**PASSPORT BY MOLINA HEALTHCARE**

**HOSPITAL SERVICES AGREEMENT**

**SIGNATURE PAGE**

In consideration of the promises and representations stated, the Parties agree as set forth in this Agreement. 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 Agreement in its entirety.

The Authorized Representative of Provider acknowledges the Provider Manual was available for review prior to entering into this Agreement and agrees that Provider will comply with the provisions set forth under the Provider Manual section and other applicable provisions related to the Provider Manual in the Agreement.

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

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| **Effective Date of Agreement** (“Effective Date”): |

**Provider Signature and Information:**

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| Provider’s Legal Name (“Provider”) – Matching the applicable tax form (i.e. W-9, Line 1): | |
| Authorized Representative’s Signature: | Authorized Representative’s Name – Printed: |
| Authorized Representative’s Title: | Authorized Representative’s Signature Date: |
| Telephone Number: | Fax Number – Official Correspondence: |
| Mailing Address – Official Correspondence: | Payment Address – If different than Mailing Address: |
| IRS 1099 Address – If different than Mailing Address: | Tax ID Number – As listed on corresponding tax form: |
| NPI – That corresponds to the above Tax ID Number: | Email Address – Official Correspondence: |

**Health Plan Signature and Information:**

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| --- | --- |
| Molina Healthcare of Kentucky, Inc., a Kentucky Corporation dba Passport by Molina Healthcare | |
| Authorized Representative’s Signature: | Authorized Representative’s Name – Printed: |
| Authorized Representative’s Title: | Authorized Representative’s Countersignature Date: |
| Mailing Address – Official Correspondence: | Email Address – Official Correspondence: |

HOSPITAL SERVICES AGREEMENT

Health Plan and Provider enter into this Agreement as of the Effective Date set forth on the Signature Page of this Agreement. The Provider and Health Plan each are referred to as a “Party” and collectively as the “Parties”.

**RECITALS**

1. WHEREAS, Health Plan is a corporation licensed and approved, or is seeking licensure and approval, by required agencies to operate a health care service plan, including without limitation, to issue benefit agreements covering the provision of health care and related services;
2. WHEREAS, Provider is approved to provide health care or related services and desires to provide services to eligible recipients; and
3. WHEREAS, the Parties intend by entering into this Agreement they will make health care or related services available to eligible recipients enrolled in various Products or who at a future date will be enrolled in Products covered under this Agreement.

NOW, THEREFORE, in consideration of the promises and representations stated, the Parties agree as follows:

**ARTICLE ONE – DEFINITIONS**

1. Capitalized words or phrases in this Agreement have the meaning set forth below, unless Health Plan is required to follow a different definition pursuant to a Law or a Government Program Requirement.
2. **Advance Directive** means a Member’s written instruction, recognized under Law, relating to the provision of health care, when the Member is not competent to make a health care decision as determined under Law.
3. **Affiliate** means an entity owned or controlled by Health Plan or Molina Healthcare, Inc.
4. **Agreement** means this Hospital Services Agreement between Provider and Health Plan and all attachments, exhibits, addenda, amendments, and incorporated documents or materials.
5. **Appeals and** **Grievance** **Programs** mean the policies and procedures established by Health Plan to timely identify, process, and resolve Member and Provider appeals, grievances, complaints, disputes, or inquiries.
6. **Centers for Medicare and Medicaid Services** **(“CMS”)** means the agency responsible for Medicare and certain parts of Medicaid, CHIP, Medicare-Medicaid Program, and the Health Insurance Marketplace.
7. **Claim** means a bill for Covered Services provided by Provider.
8. **Clean Claim** means a Claim for Covered Services submitted on an industry standard form, which has no defect, impropriety, lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely adjudication of the Claim.
9. **Covered Services** mean those health care services and supplies, including Emergency Services, provided to Members that are Medically Necessary and are benefits of a Member’s Product.
10. **Cultural Competency Plan** means a plan that ensures Members receive Covered Services in a manner that takes into account, but is not limited to, developmental disabilities, physical disabilities, differential abilities, cultural and ethnic backgrounds, and limited English proficiency.
11. **Date of Service** means the date on which Provider provides Covered Services or, for inpatient services, the date the Member is discharged.
12. **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage, Medicaid, or MMP Products, below the level of the arrangement between Health Plan (or applicant) and Provider. These written arrangements continue down to the level of the ultimate provider for health and administrative services.
13. **Emergency Services** mean covered inpatient and outpatient services furnished by a provider who is qualified to furnish the services and the services are needed to evaluate or stabilize an emergency medical condition.
14. **Encounter Data** means all data captured during the course of a single health care encounter that specifies: (i) the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative) pharmaceuticals, medical devices, and equipment associated with a Member receiving services during the encounter; (ii) the identification of the Member receiving and the provider providing the health care services during the single encounter; and (iii) a unique and unduplicated identifier for the single encounter.
15. **Government Contracts** mean those contracts between Health Plan and governmental agencies for the arrangement of health care and related services for Government Programs.
16. **Government Programs** mean various government sponsored health products in which Health Plan participates.
17. **Government Program Requirements** mean the requirements of governmental agencies for a Government Program, which includes, but is not limited to, the requirements set forth in the Government Contract.
18. **Health Insurance Marketplace** means those health insurance products/programs required by Title I of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), referred to collectively as the Affordable Care Act, including all implementing statutes and regulations.
19. **Health Plan** meansMolina Healthcare of Kentucky, Inc., a Kentucky Corporation, dba Passport by Molina Healthcare.
20. **Law** means, without limitation, federal, state, commonwealth, tribal, or local statutes, codes, orders, ordinances, and regulations applicable to this Agreement.
21. **Medicaid** means the joint federal-state or federal-commonwealth program provided for under Title XIX of the Social Security Act, as amended.
22. **Medically Necessary** **or Medical Necessity** means health care services that a Provider would render to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate in terms of type, frequency, extent, and duration.
23. **Medicare Advantage (“MA”)** means a program in which private health plans provide health care and related services through a Government Contract with CMS, which is authorized under Title XVIII of the Social Security Act, as amended (otherwise known as “Medicare”). Medicare Advantage also includes Medicare Advantage Special Needs Plans (“MA-SNP”).
24. **Medicare-Medicaid Program (“MMP”)** means a program in which private health plans provide health care and related services to beneficiaries eligible for both Medicaid and Medicare through a Government Contract with CMS and the State.
25. **Member** means a person enrolled in a Product and who is eligible to receive Covered Services.
26. **Molina Fee Schedule** means the Health Plan’s fee schedule, inclusive of all reimbursement rates Health Plan is required to reimburse Provider within this Agreement. The Molina Fee Schedule is available upon request.
27. **Molina Marketplace** means the Products offered and sold by Health Plan under the requirements of the Health Insurance Marketplace.
28. **Overpayment** means a payment Provider receives, which after applicable reconciliation, Provider is not entitled to receive pursuant to Laws, Government Program Requirements, or this Agreement.
29. **Participating Provider** means a healthcare facility or practitioner contracted with and, as applicable, credentialed by Health Plan or Health Plan’s designee.
30. **Products** mean the various health insurance programs offered by Health Plan to Members in which Provider agrees to be a Participating Provider, identified on Attachment A, Products, and which will include any successors to such Products.
31. **Provider** means the entity identified on the Signature Page of this Agreement and includes any person or entity performing Covered Services on behalf of Provider and: (i) is listed on Attachment H, Provider Identification Sheet; and (ii), when applicable, such person or entity has been approved by Health Plan as a Participating Provider. Each entity or person shall be considered an “Individual Provider”.
32. **Provider Manual** means Health Plan’s provider manuals, policies, procedures, documents, educational materials, and, as applicable, Supplemental Materials, setting forth Health Plan’s requirements and rules that Provider is required to follow.
33. **Quality Improvement Program (“QI Program”)** means the policies and procedures, interventions, and systems, developed by Health Plan for monitoring, assessing, and improving the accessibility, quality, and continuity of care provided to Members.
34. **Responsible Entity** means an entity that is financially responsible for certain Covered Services and pays Claims that are part of its financial responsibility.
35. **State Children’s Health Insurance Program (“SCHIP” or “CHIP”)** means the program established pursuant to Title XXI of the Social Security Act, as amended.
36. **Subcontractor** means an individual or organization, including Downstream Entity, with which Provider contracts for the provision of Covered Services or administrative functions related to the performance of this Agreement. For the avoidance of doubt, a Subcontractor does not include Individual Providers.
37. **Utilization Review and Management Program (“UM Program”)** means the policies, procedures, and systems developed by Health Plan for evaluating and monitoring the Medical Necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective reviews, including, but not limited to, under-utilization and over-utilization.

