**EXHIBIT 1-A**

**Compensation Schedule - Medicaid (Version 1)**

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan’s programs participation, on a fee-for-services basis, at the lesser of; (i) Provider’s, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

**I. Hospital Services:**

**Inpatient Services**

[Ninety to two hundred seventy-five percent (90-275%)] of the Provider’s State of Washington Medicaid Fee-For-Service Program Inpatient payment rates in place at the time of delivery of services as known by Health Plan. Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider’s revised rate be that through its own research or notification from Provider or State.

**Outpatient Services**

[Ninety to two hundred seventy-five percent (90-275%)] of the Provider’s State of Washington Medicaid Fee-For-Service Program Outpatient payment rate in place at the time of delivery of services. This Outpatient payment rate shall be applied for all Outpatient Services.

If there is no payment rate in the State of Washington Medicaid Fee-For-Service Program fee schedule as of the date of service, payment shall be at [fifty to two hundred seventy-five percent (50-275%)] of the prevailing local and geographically adjusted Medicare Fee-For-Service Program fee schedule, in effect on the date of service.

If there is no payment rate achieved in the above methodologies, payment shall be paid at [thirty to one hundred percent (30-100%)] of billed charges.

**II. Professional Services:**

**Hospital & Clinic Based:**

For Covered Services billed under one of Provider’s tax identification numbers, payment shall be at [ninety to two hundred seventy-five percent (90-275%)] of the State of Washington Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

If there is no payment rate in the State of Washington Medicaid Fee-For-Service Program fee schedule as of the date of service, payment shall be at [fifty to two hundred seventy-five percent (50-275%)] of the prevailing local and geographically adjusted Medicare Fee-For-Service Program fee schedule, in effect on the date of service.

If there is no payment rate achieved in the above methodologies, payment shall be paid at [thirty to one hundred percent (30-100%)] of billed charges.

**EXHIBIT 1-A**

Compensation Schedule - Medicaid (Version 2)

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan’s programs participation, on a fee-for-services basis the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

**Critical Access Hospital:**

1. **Hospital Services:**

**Inpatient:**

[Ninety to two hundred seventy-five percent (90-275%)] of the Provider’s State of Washington Medicaid Fee-For-Service Program Final Critical Access Hospital (CAH) inpatient payment rates in place at the time of delivery of services as known by Health Plan.

**Outpatient:**

[Ninety to two hundred seventy-five percent (90-275%)] of the Provider’s State of Washington Medicaid Fee-For-Service Program Final Critical Access Hospital (CAH) outpatient payment rates in place at the time of delivery of services as known by Health Plan.

1. **Professional Services:**

[Ninety to two hundred seventy-five percent (90-275%)] of the payment Provider would otherwise have been entitled to, had the Covered Services been billed directly under the Medicaid Fee-For-Service Program allowable payment rates.

If there is no payment rate in the State of Washington Medicaid Fee-For-Service Program fee schedule as of the date of service, payment shall be at [fifty to two hundred seventy-five percent (50-275%)] of the prevailing local and geographically adjusted Medicare Fee-For-Service Program fee schedule, in effect on the date of service.

If there is no payment rate achieved in the above methodologies, payment shall be paid at [thirty to one hundred percent (30-100%)] of billed charges.

**EXHIBIT 1-B**

**Compensation Schedule – Medicare (Version 1)**

Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided in accordance with Medicare, that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance or amounts paid or to be paid by other liable parties, in any, at the lesser of: (i) Provider’s billed charges; or (ii) at an amount equivalent to [ninety to two hundred seventy-five percent (90-275%)] of the Medicare Fee-For-Service Program allowable payment rates (adjusted for place of service or geography), as of the date of service. The Medicare Fee-For Service Program allowable rate deducts any cost sharing amounts, including but not limited to co-payments, deductibles, co-insurance, or amount paid or to be paid by other liable third parties that would have been deducted if the Member were enrolled in the Medicare Fee-For-Service Program.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date(s) of service, payment shall be at [fifty percent (50%) - two hundred seventy-five percent (275%)] of the Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

If there is no payment rate achieved in the above methodologies, payment shall be paid at [thirty to one hundred percent (30-100%)] of billed charges.]

