_\_\_\_  
Tax I.D. #61-0703799

## **APPENDIX A** **HOSPITAL/PROVIDER SERVICES**

### **HOSPITAL/FACILITY SERVICES**

Hospital/Facility shall provide to Members the following Hospital/Facility Services: inpatient Hospital/Facility services; emergency services; outpatient surgery services; and, ancillary and other outpatient services.

### **BEHAVIORAL HEALTH FACILITY SERVICES**

Facility shall provide to Members the following Facility Services: inpatient facility services; emergency services; outpatient services; and, ancillary and other outpatient services.

## APPENDIX B

### HOSPITAL/PROVIDER COMPENSATION

HMO shall compensate HOSPITAL for all inpatient and outpatient Medically Necessary Hospital Services rendered by Hospital to Members as outlined below.

**Inpatient Services.** For inpatient Covered Services rendered to a Covered Person during a single admission, and billed under the Hospital/Provider's tax identification number ("TIN"), HMO shall pay Hospital/Provider one hundred percent (100%) of the current KY Medicaid rates using State's DRG methodology and relative weights in accordance with 907 KAR 10:825, multiplied by the current Base Rate, with the exception of Kosair Children's Hospital downtown facility. Any applicable "add on" shall be paid at one hundred percent (100%) of the State's current payment in effect on the date of service.

For Kosair Children's Hospital downtown facility HMO shall pay Hospital/Provider one hundred percent (100%) of the current KY Medicaid rates using State's DRG methodology and relative weights in accordance with 907 KAR 10:825 multiplied by a base rate of \$ 7,300. The methodology for annual updates to this base rate is documented in the section below, Intensity Operating Allowance. Any applicable "add on" shall be paid at one hundred percent (100%) of the State's current payment in effect on the date of service.

**Inpatient Rehabilitation Services.** For inpatient Covered Services rendered to a Covered Person during a single admission, and billed under the Hospital/Provider's tax identification number ("TIN"), HMO shall pay Hospital/Provider (i) Participating Hospital's Allowable Billed Charges; or (ii) one hundred percent (100%) of the current KY Medicaid rates in accordance with 907 KAR 10:815.

Services	Methodology	Rate
<b>Inpatient Services</b>		
Inpatient Admissions (excludes Rehabilitation, Psychiatric and Transplant admissions for Liver, Heart, Lung, and Bone Marrow)	DRG, utilizing weights as prevailing under the Kentucky fee-for-service Medicaid program enacted as effective on the date of admission. Utilizing Neonatal Level III DRGs, for all Norton Hospitals	The base rate & weights as established under 907 KAR 10:825. (DRG Base Rate x Weight ) + (ALOS x HVA)  Kosair Children's Hospital, downtown location base rate = \$7,300
Inpatient Outlier In accordance with KRS Regulations in effect on the date of service		Utilizing the inpatient cost-to-charge ratio as established under 907 KAR 10:825
High Volume Per Diem	Per Diem	100% of the per diem rate as established under 907 KAR 10:825
Transfer Payments (external facility or intra-hospital)		In accordance with KRS Regulations in effect on the date of service
Transplant Services (Liver, Heart, Lung and Bone Marrow)	Percent of charges	100% of Kentucky Medicaid as established under 907 KAR 1:350. All other transplant services will fall under the DRG methodology and priced accordingly.
Inpatient Behavioral Health	Per Diem	100% of the per diem rate as established by Kentucky Medicaid
Inpatient Rehabilitation	Per Diem	100% of the per diem rate as established by Kentucky Medicaid
<b>Outpatient Services</b>		
Emergency Room	Per Case	Level 1 - \$85 (99281) Level 2 - \$170 (99282, 99283) Level 3 - \$398.16 (99284, 99285, 99291, 99292) <b>Kosair Childrens Hospitals</b> Level 3 - \$326.77 (99284, 99285, 99291, 99292) <b>Adult Facilities</b> Non-emergency - \$50