**ARTICLE TWO – PROVIDER OBLIGATIONS**

1. **Provider Standards.**
2. **Standard of Care.** Provider agrees to provide Covered Services within the scope of Provider’s business. Provider will ensure all services and interactions with Members are at a level of care and competence that equals or exceeds generally accepted and professionally recognized standards of practice, rules, and standards of professional conduct, Laws, and Government Program Requirements.
3. **Facilities, Equipment, and Personnel.** Provider’s facilities, equipment, personnel, and administrative services will be at a level and quality necessary to perform Provider’s duties under this Agreement and to comply with Laws and Government Program Requirements.
4. **Prior Authorization.** For a Covered Service that requires prior authorization, Provider will obtain prior authorization from Health Plan before providing such Covered Service. Provider will not have to obtain prior authorizations before providing Emergency Services.
5. **Use of Participating Providers.** Except in the case of Emergency Services or when Provider obtains prior authorization, Provider will only utilize Participating Providers to provide Covered Services. If a Participating Provider is not available, Provider will notify Health Plan so Health Plan can determine the appropriate provider to perform such services.
6. **Prescriptions.** When prescribing medications that a Member gets through a pharmacy, Provider will follow Health Plan's Drug Formulary/Prescription Drug List, and prior authorization and prescription policies. Provider acknowledges the authority of pharmacies to substitute generics or low-cost alternative prescriptions for the prescribed medication.
7. **Provider-Member Communication.** Health Plan encourages open Provider-Member communication regarding Medical Necessity, appropriate treatment, and care. Health Plan will not prohibit or restrict Provider from advising a Member about his or her health status, medical care or treatment, regardless of whether benefits for such care are provided under the Government Contract, if the Provider is acting within the lawful scope of practice.
8. **Member Eligibility Verification.** Provider will verify eligibility of Members before providing services unless the situation involves the provision of Emergency Services.
9. **Availability and Hours of Service.** Provider will ensure Emergency Services and Covered Services related to inpatient hospitalizations are available twenty-four (24) hours a day, seven (7) days a week. Provider will make necessary and appropriate arrangements to ensure the availability of non-emergent Covered Services during Provider’s normal business hours, unless otherwise required by Laws or Government Program Requirements.
10. **Hospital Admission.** Provider will immediately notify Health Plan of a Member hospital admission, including any inpatient admission, and when a Member is seen in the emergency department.
11. **Notification.** Provider will notify Health Plan within five (5) business days should any disciplinary or other action of any kind be implemented against a Participating Provider or health care professional which results in any suspension, reduction, or modification of hospital privileges. Provider’s notification to Health Plan will state actions taken by Provider.
12. **Staffing Privileges.** Provider agrees to use its best efforts to arrange staff privileges or other appropriate access for Participating Providers, Health Plan’s case management staff, and hospitalist providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standard of practice and credentialing standards established by Provider’s medical staff and the bylaws, rules, and regulations of Provider.
13. **Rights of Members.** Provider will observe, protect, and promote the rights of Members.
14. **Use of Name and Marketing.** Neither Provider nor Health Plan will use the other Party’s name, including, but not limited to, trademarks, service marks, or logos, in advertisements or promotional materials without prior written approval. However, Provider may refer to Health Plan in Provider’s listings of participating health plans. Additionally, Health Plan may use Provider’s name and related information in: (i) publications to identify Provider as a Participating Provider; and (ii) as may be required to comply with the Laws and Government Program Requirements.
15. **Non-Discrimination.** Provider will not differentiate or discriminate against individuals based on their status as protected veterans or because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care services. Provider will provide Covered Services in the same location, in the same manner, in accordance with the same standards, and within the same time or availability, regardless of payer.
16. **Recordkeeping.**
17. **Maintaining Member Record.** Provider will maintain a medical and billing record (“Record”) for each Member to whom Provider provides health care services. The Member’s Record will contain all information required by Laws, generally accepted and prevailing professional practices, applicable Government Program Requirements, and Health Plan’s policies and procedures. Provider will retain such Record for as long as required by Laws and Government Program Requirements. This section will survive any termination.
18. **Confidentiality of Member Record.** Provider will comply with all Laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the Health Information Technology for Economic and Clinical Health (“HITECH”) Act, Health Plan’s policies and procedures, and Government Program Requirements regarding privacy and confidentiality. Provider will not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or Record without obtaining appropriate authorization. This section does not affect or limit Provider’s obligation to make available the Record, Encounter Data, and information concerning Member care to Health Plan, a governmental agency, or another provider of health care. This section will survive any termination.
19. **Delivery of Member Information.** Provider will promptly deliver to Health Plan, upon request or as may be required by Laws, Health Plan’s policies and procedures, Government Program Requirements, or third-party payers, any information, statistical data, Encounter Data, or Record pertaining to a Member. Provider is responsible for the fees associated with producing the above items. Provider will further give direct access to the items as requested by Health Plan or as required by a governmental agency. Health Plan has the right to withhold compensation from Provider if Provider fails or refuses to give the items to Health Plan promptly. This section will survive any termination.
20. **Member Access to Member Record.** Provider will give Members access to Members’ Record and other applicable information, in accordance with Laws, Government Program Requirements, and Health Plan’s policies and procedures. This section will survive any termination.
21. **Program Participation.**
22. **Participation in Appeals and Grievance Program.** Provider will participate in and comply with Health Plan’s Appeals and Grievance Program. Provider’s failure to exhaust Health Plan’s Appeals and Grievance Programs will bar Provider from obtaining other remedies available under this Agreement.
23. **Participation in Quality Improvement Program.** Provider will participate in and comply with Health Plan’s QI Program and will cooperate in conducting peer reviews and audits of care provided by Provider.
24. **Participation in Utilization Review and Management Program.** Provider will participate in and comply with Health Plan’s UM Program. Provider will cooperate with Health Plan in audits to identify, confirm, and assess utilization levels of Covered Services.
25. **Participation in Credentialing.** Provider will participate in and comply with Health Plan’s credentialing and re-credentialing program established by Health Plan in accordance with Laws and Government Program Requirements. Provider must be credentialed by Health Plan or Health Plan’s designee, and as provided in applicable Law and Government Program Requirements, before providing Covered Services and must remain credentialed throughout the term of the Agreement to continue to be eligible to provide Covered Services. Provider will promptly notify Health Plan in writing of any change in the information submitted or relied upon by Provider to achieve or maintain credentialed status.
26. **Health Education/Training.** Provider will participate in and comply with Health Plan’s provider education and training efforts, which includes the Cultural Competency Plan and such standards, policies, and procedures as may be necessary for Health Plan to comply with Laws and Government Program Requirements.
27. **Provider Manual.** Provider will comply with the Provider Manual, which is incorporated by reference into this Agreement and may be unilaterally amended from time to time by Health Plan. Provider acknowledges the Provider Manual is available to Provider at Health Plan’s website. A physical copy of the Provider Manual is available upon request.
28. **Supplemental Materials.** Health Plan may periodically issue bulletins or other written materials in order to supplement the Provider Manual or to give additional instruction, guidance, or information (“Supplemental Materials”). Health Plan may issue Supplemental Materials in an electronic format, which includes, but is not limited to, posting on Health Plan’s interactive web-portal, and a physical copy is available upon request. Supplemental Materials become binding upon Provider as of the effective date indicated on the Supplemental Materials or, if applicable, the effective date will be determined in accordance with this Agreement.
29. **Health Plan’s Electronic Processes and Initiatives.** Provider will participate in and comply with Health Plan’s electronic processes and initiatives, including, but not limited to, electronic submission of prior authorization, access to electronic medical records, electronic claims filing, electronic data interchange (“EDI”), electronic remittance advice, electronic fund transfers, and registration and use of Health Plan’s interactive web-portal. As applicable to the Product, Provider will participate in and comply with the Kentucky Health Information Exchange (“KHIE”), which will include, but not be limited to, submitting data to KHIE, in accordance with Laws and Government Program Requirements.
30. **Information Reporting and Changes.** Provider will deliver to Health Plan a complete and accurate list of its business/practice/facility locations and, as applicable, a list of the Individual Providers that it uses to provide Covered Services every thirty (30) days, together with specific information required for administration. The information includes, but is not limited to, the information required by Health Plan to produce provider directories. If Provider does not deliver such information, Health Plan will use the last information received from Provider. Notwithstanding the above, if a Law or Government Program Requirement requires the delivery of information described in this section in another manner or different timeframe, Provider will notify Health Plan in accordance with the Law or Government Program Requirement. Health Plan also reserves the right to request such information at any time.
31. **Standing.**
32. **Requirements.** Provider represents it has the appropriate approvals, including, but not limited to, applicable licenses, certifications, registrations, and permits to provide Covered Services in accordance with Laws and Government Program Requirements. Provider will deliver evidence of any approvals to Health Plan upon request. Provider will maintain such approvals in good standing, free of disciplinary action, and in unrestricted status. Provider will promptly notify Health Plan of changes in its status, including, but not limited to, disciplinary action taken or proposed by any agency responsible for oversight of Provider.
33. **Unrestricted Status.** Provider represents to its best knowledge, information, and belief, neither it, nor any of its employees, temporary employees, volunteers, consultants, members of its board of directors, officers, or contractors (collectively, “Personnel”) have been excluded from participation in the Medicare Program, any state, commonwealth, or the District of Columbia’s Medicaid Program, or any other federal health care program (collectively “Federal Health Care Program”). Provider agrees that it must check the Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities, the System for Award Management, any other list maintained by a state, commonwealth, or federal government, and every state, commonwealth, and the District of Columbia’s Medicaid exclusion lists to determine whether Provider or any of its Personnel have been excluded from participation in any Federal Health Care Program. These databases must be checked for any new Personnel and thereafter not less than monthly. Provider will notify Health Plan immediately in writing if Provider determines that Provider or any of its Personnel are suspended or excluded from any Federal Health Care Program. Provider agrees that it is subject to 2 CFR Part 376 and will require its Personnel to agree that they are subject to 2 CFR Part 376. If a governmental agency imposes a penalty, sanction, or other monetary adjustment or withhold due to Provider’s non-compliance with this provision or any payments were made to Provider while under non-compliance with this provision, Health Plan may collect the amount: (i) by offsetting from amounts due to Provider; or (ii) Health Plan may issue a recoupment letter and Provider agrees it will remit funds pursuant to the terms of the recoupment letter. If required, such offset or recoupment will be done in a manner that is compliant with Laws and Government Program Requirements. This section will survive any termination.
34. **Legal Actions.** Provider will give prompt written notice to Health Plan of: (i) a legal claim asserted against it by a Member and of the judgment, settlement, or compromise of the claim; (ii) a criminal investigation or proceeding against Provider; (iii) a conviction for crimes involving moral turpitude or felonies; and (iv) a civil claim that may jeopardize Provider’s financial soundness. This section will survive any termination.
35. **Liability Insurance.** Provider will maintain general and professional liability insurance in coverage amounts appropriate for the size and nature of Provider’s facility and health care activities, and in compliance with Laws and Government Program Requirements. If the coverage is claims made or reporting, Provider agrees to purchase similar “tail” coverage upon termination of the Provider’s present or subsequent policy. Provider will deliver copies of such insurance policy to Health Plan within five (5) business days of a written request by Health Plan. Provider will deliver advance written notice fifteen (15) business days before any change, reduction, cancellation, or termination of such insurance coverage. This section will survive any termination.
36. **Non-Solicitation of Members.** Provider will not solicit or encourage Members to select another health plan.
37. **Laws and Government Program Requirements.**
38. **Compliance with Laws and Government Program Requirements.** Provider will comply with Laws that are applicable to this Agreement. Provider acknowledges Health Plan entered into Government Contracts and Provider will comply with the applicable Government Program Requirements that must be satisfied under this Agreement. Upon written request, Health Plan will give Provider a redacted copy of applicable Government Contracts.
39. **Fraud and Abuse Reporting.** Provider will comply with Laws and Government Program Requirements related to fraud, waste, and abuse. Provider will establish and maintain policies and procedures for identifying and investigating fraud, waste, and abuse. In the event Provider discovers an occurrence of fraud, waste, or abuse, Provider will promptly notify Health Plan. Provider will participate in investigations conducted by Health Plan or by a governmental agency. This section will survive any termination.
40. **Advance Directive.** Provider will comply with Laws and Government Program Requirements related to Advance Directives.
41. **Ownership Disclosure Information.** If applicable, Provider must disclose to Health Plan the name and address of each person, entity, or business with an ownership or control interest in the disclosing entity before the Effective Date and throughout the term of this Agreement. Provider or disclosing entity must also disclose to Health Plan whether any person, entity, or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling before the Effective Date and throughout the term of this Agreement. Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the Provider or disclosing entity also has an ownership or control interest.
42. **Reciprocity Agreements.** Provider will cooperate with Affiliates and agrees to ensure reciprocity of health care services to Affiliate’s enrollees. For Affiliate enrollees, Provider will be compensated for Clean Claims that are determined to be payable in accordance with Laws and Government Program Requirements. If there is not a Law or Government Program Requirement governing reimbursement, Provider will be compensated at the rates set forth in this Agreement. Provider will follow the hold harmless provisions of this Agreement for Affiliate’s enrollees.