**EXHIBIT 1-B**

Compensation Schedule - Medicare (Version 2)

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan’s programs participation, on a fee-for-services basis, the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

**Critical Access Hospital:**

1. **Hospital Services:**

**Inpatient Services:**

[Ninety to two hundred seventy-five percent (90-275%)] of the Provider’s Medicare Final Critical Access Hospital (CAH) inpatient payment rates in place at the time of delivery of services as known by Health Plan.

**Outpatient Services:**

[Ninety to two hundred seventy-five percent (90-275%)] of the Provider’s Medicare Final Critical Access Hospital (CAH) outpatient payment rates in place at the time of delivery of services as known by Health Plan.

1. **Professional Services:**

[Ninety to two hundred seventy-five percent (275%)] of the payment Provider would otherwise have been entitled to, had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

If there is no payment rate in the Medicare Fee-For-Service Program fee schedule as of the date of service, payment shall be at [fifty to two hundred seventy-five percent (50-275%)] of the prevailing local and geographically adjusted Medicaid Fee-For-Service Program fee schedule, in effect on the date of service.

If there is no payment rate achieved in the above methodologies, payment shall be paid at [thirty to one hundred percent (30-100%)] of billed charges.

**Updates to Payment:**

Provider shall notify Health Plan of any updates to their Medicare payment rates by CMS. Rate letter(s) shall be provided to Health Plan within 30 days of receipt by Provider.

**EXHIBIT 1-B**

Compensation Schedule - Medicare (Version 3)

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan’s programs participation, on a fee-for-services basis, at the lesser of; (i) Provider’s billed charges, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

1. **Hospital Services**

**Inpatient Services:**

[Ninety to two hundred seventy-five percent (90-275%)] of the Provider’s CMS (Centers for Medicare & Medicaid Services) inpatient payment rates in place at the time of delivery of services as known by Health Plan.

If there is no payment rate in the Medicare Fee-For-Service Program fee schedule as of the date of service, payment shall be at [fifty to two hundred seventy-five percent (50-275%)] of the prevailing local and geographically adjusted Medicaid Fee-For-Service Program fee schedule, in effect on the date of service.

If there is no payment rate achieved in the above methodologies, payment shall be paid at [thirty to one hundred percent (30-100%)] of billed charges.

**Outpatient Services:**

[Ninety to two hundred seventy-five percent (90-275%)] of the Provider’s CMS (Centers for Medicare & Medicaid Services) outpatient payment rates in place at the time of delivery of services as known by Health Plan.

If there is no payment rate in the Medicare Fee-For-Service Program fee schedule as of the date of service, payment shall be at [fifty to two hundred seventy-five percent (50-275%)] of the prevailing local and geographically adjusted Medicaid Fee-For-Service Program fee schedule, in effect on the date of service.

If there is no payment rate achieved in the above methodologies, payment shall be paid at [thirty to one hundred percent (30-100%)] of billed charges.

1. **Professional Services:**

[Ninety to two hundred seventy-five percent (90-275%)] of the payment Provider would otherwise have been entitled to, had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

If there is no payment rate in the Medicare Fee-For-Service Program fee schedule as of the date of service, payment shall be at [fifty to two hundred seventy-five percent (50-275%)] of the prevailing local and geographically adjusted Medicaid Fee-For-Service Program fee schedule, in effect on the date of service.

If there is no payment rate achieved in the above methodologies, payment shall be paid at [thirty to one hundred percent (30-100%)] of billed charges.

**Updates to Payment:**

Provider shall notify Health Plan of any updates to their Medicare payment rates by CMS. Rate letter(s) shall be provided to Health Plan within 30 days of receipt by Provider.

