PASSPORT HEALTH PLAN BY MOLINA HEALTHCARE

MUTUAL AMENDMENT

TO THE HOSPITAL SERVICES AGREEMENT

Molina Healthcare of Kentucky, Inc., a Kentucky Corporation dba Passport Health Plan by Molina Healthcare ("Health Plan") and Norton Hospitals, Inc ("Provider") enter into this Mutual Amendment ("Amendment") on the Effective Date noted below. The Provider and Health Plan each are referred to as a "Party" and are collectively referred to as the "Parties" in this Amendment.

RECITALS

A. Whereas, the Parties previously entered into a Hospital Services Agreement as may have been amended ("Agreement");

B. Whereas, the Parties desire to amend the Agreement to update Attachment B, Compensation Schedule, which has been agreed to by the Parties.

Now, therefore, in consideration of the promises and representations stated in the recitals, which are incorporated into the Amendment, and as further stated below, the Parties agree to amend the Agreement as noted in this Amendment.:

1.1 **Attachment B, Compensation Schedule**, of the Agreement is deleted and replaced by the updated Attachment B, Compensation Schedule, which is attached to this Amendment.

1.2 **Effective Date.** This Amendment will become effective June 1, 2021 ("Effective Date") and will renew with and under the terms of the Agreement.

1.3 **Use of Defined Terms.** Capitalized terms in this Amendment will have the same meanings ascribed to the terms in the Agreement unless otherwise noted in this Amendment.

1.4 **Full Force and Effect.** Except as modified by this Amendment, the Agreement will remain unaffected and will continue in full force and effect in accordance with its terms. The terms of this Amendment will prevail if there is a conflict between this Amendment and the Agreement or an earlier amendment.

1.5 **Counterparts.** This Amendment may be executed in one or more counterparts, each of which will be deemed an original, but all of which taken together will constitute one and the same instrument.

Signature Page Follows

SIGNATURE AUTHORIZATION

In consideration of the promises and representations stated, the Parties agree as set forth in this Amendment. The Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and authorization to act on behalf of its Party. The Authorized Representative further acknowledges and represents that he/she received and reviewed this Amendment in its entirety.

The Authorized Representative for each Party executes this Amendment with the intent to bind the Parties in accordance with this Amendment.

Provider Signature and Information.

Provider's Legal Name ("Provider") – as listed on applicable tax form (i.e. W-9): Norton Hospitals, Inc.	
Authorized Representative's Signature:	Authorized Representative's Name – Printed: Shelley Gast
Authorized Representative's Title: VP Managed Care	Authorized Representative's Signature Date: 6-3-21

Health Plan Signature and Information.

Molina Healthcare of Kentucky, Inc., a Kentucky Corporation dba Passport Health Plan by Molina Healthcare	
Authorized Representative's Signature:	Authorized Representative's Name – Printed: John C. Wiley
Authorized Representative's Title: VP, Network Strategy and Services	Authorized Representative's Countersignature Date: 06/03/2021

ATTACHMENT B
Compensation Schedule

1.1 **Compensation for Medicaid**

a. **Inpatient Covered Services.** Health Plan agrees to compensate Provider on a fee-for-service basis for inpatient Covered Services provided under the Medicaid Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable amounts paid or to be paid by other liable third parties and the Member for cost sharing, including, but not limited to, co-payments, deductibles, or co-insurances, if any, at an amount equivalent to one-hundred two and ½ percent (102.5%) of the Medicaid program allowable payment rate based upon Medicare Severity Diagnosis Related Group ("MS-DRG") methodology for the Date of Service.

i. **Norton Children's Hospital - Louisville.** Notwithstanding Section 1.1, a., of this Attachment, for services billed under Provider's Norton Children's Hospital downtown Louisville, Kentucky service location, Health Plan agrees to compensate Provider on a fee-for-service basis for inpatient Covered Services provided under the Medicaid Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable amounts paid or to be paid by other liable third parties and the Member for cost sharing, including, but not limited to, co-payments, deductibles, or co-insurances, if any, at an amount equivalent to one-hundred and five percent (105%) of the Medicaid program allowable payment rate based upon MS-DRG methodology for the Date of Service.