**ARTICLE THREE – HEALTH PLAN’S OBLIGATIONS**

1. **Member Eligibility Determination.** Health Plan will maintain data on Member eligibility and enrollment. Health Plan will promptly verify Member eligibility at the request of Provider.
2. **Prior Authorization Review.** Health Plan will respond with a determination on a prior authorization request in accordance with the time frames governed by Laws and Government Program Requirements after receiving all necessary information from Provider.
3. **Medical Necessity Determination.** Health Plan’s determination with regard to Medical Necessity, including, but not limited to, determinations of level of care and length of stay, will govern, subject to applicable Law and Government Program Requirements. The primary concern with respect to Medical Necessity determinations is the interest of the Member.
4. **Member Services.** Health Plan will provide services to Members, including, but not limited to, assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of Health Plan’s policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing Members with access to Health Plan’s Provider Directory.
5. **Provider Services.** Health Plan will make available a provider services department that, among other Health Plan duties, is available to assist Provider with questions about this Agreement.
6. **Corrective Action.** Health Plan and governmental agencies routinely monitor the level, manner, and quality of Covered Services provided as well as Provider’s compliance with this Agreement. If a deficiency is identified, Health Plan or an agency, in its sole discretion, may choose to issue a corrective action plan. Provider is required to accept and implement such corrective action plan. Provider is not entitled to a corrective action plan prior to any termination.

**ARTICLE FOUR - CLAIMS PAYMENT**

1. **Claims.** Provider will promptly submit to Health Plan Claims for Covered Services in a standard form that is acceptable to Health Plan. Provider is not eligible for payment on Claims submitted after one hundred and eighty (180) days from the Date of Service, unless Health Plan is required to follow a different timeframe pursuant to a Law or Government Program Requirement. When Health Plan is the secondary payer, Provider is not eligible for payment for Claims submitted after ninety (90) days from the date the primary payer adjudicated the Claim, unless Health Plan is required to follow a different timeframe pursuant to a Law or Government Program Requirement. Provider will include all medical records pertaining to the Claim if requested by Health Plan and as may be required by Health Plan’s policies and procedures.
2. **Compensation.** Health Plan will pay Provider for Clean Claims for Covered Services, that are determined to be payable, in accordance with Laws, Government Program Requirements, and this Agreement. Health Plan will make such payment within sixty (60) days, unless otherwise required by Laws or Government Program Requirements. Provider agrees to accept such payments, applicable co-payments, co-insurances, deductibles, and coordination of benefits collections as payment in full for Covered Services. Provider’s failure to comply with the terms of this Agreement may result in non-payment to Provider.
3. **Co-payments and Deductibles.** Provider is responsible for collection of co-payments, co-insurances, and deductibles, if any.
4. **Member Hold Harmless.** Provider agrees in no event, including, but not limited to, non-payment, insolvency, or breach of this Agreement by Health Plan, will Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member or person acting on Member’s behalf, for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-payments, co-insurances, or deductibles as specifically provided in the Member’s evidence of coverage or fees for non-Covered Services. This section will survive any termination, regardless of the reason for the termination, including insolvency of Health Plan.
5. **Coordination of Benefits.** Health Plan is a secondary payer where another payer is primary payer. Provider will make reasonable inquiry of Members to learn if Member has health insurance or health benefits other than from Health Plan or is entitled to payment by a third party under any other insurance or plan of any type. Provider will promptly notify Health Plan of said entitlement. In the event a coordination of benefits occurs, Provider will be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers, and payers, not to exceed the amount specified in the Compensation Schedule of this Agreement.
6. **Offset.** In the event of an Overpayment, Health Plan may collect the amount: (i) by offsetting from amounts due Provider; or (ii) Health Plan may issue a recoupment letter and Provider will remit funds pursuant to the terms of the recoupment letter. If required, the offset or recoupment will be done in a manner that is compliant with Laws and Government Program Requirements. As a material condition to Health Plan’s obligations under this Agreement, Provider agrees the offset and recoupment rights set forth in this Agreement will be deemed to be and to constitute rights of offset and recoupment authorized under Law or in equity to the maximum extent legally permissible. Such rights will not be subject to any requirement of prior or other approval from a court or other governmental agency that may now or hereafter have jurisdiction over Health Plan or Provider. This section will survive any termination.
7. **Claim Review.** Claims will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, Uniform Billing (“UB”) manual and editor, Current Procedural Terminology (“CPT”) and Healthcare Common Procedure Coding System (“HCPCS”), federal and state/commonwealth billing and payment rules, National Correct Coding Initiatives (“NCCI”) Edits, and Federal Drug Administration (“FDA”) definitions and determinations of designated implantable devices and implantable orthopedic devices. Furthermore, Provider acknowledges Health Plan’s right to conduct Medical Necessity reviews and apply clinical practice standards to determine appropriate payment. Payment may exclude certain items not billed in accordance with industry standard billing and payment rules or that do not meet Medical Necessity criteria. This section will survive any termination.
8. **Claim Auditing.** Provider acknowledges Health Plan’s right to conduct post-payment billing audits. Provider will cooperate with Health Plan’s audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Provider’s charging policies, and other related data. Health Plan will use established industry claims adjudication, and clinical practices, federal and state/commonwealth guidelines, and Health Plan’s policies and data to determine the appropriateness of the billing, coding, and payment. This section will survive any termination.
9. **Financially Responsible Entity Payments.** If Provider provides Covered Services that are the responsibility of a Responsible Entity, Provider will look solely to the Responsible Entity for payment of such Covered Services. Pursuant to Health Plan’s contract with Responsible Entity, Responsible Entity is to compensate Provider at the rate set forth in Provider’s contract with Responsible Entity. If Responsible Entity and Provider do not have a contract or have not agreed to compensation terms, Provider will be reimbursed, as determined by Provider and Responsible Entity, at: (i) one hundred percent (100%) of the governing rates provided by Law specific to the Member’s Product in place on the Date of Service; or (ii) at the rates set forth in this Agreement specific to the Member’s Product in place on the Date of Service. Except as specifically stated in this section, Provider agrees that the compensation provisions of this Agreement will be binding upon Provider and that Provider will follow the hold harmless provisions of this Agreement.
10. **Timely Submission of Encounter Data.** Provider understands Health Plan may have certain contractual reporting obligations that require timely submission of Encounter Data. If a Clean Claim does not contain the necessary Encounter Data, Provider will submit Encounter Data to Health Plan. This section will survive any termination.

**ARTICLE FIVE – TERM AND TERMINATION**

1. **Term.** This Agreement will commence on the Effective Date indicated by Health Plan and will continue in effect until terminated by either Party in accordance with the provisions of this Agreement.
2. **Termination without Cause.** This Agreement, an individual Product, or an Individual Provider under this Agreement may be terminated without cause at any time by either Party by giving at least ninety (90) days prior written notice to the other Party, if permitted by Laws and Government Program Requirements.
3. **Termination with Cause.** In the event of a breach of a material provision of this Agreement, the Party claiming the breach will give the other Party written notice of termination setting forth the facts underlying its claim that the other Party breached this Agreement. The Party receiving the notice of termination will have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other Party. During this thirty (30) day period, the Parties agree to meet as reasonably necessary and to confer in an attempt to resolve the claimed breach. If the Party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the Party who delivered the notice of termination has the right to immediately terminate this Agreement, or an individual Product or an Individual Provider under this Agreement, upon expiration of the thirty (30) day period. Notwithstanding the forgoing, either Party may immediately terminate this Agreement, an individual Product, or an Individual Provider under this Agreement, without providing the other Party the opportunity to cure a material breach should the terminating Party reasonably believe the material breach of this Agreement to be non-curable.
4. **Immediate Termination.** Notwithstanding any other provision of this Agreement, this Agreement, an individual Product, or an Individual Provider under this Agreement, may immediately be terminated upon written notice to the other Party in the event any of the following occurs:
5. Provider’s license or any other approval needed to provide Covered Services is limited, suspended, or revoked or a disciplinary proceeding is commenced against Provider by a governmental or accrediting agency;
6. Either Party fails to maintain adequate levels of insurance;
7. Provider has not or is unable to comply with Health Plan’s credentialing requirements, including, but not limited to, having or maintaining credentialing status;
8. Either Party becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider or Health Plan is appointed by appropriate authority;
9. If Provider is capitated or participating in another risk-sharing compensation methodology and Health Plan determines Provider is financially incapable of bearing capitation or other applicable risk-sharing compensation methodology;
10. Health Plan reasonably determines that Provider’s facility or equipment is insufficient to provide Covered Services;
11. Either Party is excluded from participation in state, commonwealth, or federal health care programs;
12. Provider is terminated as a provider by any state, commonwealth, or federal health care program;
13. Either Party engages in fraud or deception, or permits fraud or deception by another in connection with each Party’s obligations under this Agreement;
14. Health Plan reasonably determines that Covered Services are not being properly provided, or arranged for by Provider, and such failure poses a threat to Members’ health and safety;
15. Provider violates any Law;
16. Provider fails to satisfy the terms of a corrective action plan; or
17. Termination is required by a governmental agency.
18. **Notice to Members.** In the event of any termination, Health Plan will give reasonable advance notice to Members who are currently receiving care in accordance with Laws and Government Program Requirements.
19. **Transfer Upon Termination.** In the event of any termination, Health Plan may transfer Members to another provider.