**EXHIBIT 1-C**

**Compensation Schedule – Molina Marketplace (Version 1)**

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan’s programs participation, on a fee-for-services basis, at the lesser of; (i) Provider’s billed charges, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

**I. Hospital Services:**

**Inpatient Services:**

[Ninety to two hundred seventy-five percent (90-275%)] of the payment Provider would otherwise have been entitled to, had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date(s) of service, payment shall be at [fifty to two hundred seventy-five percent (50-275%)] of the prevailing State of Washington Medicaid Fee-For-Service Program allowable Inpatient rates, as of the date of service.Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider’s revised rate be that through its own research or notification from Provider or State.

If there is no payment rate achieved in the above methodologies, payment shall be paid at [thirty to one hundred percent (30-100%)] of billed charges.

**Outpatient Services:**

[Ninety to two hundred seventy-five percent (90-275%)] of the payment Provider would otherwise have been entitled to, had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the dates of service, payment shall be at [fifty to two hundred seventy-five percent (50-275%)] of the prevailing State of Washington Medicaid Fee-For-Service Program allowable Outpatient payment rates, as of the date of service.Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider’s revised rate be that through its own research or notification from Provider or State.

If there is no payment rate achieved in the above methodologies, payment shall be paid at [thirty to one hundred percent (30-100%)] of billed charges.

**II. Professional Services:**

**Hospital & Clinic Based:**

[Ninety to two hundred seventy-five percent (90-(275%)] of the prevailing local and geographically adjusted Medicare Fee-For-Service Program fee schedule in effect on the date of service.

If there is no payment rate in the prevailing local and geographically adjusted Medicare Fee-For-Service Program fee schedule in effect on the date of service, payment shall be at [fifty to two hundred seventy-five percent (50-275%)] of the Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

If there is no payment rate achieved in the above methodologies, payment shall be paid at [thirty to one hundred percent (30-100%)] of billed charges.

**EXHIBIT 1-C**

**Compensation Schedule – Molina Marketplace (Version 2)**

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan’s programs participation, on a fee-for-services basis, at the lesser of; (i) Provider’s billed charges, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

**Critical Access Hospital:**

1. **Inpatient Services:**

[Ninety to two hundred seventy-five percent (90-275%)] of the Provider’s Medicare Final Critical Access Hospital (CAH) inpatient payment rates in place at the time of delivery of services as known by Health Plan.

**Outpatient Services:**

[Ninety to two hundred seventy-five percent (90-275%)] of the Provider’s Medicare Final Critical Access Hospital (CAH) outpatient payment rates in place at the time of delivery of services as known by Health Plan.

1. **Professional Services:**

[Ninety to two hundred seventy-five percent (90-275%)] of the payment Provider would otherwise have been entitled to, had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

If there is no payment rate in the Medicare payment program as of the date of service, payment shall be at [fifty to two hundred seventy-five percent (50-275%)] of the prevailing State of Washington Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

If there is no payment rate achieved in the above methodologies, payment shall be paid at [thirty to one hundred percent (30-100%)] of billed charges.

**Updates to Payment:**

Provider shall notify Health Plan of any updates to their Medicare payment rates by CMS. Rate letter(s) shall be provided to Health Plan within 30 days of receipt by Provider.

**exhibit 1-C**

**Compensation Schedule** **- Molina Marketplace (Version 3)**

* 1. **Compensation for Molina Marketplace.** 
     1. **Inpatient and Outpatient Covered Services.** Except for other facility Covered Services in Section 1.1 b. of this attachment, Health Plan agrees to compensate Provider on a fee-for-service basis for inpatient and outpatient Covered Services provided under the Molina Marketplace Product that are determined by Health Plan to be payable pursuant to Laws, Government Program Requirements, and this Agreement and that are 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 the lesser of: (i) Provider’s billed charges; or (ii) the following amounts in effect for the Date of Service.
        1. **Inpatient Covered Services.** For inpatient Covered Services, at [eighty to four hundred percent (80-400%)] of the 2021 Medicare base diagnosis related group (“DRG”) rate that is used in the Medicare Fee-for-Service calculation (“Marketplace IP Rate”). Any DRGs added after 2021 will be based on the DRG weights established by CMS when the DRG is added to the Medicare fee schedule. The Service Categories identified by the Identifier Codes in Table 1 below will not be paid according to the Marketplace IP Rate and are reimbursed pursuant to the all-inclusive rates set forth in Table 1.