ii. **General**. Provider represents that per applicable Law and Government Program Requirements that Provider is eligible to receive Intensity Operating Allowance ("IOA") Payments. Calculations of the IOA Payments are based on the methodology utilized by Provider and approved by The Kentucky Cabinet for Health and Family Services, Department for Medicaid Services ("Department") and are subject to applicable Laws and Government Program Requirements. Information needed to support the operation of this section related to charges, expenses, and statistics will be generated and provided by Provider to Health Plan. Information needed to support the operation of this section related to Medicaid days, charges, and payments will be generated and provided by Health Plan to Provider. The cost report will be filed with the Health Plan within thirty (30) days of when the cost report is due to CMS. Payments due to a Party will be made by the owing Party within forty-five (45) days from the receipt of the cost report. During such forty-five (45) day period, the Parties agree to meet and confer to resolve any issues related to the cost report if an issue is raised by either Party.

b. **Outpatient Covered Services.** Health Plan agrees to compensate Provider on a fee-for-service basis for outpatient Covered Services provided under the Medicaid Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable amounts paid or to be paid by other liable third parties and the Member for cost sharing, including, but not limited to, co-payments, deductibles, or co-insurances, if any, at twenty percent (20%) of Provider's billed charges.

i. **Laboratory.** Notwithstanding Section 1.1, b., of this Attachment, for outpatient laboratory Covered Service (defined in this section to only include those services billed with the Current Procedural Terminology codes of 80000 through 89999), Health Plan agrees to compensate Provider on a fee-for-service basis for laboratory Covered Services provided under the Medicaid Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable amounts paid or to be paid by other liable third parties and the Member for cost sharing, including, but not limited to, co-payments, deductibles, or co-insurances, if any, at an amount equivalent to the Medicaid Fee-For-Service Program allowable payment rate set forth by the Commonwealth of Kentucky, subject to any retrospective adjustments. If there is code, but no payment rate, Health Plan agrees to compensate Provider on a fee-for-service basis for laboratory Covered Services provided under the Medicaid Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable amounts paid or to be paid by other liable third parties and the Member for cost sharing, including, but not limited to, co-payments, deductibles, or co-insurances, if any, at (20%) of Provider's billed charges. Payment for Laboratory Covered Services will be considered final and are not subject to cost settlement under Section 1.1, b.ii.

ii. **General.** Outpatient Covered Services, excluding laboratory services as defined above, will be paid on an interim basis as set forth in this Section 1.1, b. At the close of each of Provider's fiscal year, Provider will, in accordance with Medicare's cost report filing timeline, prepare a cost report detailing the actual cost for Covered Services provided to Members. Except as stated in the foregoing sentence, this cost report will otherwise comply with the Department's cost report filing requirements and will be subject to applicable Laws and Government Program Requirements. Settlement will be made to bring the Health Plan payments equal to 101% of those costs as noted in the cost report. The cost report will also serve as the basis for adjusting the interim rate each year. The cost report will be filed with the Health Plan within thirty (30) days of when the cost report is due to CMS. Payments due to a Party will be made by the owing Party within forty-five (45) days from the receipt of the cost report. During such forty-five (45) day period, the Parties agree to meet and confer to resolve any issues related to the cost report if an issue is raised by either Party.

c. **Radiation Therapy Covered Services.** Health Plan agrees to compensate Provider on a fee-for-service basis for Radiation Therapy Covered Services provided under the Medicaid Product that are determined by Health Plan to be payable and submitted on a Clean Claim less any applicable amounts paid or to be paid by other liable third parties and the Member for cost sharing, including, but not limited to, co-payments, deductibles, or co-insurances, if any, at thirty-three, sixty four hundredths percent (33.64%) of Provider's billed charges.