**ARTICLE SIX – GENERAL PROVISIONS**

1. **Indemnification.** Each Party will indemnify and hold harmless the other Party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys’ fees, which result from the duties and obligations of the indemnifying Party or its officers, directors, shareholders, employees, agents, and representatives under this Agreement. This section will survive any termination.
2. **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor will it be construed to create, any relationship between the Parties other than that of independent parties contracting with each other solely for the purpose of effectuating this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the Parties. Nothing herein contained will prevent the Parties from entering into similar arrangements with other parties. Each Party will maintain separate and independent management and will be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor will it be construed to create, any right in any third party to enforce this Agreement.
3. **Governing Law.** The laws of the Commonwealth of Kentucky will govern this Agreement to the extent such laws are not deemed preempted by federal laws.
4. **Entire Agreement.** This Agreement, including attachments, addenda, amendments, Supplemental Materials, and incorporated documents or materials, contains the entire agreement between the Parties relating to the rights granted and obligations imposed by this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, between the Parties and relating to the subject matter of this Agreement, are of no force or effect.
5. **Severability.** If a term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.
6. **Headings and Construction.** The headings in this Agreement are for reference purposes only and are not considered a part of this Agreement in construing or interpreting its provisions. It is the Parties’ desire that if a provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is construed against its drafter will not apply to the interpretation of the ambiguous provision. The following rules of construction apply to this Agreement: (i) the word “day” means calendar day unless otherwise specified; (ii) the term “business day” means Monday through Friday, except federal holidays; (iii) all words used in this Agreement will be construed to be of such gender or number as circumstances require; (iv) references to specific statutes, regulations, rules or forms, such as CMS-1500, include subsequent amendments or successors to them; and (v) references to any government department or agency include any successor departments or agencies.
7. **Non-exclusivity.** This Agreement will not be construed to be an exclusive Agreement between the Parties. Nor will it be deemed to be an Agreement requiring Health Plan to refer Members to Provider.
8. **Amendments.**
9. **Regulatory Amendments.** Health Plan may immediately amend this Agreement to maintain consistency or compliance with applicable policy, directive, Law, or Government Program Requirement at any time and without Provider’s consent. Such regulatory amendment will be binding upon Provider.
10. **Non-Regulatory Amendments.** Notwithstanding the Regulatory Amendments section, Health Plan may otherwise amend this Agreement upon thirty (30) days prior written notice to Provider. If Provider does not deliver a written disapproval to such amendment within the thirty (30) day period, the amendment will be deemed accepted by and binding upon Provider. If Health Plan receives a written disapproval within the thirty (30) day period, the Parties agree to meet and confer in good faith to determine if a revised amendment can be accepted by and binding upon the Parties.
11. **Delegation or Subcontract.** Upon the Effective Date, Provider will submit to Health Plan a list identifying each of Provider’s Subcontractors and a description of the services the Subcontractor provides. After the Effective Date, Provider will not subcontract with a Subcontractor without the prior written consent of Health Plan. Such arrangement with a Subcontractor will be in writing and will bind Subcontractor to the terms required by Health Plan.
12. **Assignment.** Provider may not assign or transfer, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Parties and respective successors in interest and assignees. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment.
13. **Dispute Resolution.**
14. **Meet and Confer.** Any claim or controversy arising out of or in connection with this Agreement will first be resolved, to the extent possible, via “Meet and Confer”. The Meet and Confer will begin when one Party delivers written notice to the other that it intends to arbitrate a dispute and the basis for its belief that it will prevail in arbitration. After providing notice of the intent to arbitrate, the Meet and Confer will be held as an informal face-to-face meeting held in good faith between appropriate representatives of the Parties and at least one (1) person authorized to settle outstanding claims and pending arbitration matters. The Parties will commence the face-to-face portion of the Meet and Confer within forty-five (45) days of receiving notice of an intent to arbitrate or service of an arbitration demand. Such face-to-face Meet and Confer discussion will occur at a time and location agreed to by the Parties (within the forty-five (45) days) and if both Parties agree that more face-to-face discussions would be beneficial, the Parties can agree to have more than one (1) in person settlement discussion or a combination of in person, phone meetings and exchange of correspondence.
15. **Binding Arbitration.** The Parties agree that any dispute not resolved via Meet and Confer will be settled in binding arbitration administered by Judicial Arbitration and Mediation Services (“JAMS”), or if mutually agreed upon, pursuant to another agreed upon Alternative Dispute Resolution (“ADR”) provider in accordance with that ADR provider’s Commercial Arbitration Rules, in Louisville, Kentucky. However, matters that primarily involve Provider's professional competence or conduct i.e., malpractice, professional negligence, or wrongful death will not be eligible for arbitration.

Any arbitration in which the total amount disputed by one Party is equal to or exceeds one million dollars ($1,000,000.00) will be resolved by a panel of three (3) arbitrators. In the event a panel of three (3) arbitrators will be used, the claimant will select one (1) arbitrator; the respondent will select one (1) arbitrator; and the two (2) arbitrators selected by the claimant and respondent will select the third arbitrator whose determination will be final and binding on the Parties. If possible, each arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care.

Any arbitration in which the total amount disputed by one Party is equal to or exceeds five hundred thousand dollars ($500,000.00), but less than one million dollars ($1,000,000.00), the claimant and respondent will each select a single arbitrator and the two (2) arbitrators selected by the claimant and respondent will select a single arbitrator who will be responsible for the arbitration proceedings (“Selected Arbitrator”). Each Party can strike no more than one (1) Selected Arbitrator. The Selected Arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care.

Any arbitration in which the total amount disputed by one Party is less than five hundred thousand dollars ($500,000.00) will be resolved by a single arbitrator. In the event a single arbitrator is used, the arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care.

Civil discovery for use in such arbitration may be conducted in accordance with federal rules of civil procedure and federal evidence code, except where the Parties agree otherwise. The arbitrator selected will have the power to enforce the rights, remedies, duties, liabilities, and obligations of discovery by the imposition of the same terms, conditions, and penalties as can be imposed in like circumstances in a civil action by a court in the same jurisdiction. The provisions of federal rules of civil procedure concerning the right to discovery and the use of depositions in arbitration are incorporated herein by reference and made applicable to this Agreement. However, in any arbitration in which the total amount disputed by one Party is less than one million dollars ($1,000,000.00) the Parties agree that each Party will have the right to take no more than three (3) depositions of individuals or entities, excluding deposition of expert witnesses, and the Parties agree to exchange copies of all exhibits and demonstrative evidence to be used at the arbitration prior to the arbitration as deemed appropriate by the arbitrator. The Parties agree that in any arbitration in which the total amount disputed by one Party is less than five hundred thousand dollars ($500,000.00) each Party will have the right to take no more than one (1) deposition of individuals or entities and one (1) expert witness, and the Parties agree to exchange copies of all exhibits and demonstrative evidence to be used at the arbitration prior to the arbitration as deemed appropriate by the arbitrator. Regardless of the amount in dispute, rebuttal and impeachment evidence need not be exchanged until presented at the arbitration hearing.

The arbitrator will have no authority to give a remedy or award damages that would not be available to such prevailing Party in a court of law, nor will the arbitrator have the authority to award punitive or liquidated damages. The arbitrator will deliver a written reasoned decision within thirty (30) days of the close of arbitration, unless an alternate agreement is made during the arbitration. The Parties agree to accept any decision by the arbitrator, which is grounded in applicable law, as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction. The award may be reviewed, vacated, or modified pursuant to the Federal Arbitration Act (“FAA”), 9 USC sections 9-11. Grounds for vacating an award, include where the award was procured by corruption, fraud, or undue means, and where the arbitrators were guilty of misconduct, exceeded their powers, evident material miscalculation, evident material mistake, imperfect(ions) in (a) matter of form not affecting the merits, and where a decision is not grounded in applicable law. When a decision is not grounded in applicable law, any Party will have the right to appeal the decision in addition to those rights to vacate or appeal already existing pursuant to the FAA or applicable state or commonwealth arbitration laws. Any such appeal may be made to a court having jurisdiction over the Parties or the dispute. Notice of intent to Appeal based on failure to render a decision grounded in law must be given to the other Party within fifteen (15) days after the decision is communicated to the Parties; and the appeal must be formally initiated by filing in court within thirty (30) days after the decision is communicated to the Parties. If a court decides it will not hear an appeal because it deems appeals from arbitration not subject to appeal, there is no right for any additional appeal in any other venue.

Each Party shall bear its own costs and expenses, including its own attorneys’ fees, and shall bear an equal share of the arbitrator and administrative fees of arbitration. The Parties agree that one or the other may request a court reporter transcribe the entire proceeding, in which case the Parties will split the cost of the court reporter, but each may elect to purchase or forego purchasing a transcript.