**Table 1**

|  |  |  |  |
| --- | --- | --- | --- |
| **Service Category** | **Identifier Codes** | **Reimbursement Methodology** | **Reimbursement Rate** |
| Vaginal Delivery | MS-DRG 768, 796-798, 805-807 | Case Rate  (1-2 Days) | [$0-20,000] |
| Vaginal Delivery Additional Days | MS-DRG 768, 796-798, 805-807 | Per Diem  (3+ Days) | [$0-10,000] |
| C-Section Delivery | MS-DRG 783-788 | Case Rate  (1-3 Days) | [$0-30,000] |
| C-Section Delivery Additional Days | MS-DRG 783-788 | Per Diem  (4+ Days) | [$0-10,000] |
| NICU Level 2 | Revenue Code 172 | Per Diem | [$0-15,000] |
| NICU Level 3 | Revenue Code 173 | Per Diem | [$0-15,000] |
| NICU Level 4 | Revenue Code 174 | Per Diem | [$0-15,000] |
| Normal Newborn/Boarder Baby, NICU Level 1 | Revenue Code 170, 171, 179 or MS-DRG 795 | Per Diem | [$0-10,000] |

* + - 1. **Outpatient Covered Services.** For outpatient Covered Services, at [eighty to four hundred percent (80-400%)] of the applicable 2021 Medicare fee schedule, including 2021 Medicare Outpatient Prospective Payment System (“OPPS”) and 2021 Medicare Ambulatory Surgical Center (“ASC”) Payment System, (“Marketplace OP Rate”). Any Ambulatory Payment Classification (“APC”) added after 2021 will be based on the APC initial payment rates established by CMS when the APC is added to the Medicare fee schedule. The Service Category identified by the Identifier Codes in Table 2 below will not be paid according to the Marketplace OP Rate and is reimbursed pursuant to the all-inclusive rate set forth in Table 2.

**Table 2**

|  |  |  |  |
| --- | --- | --- | --- |
| **Service Category** | **Identifier Codes** | **Reimbursement Methodology** | **Reimbursement Rate** |
| Emergency Room (All Levels) | Revenue codes 450-459 with CPT Codes 99281-99285 | Case Rate | [$0-15,000] |

* + - 1. **Marketplace IP and OP Rate Updates.** Except when otherwise set forth by a Law or Government Program Requirement, Provider agrees that Health Plan will implement updates or revisions to the Marketplace IP Rate or the Marketplace OP Rate on a prospective basis within sixty (60) days of the update or revision from the agency. The update or revision will be applied to all Claims received after the implementation and Health Plan will not be required to retrospectively adjust any Claims.
      2. **Other Inpatient and Outpatient Covered Services.** For those inpatient and outpatient Covered Services which cannot be compensated pursuant to Sections 1.1 a. i. or ii. of this Attachment, Provider will be compensated at [ten to one hundred percent (10%-100%)] of Provider’s billed charges.
    1. **Other Facility Covered Services**. Health Plan agrees to compensate Provider on a fee-for-service basis for other facility Covered Services, outlined below, provided under the Molina Marketplace Product that are determined by Health Plan to be payable pursuant to Laws, Government Program Requirements, and this Agreement and that are 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 the lesser of: (i) Provider’s billed charges; or (ii) the following amounts in effect for the Date of Service.
       1. **Cancer Hospital, Children’s Hospital, and Critical Access Hospital Inpatient and Outpatient Covered Services.** For inpatient and outpatient Covered Services provided by a cancer hospital, children’s hospital, or critical access hospital, at [eighty to four hundred percent (80-400%)] of the Medicare allowable payment rate. This rate is determined by the Provider’s most recently received per-visit rate letter from the Centers for Medicare and Medicaid Services. Provider will provide Health Plan with its updated per-visit rate letter within thirty (30) days of receipt and in accordance with the Notice Section of this Agreement. Health Plan will update Provider’s payment rate by the first (1st) day of the month following the date of receipt by Health Plan so long as Health Plan receives the rate letter before the fifteenth (15th) of the preceding month. If Provider does not deliver such information or information is received after the fifteenth (15th) of the preceding month, Health Plan will use the last information received from Provider. There will be no retroactive adjustments.
       2. **Inpatient Psychiatric Facility, Inpatient Rehabilitation Facility, and Long-Term Care Facility Inpatient and Outpatient Covered Services.** For inpatient and outpatient Covered Services provided by an inpatient psychiatric facility, inpatient rehabilitation facility, or long-term care facility, at [eighty to four hundred percent (80-400%)] of the 2021 Medicare allowable payment rate for the applicable facility type.
       3. **Skilled Nursing Facility Covered Services.** For skilled nursing facility Covered Services, at the all-inclusive rates set forth in Table 3. Provider will not be entitled to any other payment besides what is below for any other skilled nursing facility Covered Service they perform.