Observation	Per Case	\$750
Cardiac Catheterization	Per Case	Left or Right - \$2,500 Both - \$3,000
Lithotripsy	Per Case	\$4,000
Surgery	ASC Grouper, Per Case	
Grouper Level		<u>Case Rate</u>
1		\$69.02
2		\$147.91
3		\$273.22
4		\$386.82
5		\$532.17
6		\$715.04
7		\$957.67
8		\$1,175.68
9		\$1,292.16
10		\$1,505.97
11		\$1,636.28
12		\$1,740.03
13		\$1,854.59
14		\$2,076.29
15		\$2,280.08
16		\$2,552.83
17		\$2,895.45
18		\$3,198.38
19		\$3,568.03
20		\$4,549.50
21		\$6,232.11
22		\$7,772.43
Carve-Out Procedures		See table below
CT Scan, with and without contrast	Flat Rate	\$500
MRI, with and without contrast	Flat Rate	\$750
Mammogram	Flat Rate	\$150
Ultrasound	Flat Rate	\$150
Electrocardiogram	Fee Schedule	100% of DMS Physician Fee Schedule
Implants	Percent of Charges	33.64%
Outpatient Radiology	Fee Schedule	200% of DMS Physician Fee Schedule
Outpatient Pathology and Laboratory	Fee Schedule	100% of DMS Hospital Outpatient Lab Fee Schedule
Radiation Therapy	Percent of Charges	33.64%
Audiology Services	Fee Schedule	100% of DMS Physician Fee Schedule
Occupational Therapy	Fee Schedule	100% of DMS Physician Fee Schedule
Physical Therapy	Fee Schedule	100% of DMS Physician Fee Schedule
Speech Therapy	Fee Schedule	100% of DMS Physician Fee Schedule
Chemotherapy Administration	Fee Schedule	100% of DMS Physician Fee Schedule
All Drugs (CPT/HCPCS and NDC # required)	Fee Schedule	100% of Medicare Part B Drug Price File
All Other Services	Percent of Charges	18.18%

#### SURGERY CARVE-OUT PROCEDURES

CPT Code	Description	Rate
23470	Reconstruct shoulder joint	\$9,300
24361	Reconstruct elbow joint	\$9,300
24363	Replace elbow joint	\$9,300
24366	Reconstruct head of radius	\$9,300
25441	Reconstruct wrist joint	\$9,300

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25442	Reconstruct wrist joint	\$9,300
25446	Wrist replacement	\$9,300
27446	Revision of knee joint	\$9,300
33208	Insrt heart pm atrial & vent	\$9,750
33214	Upgrade of pacemaker system	\$9,750
33224	Insert pacing lead & connect	\$9,750
33225	L ventric pacing lead add-on	\$9,750
33230	Insrt pulse gen w/dual leads	\$24,000
33231	Insrt pulse gen w/mult leads	\$24,000
33240	Insrt pulse gen w/singl lead	\$24,000
33249	Nsrt pace-defib w/lead	\$30,000
33262	Remv&replc cvd gen sing lead	\$24,000
33263	Remv&replc cvd gen dual lead	\$24,000
33264	Remv&replc cvd gen mult lead	\$24,000
37227	Fem/popl revasc stnt & ather	\$14,300
37231	Tib/per revasc stent & ather	\$14,300
53445	Insert uro/ves nck sphincter	\$12,000
53447	Remove/replace ur sphincter	\$12,000
54401	Insert self-contd prosthesis	\$12,000
54405	Insert multi-comp penis pros	\$12,000
54410	Remove/replace penis prosth	\$12,000
54416	Remv/repl penis contain pros	\$12,000
61885	Insrt/redo neurostim 1 array	\$15,250
61886	Implant neurostim arrays	\$20,100
62361	Implant spine infusion pump	\$13,600
62362	Implant spine infusion pump	\$13,600
63685	Insrt/redo spine n generator	\$15,250
64568	Inc for vagus n elect impl	\$24,400
64590	Insrt/redo pn/gastr stimul	\$15,250
69714	Implant temple bone w/stimul	\$9,300
69715	Temple bne implnt w/stimulat	\$9,300
69717	Temple bone implant revision	\$9,300
69718	Revise temple bone implant	\$9,300
69930	Implant cochlear device	\$29,000

When an inpatient per diem adjustment goes into effect during an inpatient stay, the inpatient per diem in effect as of the admission date will be applied to all days within a stay that spans calendar years.

HMO shall pay HOSPITAL for behavioral Health services only to the extent such behavioral Health services constitute Covered Services under the State Contract.