Arbitration must be initiated within one (1) year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered with reasonable diligence; otherwise it will be deemed waived. The use of binding arbitration will not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

1. **Notice.**
2. **Delivery.** All notices required or permitted by this Agreement, except for Supplemental Materials, will be in writing and delivered: (i) in person; (ii) by U.S. Postal Service (“USPS”) registered, certified, or express mail with postage prepaid; (iii) by overnight courier that guarantees next day delivery; (iv) by facsimile transmission; or (v) by email. Notice is deemed given: (i) on the date of personal delivery; (ii) on the second day after the postmark date for USPS registered, certified, or express mail with postage prepaid; (iii) on the date of delivery shown by overnight courier; or (iv) on the date of transmission for facsimile or email.
3. **Addresses.** The mailing address, email address, and facsimile number set forth under the Signature Page will be the particular Party’s information for delivery of notice. Each Party may change its information through written notice in compliance with this section without amending this Agreement. Notice will be sent to the attention of the Authorized Representative.
4. **Waiver.** A failure or delay of a Party to exercise or enforce any provision of this Agreement will not be deemed a waiver of any right of that Party. Any waiver must be specific, in writing, and executed by the Parties.
5. **Execution in Counterparts and Duplicates.** This Agreement may be executed in counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. The Parties agree facsimile signatures, pdf signatures, photocopied signatures, electronic signatures, or signatures scanned and sent via email will have the same effect as original signatures.
6. **Conflict with Health Plan Product.** Nothing in this Agreement modifies any benefits, terms, or conditions contained in the Member’s Product. In the event of a conflict between this Agreement and any benefits, terms, or conditions of a Product, the benefits, terms, and conditions contained in the Member’s Product will govern.
7. **Force Majeure.** Neither Party will be liable or deemed to be in default for any delay or failure to perform any duty under this Agreement resulting directly or indirectly, from acts of God, civil or military authority, acts of a public enemy, war, accident, fire, explosion, earthquake, flood, strikes by either Party’s employees, or any other similar cause beyond the reasonable control of such Party if it is determined that such Party: (i) used the efforts a reasonable person would during a force majeure event to perform its duties under this Agreement; and (ii) the Party’s inability to perform its duties during the force majeure event is not due to its failure to take measures to protect itself against the force majeure event.
8. **Confidentiality.** Any information disclosed by either Party in fulfillment of its duties under this Agreement, including, but not limited to, health care information, compensation rates, and the terms of the Agreement, will be kept confidential. Information provided to Provider, including, but not limited to, Member lists, QI Program, certification/credentialing criteria, compensation rates, and any other administrative protocols or procedures of Health Plan, is the proprietary property of Health Plan and will be kept confidential. Provider will not disclose or release such material to a third party without the written consent of Health Plan. This section will survive any termination.
9. **Adjustments.** If a governmental agency imposes a penalty, sanction, or other monetary adjustment or withhold due to Provider’s non-compliance with this Agreement, Health Plan will be able to collect the amount imposed on or withheld from Health Plan. Health Plan may collect the amount: (i) by offsetting from amounts due to Provider; or (ii) Health Plan may issue a recoupment letter and Provider will remit funds pursuant to the terms of the recoupment letter. If required, such offset or recoupment will be done in a manner that is compliant with Laws and Government Program Requirements. This section will survive any termination.
10. **Expenses.** Unless otherwise specifically stated in the Agreement, all costs and expenses incurred in connection with this Agreement will be paid by the Party incurring the cost or expense.

**ATTACHMENT A**

**Products**

Provider’s participation in the Medicaid Product listed below is contingent upon Health Plan executing a Government Contract with the appropriate governmental agency. Provider agrees to participate in the Medicaid Product on the date it becomes operational for Health Plan under its Government Contract and Provider shall be bound to the terms of this Agreement. For all other Products, Provider’s participation in each Product listed below is contingent upon the Product being offered by the appropriate governmental agency and upon Health Plan executing a Government Contract with the appropriate governmental agency. Subject to applicable Laws and Government Program Requirements, Provider agrees to participate in each Product on the date it becomes operational for Health Plan under its Government Contract and Provider shall be bound to the terms of this Agreement.

1. **Medicaid** – including, any Medicaid or CHIP programs identified in the Kentucky Medicaid Managed Care Government Contract between the Commonwealth of Kentucky and Health Plan.
2. **Medicare Advantage** – including, but not limited to, Molina Medicare Options, Molina Medicare Options Plus and any other Medicare Advantage programs Health Plan offers in the future.
3. **Medicare-Medicaid Program**
4. **Health Insurance Marketplace** – including, but not limited to, Molina Marketplace.

**Attachment B**

**Compensation Schedule**

1. **Compensation for Medicaid.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the Medicaid Product, that are determined by Health Plan to be payable pursuant to Laws, Government Program Requirements, and this Agreement 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 the lesser of the following amounts in effect for the Date of Service: (i) Provider’s billed charges; or (ii) an amount equivalent to the Medicaid Fee-For-Service Program allowable payment rate as set forth by the Commonwealth of Kentucky. If there is a code in the Commonwealth of Kentucky Program fee schedule for the Date of Service, but there is no payment rate, Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided, that are determined by Health Plan to be payable pursuant to Laws, Government Program Requirements, and this Agreement 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 the lesser of the following amounts in effect for the Date of Service: (i) Provider’s billed charges; or (ii) at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate (adjusted for locality or geography).

Unless prohibited by Law, Provider agrees that Health Plan will implement updates or revisions to the Medicaid or Medicare Fee-for-Service Program fee schedules on a prospective basis within sixty (60) days of the update or revision from the agency. The update or revision will be applied upon implementation to all Claims received after the implementation.

1. **Compensation for Medicare Advantage.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the Medicare Advantage Product, that are determined by Health Plan to be payable pursuant to Laws, Government Program Requirements, and this Agreement 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 the lesser of the following amounts in effect for the Date of Service: (i) Provider’s billed charges; or (ii) at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate (adjusted for locality or geography).

Unless prohibited by Law, Provider agrees that Health Plan will implement updates or revisions to the Medicare Fee-for-Service Program fee schedules on a prospective basis within sixty (60) days of the update or revision from the agency. The update or revision will be applied upon implementation to all Claims received after the implementation.

1. **Compensation for Medicare-Medicaid Program.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the Medicare-Medicaid Program Product, that are determined by Health Plan to be payable pursuant to Laws, Government Program Requirements, and this Agreement 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 the lesser of the following amounts in effect for the Date of Service: (i) Provider's billed charges; or (ii) pursuant to the methodology described below.

Provider will receive an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate (adjusted for locality or geography) and any portion, if any, that the Medicaid agency or Medicaid managed care plan would have been responsible for paying if the Member was enrolled in the Medicare Fee-For-Service Program. The Medicare Fee-For-Service Program allowable payment rate deducts any cost sharing amounts, including, but not limited to, co-payments, deductibles, co-insurances, or amounts 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 Provider bills for Covered Services covered by Medicaid or that are primary to Medicaid, Provider will receive an amount equivalent to the Medicaid Fee-For-Service Program allowable payment rate as set forth by the Commonwealth of Kentucky.

Unless prohibited by Law, Provider agrees that Health Plan will implement updates or revisions to the Medicaid or Medicare Fee-for-Service Program fee schedules on a prospective basis within sixty (60) days of the update or revision from the agency. The update or revision will be applied upon implementation to all Claims received after the implementation.

1. **Compensation for Health Insurance Marketplace.**
2. **Inpatient and Outpatient Covered Services.** Except for other facility Covered Services in Section 1.4 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 Health Insurance 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.
3. **Inpatient Covered Services.** For inpatient Covered Services, at one hundred percent (100%) 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) | $X,XXX |
| Vaginal Delivery Additional Days | MS-DRG 768, 796-798, 805-807 | Per Diem  (3+ Days) | $X,XXX |
| C-Section Delivery | MS-DRG 783-788 | Case Rate  (1-3 Days) | $X,XXX |
| C-Section Delivery Additional Days | MS-DRG 783-788 | Per Diem  (4+ Days) | $X,XXX |
| NICU Level 2 | Revenue Code 172 | Per Diem | $X,XXX |
| NICU Level 3 | Revenue Code 173 | Per Diem | $X,XXX |
| NICU Level 4 | Revenue Code 174 | Per Diem | $X,XXX |
| Normal Newborn/Boarder Baby, NICU Level 1 | Revenue Code 170, 171, 179 or MS-DRG 795 | Per Diem | $X,XXX |

1. **Outpatient Covered Services.** For outpatient Covered Services, at one hundred percent (100%) 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 | $X,XXX |

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 1.4 a. i. or ii. of this Attachment, Provider will be compensated at thirty percent (30%) of Provider’s billed charges.
3. **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 Health Insurance 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.
4. **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 one hundred percent (100%) 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.
5. **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 one hundred percent (100%) of the 2021 Medicare allowable payment rate for the applicable facility type.
6. **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 | $XX |
| SNF - Level II | Type of Bill: 211-214 or 181-184  Revenue Code: 0192 | Per diem | $XX |
| SNF - Level III | Type of Bill: 211-214 or 181-184  Revenue Code: 0193 | Per diem | $XX |
| SNF - Level IV | Type of Bill: 211-214 or 181-184  Revenue Code: 0194 | Per diem | $XX |
| SNF – Level V | Type of Bill: 211-214 or 181-184  Revenue Code: 0199 | Per diem | $XX |

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 | $XX |
| Intermittent Peritoneal Dialysis (IPD) | Revenue Code: 0831  CPT Code: 90999 | Per treatment | $XX |
| Ultrafiltration | Revenue Code: 0881  CPT Code: 90999 | Per treatment | $XX |
| Continuous Ambulatory Peritoneal Dialysis (CAPD) | Revenue Code: 0841  CPT Code: 90945 | Per treatment | $XX |
| Continuous Cycling Peritoneal Dialysis (CCPD) | Revenue Code: 0851  CPT Code: 90945 | Per treatment | $XX |
| CAPD Training Treatment | Revenue Code: 0841  CPT Code: 90993 | Per treatment | $XX |
| CCPD Training Treatment | Revenue Code: 0851  CPT Code: 90993 | Per treatment | $XX |
| Home Hemodialysis Training | Revenue Code: 0821  CPT Code: 90993 | Per treatment | $XX |

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 Health Insurance 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.
2. **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 | $XX |
| Medical Social Services | Revenue Code: 056X | Per visit | $XX |
| Home Health Aide | Revenue Code: 057X | Per visit | $XX |
| Physical Therapy | Revenue Code: 042X | Per visit | $XX |
| Occupational Therapy | Revenue Code: 043X | Per visit | $XX |
| Speech-Language Pathology | Revenue Code: 044X | Per visit | $XX |

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 | $XX |
| Continuous Home Hospice Care | Revenue Code: 0652 | Per hour | $XX |
| Inpatient Respite Care | Revenue Code: 0655 | Per diem | $XX |
| General Inpatient Care (Non-Respite) | Revenue Code: 0656 | Per diem | $XX |

1. **Professional and Other Covered Services.** For professional and other Covered Services which are not otherwise reimbursed pursuant to Section 1.4 of this attachment, Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the Health Insurance 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.
2. **Professional and Other Covered Services Except Drugs and Immunizations.** For professional and other Covered Services, at one hundred percent (100%) 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.
3. **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 one hundred percent (100%) 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.
4. **Modifications of Molina Fee Schedule.**
5. **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 ninety (90) days’ prior written notice of any material modification.
6. **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.