**Table 3**

|  |  |  |  |
| --- | --- | --- | --- |
| **Service Category** | **Identifier Codes** | **Reimbursement Methodology** | **Reimbursement Rate** |
| Skilled Nursing Facility (“SNF”) - Level I | Type of Bill: 211-214 or 181-184  Revenue Code: 0191 | Per diem | [$0 – 2,500] |
| SNF - Level II | Type of Bill: 211-214 or 181-184  Revenue Code: 0192 | Per diem | [$0 – 3,000] |
| SNF - Level III | Type of Bill: 211-214 or 181-184  Revenue Code: 0193 | Per diem | [$0 – 3,500] |
| SNF - Level IV | Type of Bill: 211-214 or 181-184  Revenue Code: 0194 | Per diem | [$0 – 4,000] |
| SNF – Level V | Type of Bill: 211-214 or 181-184  Revenue Code: 0199 | Per diem | [$0 – 4,500] |

* + - 1. **Dialysis Center Covered Services.** For dialysis center Covered Services, at the all-inclusive rates set forth in Table 4.Provider will not be entitled to any other payment besides what is below for any other dialysis Covered Service they perform. When ultrafiltration is performed on the same date as the dialysis treatment; there is no separate payment. When ultrafiltration is performed on a day other than the day of a dialysis treatment, the dialysis center must document the medical necessity of why the ultrafiltration could not have been performed at the time of the dialysis treatment and provide the medical record with the Claim. If Health Plan considers the medical justification appropriate, Provider will receive the ultrafiltration per treatment rate.

**Table 4**

|  |  |  |  |
| --- | --- | --- | --- |
| **Service Category** | **Identifier Codes** | **Reimbursement Methodology** | **Reimbursement Rate** |
| Hemodialysis – in-center or home | Revenue Code: 0821  CPT Code: 90999 | Per treatment | [$0 – 5,000] |
| Intermittent Peritoneal Dialysis (IPD) | Revenue Code: 0831  CPT Code: 90999 | Per treatment | [$0 – 5,000] |
| Ultrafiltration | Revenue Code: 0881  CPT Code: 90999 | Per treatment | [$0 – 5,000] |
| Continuous Ambulatory Peritoneal Dialysis (CAPD) | Revenue Code: 0841  CPT Code: 90945 | Per treatment | [$0 – 3,000] |
| Continuous Cycling Peritoneal Dialysis (CCPD) | Revenue Code: 0851  CPT Code: 90945 | Per treatment | [$0 – 3,000] |
| CAPD Training Treatment | Revenue Code: 0841  CPT Code: 90993 | Per treatment | [$0 – 5,000] |
| CCPD Training Treatment | Revenue Code: 0851  CPT Code: 90993 | Per treatment | [$0 – 5,000] |
| Home Hemodialysis Training | Revenue Code: 0821  CPT Code: 90993 | Per treatment | [$0 – 5,000] |