Notes
1) Service paid as a Per Case payment. Per Case payment, when combined with any applicable allowed amounts for implantable devices represents a global fee for all services. If multiple case rate services are billed during the same episode, the case rate with the greatest payment, combined with applicable payment for implantable

	devices will represent the allowed amount.
2)	Service paid as a Flat Rate. Flat Rates are comprehensive; however, a flat rate must be paid in addition to other Flat Rate services.
3)	Services paid based on ASC Grouper apply to CPT code range 10000 – 69999. Reimbursement for outpatient surgical procedures will be at the highest case rate performed on the same day. Hospital will bill with the appropriate CPT code for description of the surgery. Carve-Out category will be reimbursed a comprehensive rate, excluding separate reimbursement for implants.
4)	Billing for implants requires applicable revenue code and HCPCS code.
5)	Laboratory, radiology, EKG and pathology services reimbursement is based upon the technical component of the DMS Fee Schedule, and shall not be considered as inclusive of any professional component, nor interpretive fees which shall be billed separately by provider. Services reimbursed on a fee schedule will not be paid in addition to per case or flat rate payments.
6)	In the event that Facility establishes a rate increase for its current charges in excess of the Medical Care Services - Hospital Services component of the Consumer Price Index (CPI), during any one year term that this agreement is in effect, facility shall adjust rates reimbursed under a percentage of billed charge methodology such that Plan shall not be subject to increases in excess of that represented by CPI increases noted herein. Facility shall provide Plan thirty (30) days written notice of rate increases.
7)	The amount payable under the terms of this contract shall be the lesser amount of: the contracted rate, or provider's usual and customary charge with the exception of Behavioral Health and Inpatient services.

Intensity Operating Allowance (IOA). Pursuant to the Monthly Supplemental Payments as defined in Section 29.10 of the Managed Care Contract, HMO is required to make monthly supplemental payments to the specified providers on or before the last business day of the month of service for which capitation is paid. The payment shall be an amount defined by the State which shall be equal to the amount included in the data book trended forward and based upon the increase in the contractor's weighted average rate for each year of the contract. 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. An Intensity Operating Allowance will only be paid to Hospital if received by HMO from the Commonwealth of Kentucky.

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. Such cost estimates will be based on the CMS 2552-10 cost report, or successor forms, and paid claims data for HMO members for the 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 for fiscal years, beginning with the year ending December 31, 2013, 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 payment. The difference will be due to or from the HMO within three months of the date the cost report is filed with the HMO.

GME Supplemental Payments. Pursuant to Section 29.6 of the Managed Care Contract, HMO is required to make payments to Hospital/Provider for graduate medical education. (See Note 8). 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. A GME Supplemental Payment will only be paid to Hospital if received by HMO from the Commonwealth of Kentucky.

**Ambulance Services.** Provider shall provide to Members those Medically Necessary Covered Services, which are within the scope, capacity and license of Provider.

Provider agrees to bill HMO at its usual and customary charges and accept HMO's fee schedule as payment in full for covered services provided to Members.

\*\*Note: If the State's DRG and relative weight methodology changes and causes a financial material change: the provider and HMO agree to work together immediately to make the state methodology change revenue neutral to provider.

**APPENDIX C**  
**HOSPITAL/PROVIDER ROSTER**

<b>Hospital/Provider</b>	<b>Tax I.D.</b>	<b>KY Medical Assistance I.D.</b>
<b>Norton Hospitals Inc., d/b/a:</b>		
Norton Suburban Hospital	61-0703799	
Norton Audubon Hospital	61-0703799	
Norton Brownsboro Hospital	61-0703799	
Norton Hospital/Pavilion	61-0703799	
Kosair Children's Hospital & Just for Kids Transport	61-0703799	
Norton Women's and Children's Hospital	61-0703799	
Kosair Children's Hospital – St. Matthews	61-0703799	
Kosair Children's Medical Center - Brownsboro	61-0703799	
Norton Diagnostic Center – Fern Creek	61-0703799	
Norton Diagnostic Center at Old Brownsboro Crossing	61-0703799	
Norton Diagnostic Center - DuPont	61-0703799	
Norton Cardiovascular Diagnostic Center - Dixie	61-0703799	
Norton Cardiovascular Diagnostic Center – Springs	61-0703799	
Norton Diagnostic Center – St. Matthews	61-0703799	
Norton Cancer Institute	61-0703799	
Louisville Oncology	61-0703799	