**ATTACHMENT B-1**

**Charge Description Master Limit Protection**

This attachment sets forth the Charge Description Master Limit Protection for the Health Insurance Marketplace Product. 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. Health Plan and Provider hereby 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**:
5. Compensation adjustment calculations for first twelve (12) months following the Effective Date:
6. Provider’s CDM Increase: 9%
7. Compensation Payment Rate: 30% of Provider’s CDM
8. Compensation Adjustment Calculation = 0.30 / 1.09 = 27.52% of Provider’s CDM
9. Compensation adjustment calculations for each twelve (12) month period following the first anniversary after the Effective Date:
10. Provider’s CDM Increase: 9%
11. CDM Limit: 3%
12. Compensation Payment Rate: 30% of Provider’s CDM
13. Compensation Adjustment Calculation = 1.03 / 1.09 x 0.30 = 28.35% of Provider’s CDM.

**ATTACHMENT C**

**Commonwealth of Kentucky Required Provisions**

**Commonwealth Laws**

This attachment sets forth applicable Commonwealth Laws or other provisions necessary to reflect compliance with Commonwealth Laws. This attachment will be automatically modified to conform to subsequent changes to Law. 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. Any purported modification or any provision in this attachment that is inconsistent with Law will not be effective and will be interpreted in a manner that is consistent with the applicable Law. For the avoidance of doubt, this attachment does not apply to the Medicare Advantage Product or the Medicare-Medicaid Product to the extent such Products are preempted by Federal Law.

1. **Definitions**
2. **Clean Claim** means “a properly completed billing instrument, paper or Electronic, including the required Health Claim Attachments, submitted in the applicable forms. A clean claim from an institutional provider shall consist of: (i) the UB-92 data set or its successor submitted on the designated paper or Electronic format as adopted by the NUBC; (ii) entries stated as mandatory by the NUBC; and (iii) any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service. A Clean Claim for dentists shall consist of the form and data set approved by the American Dental Association. A Clean Claim for pharmacists shall consist of a universal claim form and data set approved by the National Council on Prescription Drug Programs. A Clean Claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or Electronic format as adopted by the National Uniform Claims Committee.
3. **Electronic or Electronically** means electronic mail, computerized files, communications, or transmittals by way of technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.
4. **Health Claim Attachments** means medical information from a covered person's medical record required by the insurer containing medical information relating to the diagnosis, the treatment, or services rendered to the covered person and as may be required pursuant to Kentucky Revised Statutes 304.17A-720.
5. **Hold Harmless and Continuity of Care.**
6. Provider may not, under any circumstance, including: (i) non-payment of moneys due to the Providers by Health Plan; (ii) insolvency of Health Plan; or (iii) breach of the Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against Member, dependent of Member, or any persons acting on their behalf, for services provided in accordance with the Agreement. This provision shall not prohibit collection of deductible amounts, copayment amounts, coinsurance amounts, and amounts for non-Covered Services.
7. If the Agreement is terminated for any reason, other than a quality of care issue or fraud, the Provider shall continue to provide Covered Services and Health Plan shall continue to reimburse Provider in accordance with the Agreement until Member or the dependent of the Member is discharged from an inpatient facility, or the active course of treatment is completed, whichever time is greater, and in the case of a pregnant woman, services shall continue to be provided through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy at the time the Agreement is terminated.
8. Sections 1.2 a and b will survive any termination of the Agreement.
9. **Payment or Fee Schedules.** Health Plan will, upon request of Provider, make available to Provider, when contracting or renewing an existing contract with Provider, the payment or fee schedules or other information sufficient to enable Provider to determine the manner and amount of payments under the contract for the Provider's services prior to the final execution or renewal of the contract and shall provide any change in such schedules at least ninety (90) days prior to the effective date of the amendment pursuant to KRS 304.17A-577.
10. **Subcontractor.** If Provider enters into any subcontract agreement with another provider to provide their licensed health care services to Members, dependent of the Member, where the subcontracted provider will bill the managed care plan or subscriber or enrollee directly for the subcontracted services, the subcontract agreement must meet all requirements of KRS 304.17A-527 and all such subcontract agreements shall be filed with the commissioner in accordance with this subsection.
11. **Material Change.**
12. For the purposes of this section, capitalized words or phrases will have the meaning set forth below.
13. **Material Change** means a change to a contract, the occurrence and timing of which is not otherwise clearly identified in the contract, that decreases the health care provider's payment or compensation or changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expense, and includes any changes to provider network requirements, or inclusion in any new or modified insurance products.
14. **Real-Time Communication** means any mode of telecommunications in which all users can exchange information instantly or with negligible latency and includes the use of traditional telephone, mobile telephone, teleconferencing, and videoconferencing.
15. If Health Plan makes any Material Change to the Agreement, for any Products that are not preempted by federal Law, Health Plan shall provide Provider with at least ninety (90) days' notice of the Material Change. The notice of a Material Change required under this section shall: (i) provide the proposed effective date of the change; (ii) include a description of the Material Change; (iii) include a statement that the participating provider has the option to either accept or reject the proposed material change in accordance with this section; (iv) provide the name, business address, telephone number, and electronic mail address of a representative of the insurer to discuss the Material Change, if requested by the participating provider; (v) provide notice of the opportunity for a meeting using Real-Time Communication to discuss the proposed changes if requested by the participating provider (If requested by Provider, the opportunity to communicate to discuss the proposed changes may occur via electronic mail instead of Real-Time Communication); and (vi) provide notice that upon three (3) Material Changes in a twelve (12) month period, Provider may request a copy of the contract with Material Changes consolidated into it. Provision of the copy of the Agreement by the Health Plan shall be for informational purposes only and shall have no effect on the terms and conditions of the Agreement.
16. If a Material Change relates to Provider's inclusion in any new or modified insurance products, or proposes changes to the Provider's membership networks: (i) the Material Change shall only take effect upon the acceptance of the Provider, evidenced by a written signature; and (ii) the notice of the proposed Material Change shall be sent by certified mail, return receipt requested.
17. For any other Material Change not addressed in Section 1.5 c:
18. (i) The Material Change shall take effect on the date provided in the notice unless Provider objects to the change in accordance with this paragraph; (ii) a participating provider who objects under this paragraph shall do so in writing and the written protest shall be delivered to Health Plan within thirty (30) days of the Provider's receipt of notice of the proposed Material Change; (iii) within thirty (30) days following Health Plan's receipt of the written objection, Health Plan and Provider shall confer in an effort to reach an agreement on the proposed change or any counterproposals offered by Provider; and (iv) if Health Plan and Provider fail to reach an agreement during the thirty (30) day negotiation period described in subparagraph “iii” of this paragraph, then thirty (30) days shall be allowed for the Parties to unwind their relationship, provide notice to patients and other affected parties, and terminate the Agreement pursuant to its original terms; and
19. The notice of proposed Material Change shall be sent in an orange-colored envelope with the phrase "ATTENTION! CONTRACT AMENDMENT ENCLOSED!" in no less than fourteen (14) point boldface Times New Roman font printed on the front of the envelope. This color of envelope shall be used for the sole purpose of communicating proposed Material Changes and shall not be used for other types of communication from a Health Plan.
20. If Health Plan makes a change to this Agreement that changes an existing prior authorization, precertification, notification, or referral program, or changes an edit program or specific edits, the insurer shall provide notice of the change to Provider at least fifteen (15) days prior to the change.
21. Any notice required to be mailed pursuant to this Section shall be sent to Provider's point of contact, as set forth in the Agreement. If no point of contact is set forth in the Agreement, Health Plan shall send the requisite notice to the Provider's place of business addressed to the Provider.
22. **Nondiscrimination Against Provider in Geographic Coverage Area.** Health Plan will not discriminate against any provider who is located within the geographic coverage area of Health Plan and who is willing to meet the terms and conditions for participation established by Health Plan, including the Kentucky State Medicaid program and Medicaid partnerships.

**ATTACHMENT D**

**Medicaid and CHIP**

**Laws and Government Program Requirements**

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the Medicaid and CHIP Products. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. 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 for the Medicaid and CHIP Products. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to Medicaid and CHIP Products.

**Article One**

1. **Definitions.**
2. **Department** means The Kentucky Cabinet for Health and Family Services, Department for Medicaid Services.
3. **Medically Necessary or Medical Necessity** means Covered Services which are medically necessary as defined under 907 KAR 3:130, meet national standards, if applicable, and provided in accordance with 42 CFR 440.230, including children’s services pursuant to 42 USC 1396d(r).
4. **Subcontractor** means any individual or entity other than a provider, physician health organization, or network provider, with which Health Plan has entered into a written agreement for the purpose of fulfilling Health Plan’s obligations under the Commonwealth Government Contract.
5. **Subcontract** means any agreement entered into, directly or indirectly, by Health Plan to delegate the responsibility of any major service or group of services, including administrative functions or Covered Services, specifically related to securing or fulfilling Health Plan’s obligations under the Commonwealth Government Contract. Administrative functions are any requirements under the Commonwealth Government Contract other than the direct provision of services to Members such as, but not limited to, utilization or medical management, claims processing, member grievances and appeals, and the provision of data or information necessary to fulfill Health Plan’s obligations.