* + 1. **Home Health and Hospice Covered Services**. Health Plan agrees to compensate Provider on a fee-for-service basis for home health and hospice. Covered Services provided under the Molina Marketplace Product that are determined by Health Plan to be payable pursuant to Laws, Government Program Requirements, and this Agreement and that are 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 the lesser of: (i) Provider’s billed charges; or (ii) the following amounts in effect for the Date of Service.
       1. **Certified Home Health Covered Services.** For certified home health Covered Services, at the all-inclusive rates set forth in Table 5. Provider will not be entitled to any other payment besides what is below for any other home health Covered Service they perform.

**Table 5**

|  |  |  |  |
| --- | --- | --- | --- |
| **Service Category** | **Identifier Codes** | **Reimbursement Methodology** | **Reimbursement Rate** |
| Skilled Nursing | Revenue Code: 055X | Per visit | [$0 – 2,000] |
| Medical Social Services | Revenue Code: 056X | Per visit | [$0 – 2,000] |
| Home Health Aide | Revenue Code: 057X | Per visit | [$0 – 1,000] |
| Physical Therapy | Revenue Code: 042X | Per visit | [$0 – 2,000] |
| Occupational Therapy | Revenue Code: 043X | Per visit | [$0 – 2,000] |
| Speech-Language Pathology | Revenue Code: 044X | Per visit | [$0 – 2,000] |

* + - 1. **Hospice Covered Services.** For hospice Covered Services, at the all-inclusive rates set forth in Table 6. Provider will not be entitled to any other payment besides what is below for any other hospice Covered Service they perform.

**Table 6**

|  |  |  |  |
| --- | --- | --- | --- |
| **Service Category** | **Identifier Codes** | **Reimbursement Methodology** | **Reimbursement Rate** |
| Routine Home Hospice Care | Revenue Code: 0651 | Per diem | [$0 – 2,500] |
| Continuous Home Hospice Care | Revenue Code: 0652 | Per hour | [$0 – 1,000] |
| Inpatient Respite Care | Revenue Code: 0655 | Per diem | [$0 – 6,000] |
| General Inpatient Care (Non-Respite) | Revenue Code: 0656 | Per diem | [$0 – 8,000] |

* + 1. **Professional and Other Covered Services.** For professional and other Covered Services which are not otherwise reimbursed pursuant to Section 1.1 of this attachment,Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the Molina Marketplace Product that are determined by Health Plan to be payable pursuant to Laws, Government Program Requirements, and this Agreement and that are 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 the lesser of: (i) Provider’s billed charges; or (ii) the following amounts in effect for the Date of Service.
       1. **Professional and Other Covered Services Except Drugs and Immunizations****.** For professional and other Covered Services, at [eighty to four hundred percent (80-400%)] of the prevailing Molina Fee Schedule. If a HCPCS/CPT code is not on the prevailing Molina Fee Schedule, that code is not a Covered Service.
       2. **Drugs and Immunizations.** Drugs and immunizations are excluded from the Molina Fee Schedule when there is a Medicare payment rate for the Date of Service and will be reimbursed at [eighty to four hundred percent (80-400%)] of the Medicare fee schedule in effect for the Date of Service. If there is no Medicare payment rate for the Date of Service, such drugs and immunizations will be included on the Molina Fee Schedule and will be paid according to the Molina Fee Schedule. Except when otherwise set forth by a Law or Government Program Requirement, Provider agrees that Health Plan will implement updates or revisions to the Medicare Fee Schedule on a prospective basis within sixty (60) days of the update or revision from the agency. The update or revision will be applied to all Claims received after the implementation and Health Plan will not be required to retrospectively adjust any Claims.
    2. **Modifications of Molina Fee Schedule.**
       1. **Material Changes to Existing Codes (does not include the addition and deletion of codes).** Health Plan shall review and, where appropriate, update the prevailing Molina Fee Schedule of any material changes and will provide no less than sixty (60) days’ prior written notice of any material modification.
       2. **Addition and Deletion of Codes.** Health Plan and Provider recognize that new codes will be added or deleted periodically by Centers for Medicare and Medicaid Services (“CMS”) and American Medical Association (“AMA”). Health Plan will establish a rate for codes added to the Molina Fee Schedule. Provider’s contracted percentage of the Molina Fee Schedule will be applied to these rates. Health Plan will automatically remove HCPCS and CPT Codes determined to be no longer valid by AMA, effective on the date announced by AMA.

**EXHIBIT 1-C-1**

**Charge Description Master Limit Protection - Molina Marketplace (Version 3)**

This attachment sets forth the Charge Description Master Limit Protection. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. The Parties agree to the terms and conditions in this attachment relating to Covered Services that are paid at a percentage of Provider’s billed charges. Such charges will use Provider’s schedule of charges, chargemaster, or other charge-based methodology (collectively referred to herein as Charge Description Master or “CDM”) and any increases by Provider to its CDM (“CDM Increases”) as set forth in this attachment.

1. **Notification of CDM Increases**. Provider shall notify Health Plan in writing if any increase is made to its CDM during the term of this Agreement. Such written notice shall be made at least sixty (60) days prior to the effective date of such increase and shall include information in an electronic format acceptable to Health Plan for Health Plan to calculate and verify the amount of the increase including, but not limited to, Provider’s prior and current calendar year CDM with rates, industry standard coding and effective dates. In the event Health Plan determines that Provider has increased its CDM and failed to notify Health Plan as set forth above, Health Plan shall have the right to adjust compensation payments and rates as set forth below (“Adjustment to Compensation”), retroactive to the effective date of the CDM increase and in accordance with the offset provision in this agreement.  Health Plan shall have the right to audit Provider's CDM in order to calculate and verify any increase to Provider's CDM during the term of this Agreement.
2. **Limit on CDM Increases**. For all payments and rates based on Provider’s CDM, percent of CDM reimbursements, and impacted by CDM Increases, including fixed rates, Health Plan shall calculate Provider’s payment and rate during the first twelve (12) months following the Effective Date of this Agreement pursuant to Provider’s CDM in effect on the Effective Date of this Agreement (the “CDM Restricted Period”). Thereafter, Provider is limited to an annual CDM Increase not to exceed three percent (3%) for each twelve (12) month period following the first anniversary of the Effective Date of this Agreement (the “CDM Limit”).
3. **Adjustment to Compensation**. In the event Provider increases its CDM during the CDM Restricted Period or, thereafter, increases its CDM by more than the CDM Limit, Health Plan shall adjust compensation impacted by any such CDM Increases downwards in order to compensate Provider at an amount consistent with Provider’s CDM prior to such CDM Increase, including, but not limited to, fee for service payments and/or fixed or flat payment rates. Health Plan’s adjustment shall be retroactive to the date determined by Health Plan to be the effective date of Provider’s CDM Increase. Health Plan shall have the right to offset Provider’s compensation to recoup overpayments resulting from Provider increasing its CDM during the Restricted Period and/or increasing its CDM more than the CDM Limit. Offsets will be implemented in accordance with any applicable offset notification provisions of this Agreement or required by law.
4. **Adjustment** **to** **Compensation** **Examples**.
   1. Compensation adjustment calculations for first twelve (12) months following the Effective Date:
      1. Provider’s CDM Increase: 9%
      2. Compensation Payment Rate: 30% of Provider’s CDM
      3. Compensation Adjustment Calculation = 0.30 / 1.09 = 27.52% of Provider’s CDM
   2. Compensation adjustment calculations for each twelve (12) month period following the first anniversary after the Effective Date:
      1. Provider’s CDM Increase:  9%
      2. CDM Limit: 3%
      3. Compensation Payment Rate: 30% of Provider’s CDM
      4. Compensation Adjustment Calculation = 1.03 / 1.09 x 0.30 = 28.35% of Provider’s CDM.