**Article Two**

1. **Standard Provisions.** Notwithstanding any other term of the Agreement, the Parties agree and acknowledge that the Department may require amendment of provisions or additional provisions of the Agreement. These requirements of Article Two also apply to Subcontractors that are developing provider networks.
2. **General Provisions.**
3. Provider will comply with all applicable Commonwealth and federal statutes, regulations, policies, procedures and rules.
4. During the term of this Agreement, Provider shall indemnify and hold the Cabinet for Health and Family Services (“CHFS”) harmless from all claims, losses, or suits relating to activities undertaken by Provider pursuant to the Commonwealth Government Contract.
5. Provider is not a third-party beneficiary to the Commonwealth Government Contract and Provider is performing services as agreed upon with Health Plan and outlined in this Commonwealth Government Contract.
6. If the Department determines that any Agreement provision conflicts with the contract between Health Plan and the Commonwealth of Kentucky (“Commonwealth Government Contract”), such provision shall be null and void and all other provisions shall remain in full force and effect.
7. Provider will maintain throughout the term of this Agreement and at its own expense professional and comprehensive general liability and medical malpractice insurance.
8. **Marketing.** If applicable, Provider will comply with the marketing restrictions as set forth in the Commonwealth Government Contract.
9. **Provision of Services.**
10. The Covered Services, tasks, and reporting to be performed by Provider are set forth in this Agreement and the Provider Manual, and if applicable, the delegated services attachment. Members may access services as set forth in the Member Handbook.
11. Emergency Services will be provided without the requirement for a prior authorization.
12. If this Agreement includes primary care services, primary care provider (“PCP”) requirements set forth in the Commonwealth Government Contract shall apply.
13. Laboratory service providers must meet all applicable requirements of the Clinical Laboratory Improvement Amendments (“CLIA”) of 1988.
14. Providers will meet appointment waiting time standards set forth in the Commonwealth Government Contract.
15. **Enrollee Services.**
16. The Medicaid population to be served are set forth in Attachment A, Products.
17. Provider will comply with enrollee rights and responsibilities as outlined in the Commonwealth Government Contract.
18. Provider will comply with applicable cultural competency requirements.
19. Provider will keep Member information confidential as defined by Federal and State statutes or regulations.
20. Provider will display notices of the Member’s right to appeal adverse action affecting services in public areas of the Provider’s facility(ies) in accordance with Department rules and regulations, subsequent amendments.
21. Provider’s responsibilities and prohibited activities regarding Member cost sharing are set forth in this Agreement and the Provider Manual.
22. **Quality and Utilization Management.**
23. Any physician incentive plan and/or value-based payment program will be set forth in an amendment to this Agreement or in Supplemental Materials.
24. Provider will participate and cooperate in internal and external quality management or quality improvement activities, such as, monitoring, utilization review, peer review and/or appeal procedures established by the Health Plan and/or the Department.
25. **Claims and Payment.**
26. The reimbursement rates and terms that Health Plan will pay Provider are set forth in this Agreement. Provider will promptly submit the information needed for payment. Provider will submit timely, complete, and accurate encounter claims.
27. Health Plan will provide for timely payment to Provider for Covered Services provided upon approval of a Clean Claim properly submitted by the Provider within the required timeframes set forth in this Agreement. Acceptable billing and coding requirements and Provider’s responsibilities for third party liability are set forth in this Agreement and the Provider Manual.
28. Provider shall accept payment from Health Plan as payment for services performed, and cannot request payment from the Department or the Member, unless the Member is required to pay a co-payment for the service rendered. Provider is prohibited from directly receiving payment or any type of compensation from the Member, except for Member co-pays or deductibles from Member for providing Covered Services. Member co-payments, co-insurance, or deductible amounts cannot exceed amounts specified in 907 KAR 1:604. Co-payments, co-insurance, or deductible amounts may be increased only with the approval of the Department.
29. **Records Maintenance and Audit Requirements.**
30. Provider will maintain all records relating to services provided to Members for a ten (10) year period and to make all Member medical records or other service records available for the purpose of quality review conducted by the Department, or their designated agents both during and after the term of the Agreement.
31. Provider will allow authorized representatives of the Department, or other Commonwealth and federal agencies to have reasonable access to premises, physical facilities, equipment and records for financial and medical audit purposes both during and after the term of the Agreement.
32. **Oversight and Monitoring.**
33. Provider will timely submit to Health Plan any information, including reports and clinical information, necessary for Health Plan to perform its obligations under the Commonwealth Government Contract.
34. Health Plan will monitor the Provider’s performance on an ongoing basis and subject Provider to formal periodic review.
35. Health Plan will monitor Provider’s performance and quality of services delivered under the Agreement.
36. Provider will comply with corrective action plans required by Health Plan.
37. **Program Integrity.** As a condition of receiving any amount of payment, Provider will comply with Program Integrity requirements of the Commonwealth Government Contract, as applicable.
38. **Non-Allowable Provisions.** No term of the Agreement will be construed to: (i) prohibit Provider from entering into a contractual relationship with another managed care organization (“MCO”) contracted to provide services for the Kentucky Medicaid managed care program; (ii) include incentives or disincentives that encourages Provider not to enter into a contractual relationship with another MCO contracted to provide services for the Kentucky Medicaid managed care program; (iii) contain any provisions that prohibit or otherwise restrict health professionals from advising patients about their health status or medical care or treatment as provided in section 1932(b)(3) of the Social Security Act or 42 CFR 438.102; (iv) prohibit Provider from acting within the Provider’s lawful scope of practice; (v) prohibit Provider from discussing treatment or non-treatment options with Members that may not reflect Health Plan’s position or may not be covered by Health Plan; (vi) prohibit Provider from advocating on behalf of the Member in any grievance system or utilization review process, or individual authorization process to obtain necessary Covered Services; and (vii) require Provider to participate or accept other plans or products offered by Health Plan unrelated to providing Covered Services to Members.
39. **Termination.** In addition to the terminations terms set forth in the Agreement, Health Plan may terminate Provider: (i) for violating applicable State or federal statutes, rules and regulations and in accordance with the Commonwealth Government Contract; and (ii) if the Department directs the Health Plan to terminate or modify this Agreement when the Department has determined such termination or modification in the best interests of the Commonwealth. In the event of a termination, Provider will provide for continuity of care when a Provider’s participation terminates during the course of a Member’s treatment.
40. **Ownership or Controlling Interest / Fraud and Abuse.** Provider, nor any individual who has a direct or indirect ownership or controlling interest of five percent (5%) or more of the Provider, nor any officer, director, agent or managing employee (i.e., general manager, business manager, administrator, director or like individual who exercises operational or managerial control over the Provider or who directly or indirectly conducts the day-to-day operation of the Provider) is an entity or individual: (i) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. §1320a-7(a)) or of any offense related to Fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)-(3) of the Social Security Act (42 U.S.C. §1320a-7(b)(1)-(3)); (ii) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (iii) who has been excluded from participation in a program under Title XVIII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the BBA or under a Commonwealth health care program.
41. **Kentucky Health Information Exchange.** Provider will sign a participation agreement with the Kentucky Health Information Exchange (“KHIE”) within one (1) month of signing this Agreement. Provider will engage with KHIE for the purpose of connecting their electronic health records (“EHR”) system to the health information exchange to share their patient electronic records. The data set required for submission is a Summary of Care Record. Hospitals that contract with “Your MCO” will be required to also submit ADTs (Admission, Discharge, Transfer messages) to KHIE. If Provider does not have an electronic health record they must still sign a participation agreement with KHIE and sign up for “Direct Secure Messaging” services so that clinical information can be shared securely with other providers in their community of care.
42. **ADA.** All service locations, as defined in the Commonwealth Government Contract, must meet the requirements of the Americans with Disabilities Act, Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures applicable to health care facilities.
43. **PCP Changes.** Health Plan shall have written policies and procedures for allowing Members to select or be assigned to a new PCP when such a change is mutually agreed to by Health Plan and Provider, when a PCP is terminated from coverage, or when a PCP change is as part of the resolution to an appeal.
44. **Billing of Enrollees.** Neither Provider, nor a Subcontractor, will bill a Member for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under the Commonwealth Government Contract. This provision shall remain in effect even if Health Plan becomes insolvent. However, if a Member agrees in advance in writing to pay for a Non-Medicaid covered service, then either the Health Plan, Provider, or Subcontractor may bill the Member. The standard release form signed by the Member at the time of services does not relieve the Health Plan, Provider, and Subcontractor from the prohibition against billing a Medicaid Members in the absence of a knowing assumption of liability for a non-Medicaid Covered Service. The form or other type of acknowledgement relevant to Medicaid Member liability must specifically state the services or procedures that are not covered by Medicaid.
45. **Provider Maintenance of Medical Records.** Provider will maintain Member medical records on paper or in an electronic format. Medical records shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals’ findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Agreement. The Medical Record shall be signed by the provider of service.The Member’s medical record is the property of the provider who generates the record. However, each Member or his/her representative is entitled to one (1) free copy of his/her medical record. Additional copies shall be made available to Members at cost. Medical records shall generally be preserved and maintained by Provider for a minimum of five (5) years unless federal requirements mandate a longer retention period (i.e., immunization and tuberculosis records are required to be kept for a person’s lifetime). PCPs will maintain a primary medical record for each Member, which contains sufficient medical information from all providers involved in the Member’s care, to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, meet the Commonwealth Government Program Requirements.
46. **Provider Grievances and Appeals.** Provider has the right to file an internal appeal with Health Plan regarding a denial of the following: (i) a health care service; (ii) claim for reimbursement; (iii) Provider payment; and (iv) contractual issues. Health Plan shall provide information specified in 42 CFR 438.10(g)(2)(XI) about the Member grievance and appeal system to all service providers and Subcontractors at the time they enter into a contract.
47. **Ethical Reasons.** Health Plan shall not require Provider to perform any treatment or procedure that is contrary to the Provider’s conscience, religious beliefs, or ethical principles in accordance with 42 CFR 438.102.
48. **Medicaid Enrollment.** Provider is not required to participate in the Kentucky Medicaid Fee-for-Service Program as a condition of participation in Health Plan’s network but Provider must be enrolled in the Kentucky Medicaid Program.
49. **Timely Filling.** Health Plan will consider timely claims filing to be within three-hundred sixty-five (365) days of the date of service. In accordance with 42 CFR 447.46, Health Plan shall comply with the timely claims payment requirements of 42 CFR 447.45. Health Plan will further comply with the Prompt-Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and KRS 304.99-123, as may be amended.
50. **Forms.** For any Medicaid service provided by Provider that requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be completed according to the appropriate Kentucky Administrative Regulation. As applicable, Provider or Subcontractor will retain the form in the event of audit and a copy shall be submitted to the Department upon request.
51. **Preventable Diseases.** Health Plan shall not pay Provider for provider-preventable conditions as set forth in the Commonwealth Government Contract. Provider will report provider-preventable conditions associated with Claims for payment or Member treatments for which payment would otherwise be made.
52. **Mental Health Parity.** Provider must comply with the Mental Health Parity and Addiction Equity Act of 2008 and 42 CFR 438 Subpart K, including the requirements that treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by Health Plan and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.
53. **Emergency Care, Urgent Care, and Post Stabilization Care.** Emergency Care as defined in 42 USC 1395dd and 42 CFR 438.114 shall be available to Members twenty-four (24) hours a day, seven (7) days a week. Urgent Care means care for a condition that is not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment. Urgent Care services shall be made available within forty-eight (48) hours of request. Post Stabilization Care services are covered and reimbursed in accordance with 42 C.F.R. 422.113(c) and 438.114(e). Health Plan will not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. An emergency medical services provider shall have a minimum of ten (10) days to notify Health Plan of the Member's screening and treatment before refusing to cover the Emergency Services based on a failure to notify. A Member who has an Emergency Medical Condition shall not be liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition.
54. **Coordination with Behavioral Health.** PCPs will have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Such screening and evaluation procedures shall be submitted to the Department for approval.
55. **Follow-Up.** As applicable, Provider will ensure that all Members receiving inpatient behavioral health services will be scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge. Behavioral health service providers will contact Members who have missed an appointment within twenty-four (24) hours to reschedule appointments.
56. **Court-Ordered Psychiatric Service.** Health Plan must provide inpatient psychiatric services to Members under the age of twenty-one (21) and over the age of sixty-five (65) who have been ordered to receive the services by a court of competent jurisdiction under the provisions of KRS 645, Kentucky Mental Health Act of The Unified Juvenile Code and KRS 202A, Kentucky Mental Health Hospitalization Act. Health Plan cannot deny, reduce, or controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a court-ordered commitment for Members under the age of twenty-one (21) or over the age of sixty-five (65). Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.
57. **Continuity of Care Upon Discharge from a Psychiatric Hospital.**
58. Health Plan shall coordinate with providers of behavioral health services, and state operated or state contracted psychiatric hospitals and nursing facilities regarding admission and discharge planning, treatment objectives, and projected length of stay for Members committed by a court of law and/or voluntarily admitted to the state psychiatric hospital. Health Plan shall enter into a collaborative agreement with the state operated or state contracted psychiatric hospital assigned to their Medicaid Region in accordance with 908 KAR 3:040 and in accordance with federal Olmstead law. At a minimum, the agreement shall include responsibilities of the behavioral health service provider to ensure continuity of care for successful transition back into community-based supports. In addition, the Health Plan and behavioral health service providers shall participate in quarterly continuity of care meetings hosted by the state operated or state contracted psychiatric hospital.
59. Behavioral health service providers will assign a case manager prior to or on the date of discharge and provide basic, targeted, or intensive case management services as Medically Necessary to Members with serious mental illness (“SMI”) and co-occurring conditions who are discharged from a state operated or state contracted psychiatric facility or state operated nursing facility for Enrollees with SMI. The case manager and other identified behavioral health service providers shall participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws.Health Plan shall ensure the behavioral health service providers assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (“KPAP”) or other similar assistance programs.
60. **Medical Records.**
61. The following applies to Subcontractors. Subcontractors will provide access to the Medical Records of Members to Health Plan, the Department, the Office of the Inspector General and other authorized Commonwealth and federal agents thereof, for purposes of auditing.
62. The following applies to Provider if Provider is a PCP. When a Member changes PCP, the medical records or copies of medical records shall be forwarded to the new PCP or partnership within ten (10) Days from receipt of request. PCPs shall have Members sign a release of medical records before a medical record transfer occurs.
63. **Critical Access Hospital.** Health Plan will reimburse Provider, which is a Critical Access Hospital, at rates that are equal to those established by CMS for Medicare reimbursement to a Critical Access Hospital in accordance with 907 KAR 10:815. The Parties further agree to comply with the requirements set forth in 907 KAR 10:815 and other applicable Laws, including, but not limited to those requirements related to cost reporting and settlement.

**Article Three**

1. **Subcontracts.** The following provisions apply to Subcontractors, who are not considered a Provider, Physician Health Organization, or Network Provider as defined in the Commonwealth Government Contract.
2. If Health Plan delegates responsibilities to Subcontractor, the delegated services addendum/agreement will comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6 and will comply with all Medicaid laws and regulations including applicable sub-regulatory guidance and contract provisions. Health Plan shall oversee and remain accountable for any functions and responsibilities that it delegates to Subcontractor in compliance with 42 C.F.R. 438.230. Before any delegation, Health Plan will evaluate the Subcontractor’s ability to perform the activities to be delegated. If Health Plan delegates the selection of providers to another entity, Health Plan retains the right to approve, suspend, or terminate any provider selected by Subcontractor.
3. Subcontractor agrees to comply with the following laws: (i) Title VI of the Civil Rights Act of 1964 (Public Law 88-352); (ii) Title IX of the Education Amendments of 1972 (regarding education, programs and activities); (iii) The Age Discrimination Act of 1975; (iv)The Rehabilitation Act of 1973; (v) Rules and regulations prescribed by the United States Department of Labor in accordance with 41 CFR Parts 60-741; and (vi) Regulations of the United States Department of Labor recited in 20 CFR Part 741, and Section 504 of the Federal Rehabilitation Act of 1973 (Public Law 93-112).
4. The Parties agree that subcontracts are subject to Department approval, in the event the Department does not approve a Subcontract prior to its scheduled effective date, the subcontract will be effective contingent upon receiving the Department’s approval. Subcontractors must be eligible to participate in the Medicaid program, pursuant to Commonwealth and Federal regulations. Health Plan will evaluate each prospective Subcontractor’s ability to perform delegated duties as further set forth in a delegated services addendum/agreement to this Agreement. No Subcontract shall in any way relieve the Health Plan of any responsibility for the performance of its duties pursuant to the Commonwealth Government Contract.
5. Attachment A, Products, identifies the population covered by the Subcontract unless otherwise set forth in the Agreement.
6. The specific amount, duration, and scope of delegated services and reporting responsibilities of Subcontractor are set forth in this Agreement, including, if applicable, the delegated services addendum/agreement. Subcontractor will provide information and data with the level of detail and on a timeline specified by Health Plan and Department.
7. Subcontractor will participate in meetings with the Department by staff as requested by the Department.
8. Subcontractor will provide ongoing and ad hoc reporting to the Department as defined and upon request. The Department shall have unlimited but not exclusive rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by Subcontractor resulting from the Commonwealth Government Contract. However, the Department shall not disclose proprietary information that is afforded confidential status by State or Federal regulations.
9. Subcontractor shall support Health Plan and the Department, upon request, in responding to legislative or other stakeholder requests. Support may include provision of data or other information, participation in drafting of materials or reports, or attendance in required meetings or other forums.
10. All materials developed by Subcontractor specific to the Commonwealth Government Contract shall include the name and logo of the Health Plan for which the material is applicable. Subcontractor shall not publish materials that are used for more than one managed care organization (“MCO”) without each MCO being identified on the materials.
11. Data and information about Covered Services and Members as applicable to this Commonwealth Government Contract: (i) cannot be held as proprietary unless agreed to by the Department; and (ii) must be made available to the Department.
12. For Subcontractors that will contract with providers, the following provision apply: (i) subcontractor will only use Medicaid enrolled providers in accordance with this Commonwealth Government Contract; (ii) Subcontractor will include all requirements set forth in Appendix C., “Required Standard Provision for Network Provider Contracts” in its agreements; and (iii) Subcontractor will follow the required policies and processes for credentialing conducted by the Credentialing Verification Organization (“CVO”).
13. If Subcontractor has NCQA/URAC or other national accreditation, Subcontractor shall provide Health Plan with a copy of its’ current certificate of accreditation together with a copy of the survey report.
14. This Agreement discloses the method of compensation or other consideration to be received from Health Plan and no provision in this agreement will be construed to provide incentives, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services.
15. Subcontractor may not assign, or further subcontract, this Agreement without the prior written consent of the Department.
16. Notwithstanding any other provision, the Commonwealth is the intended third-party beneficiary of the Subcontract and, as such, the Commonwealth is entitled to all remedies entitled to third party beneficiaries under law.
17. Subcontractor, when applicable, agrees to timely submit encounter records in the format specified by the Department so that Health Plan can meet the specifications required by this Commonwealth Government Contract.
18. The terms of the Commonwealth Government Contract are incorporated to the fullest extent applicable to the service or activity delegated pursuant to the Subcontract, including without limitation, the obligation to comply with all applicable federal and Commonwealth law and regulations, including but not limited to, KRS 205.8451-8483, all rules, policies and procedures of FAC and the Department, applicable sub-regulatory guidance and contract provisions, and all standards governing the provision of Covered Services and information to Enrollees, all QAPI requirements, all record keeping and reporting requirements, all obligations to maintain the confidentiality of information, all rights of FAC, the Department, the Office of the Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations, all indemnification and insurance requirements, and all obligations upon termination.
19. Subcontractor will participate in readiness reviews as requested by the Department, including submission of requested materials, participation in meetings, and onsite reviews.
20. Health Plan will conduct ongoing monitoring of the Subcontractor’s performance of the full scope of required services and the quality of services rendered to Members in accordance with the terms of this Commonwealth Government Contract, including those with accreditation. The frequency and method of reporting to Health Plan; the process by which Health Plan evaluates the Subcontractor’s performance; requirement for formal review according to a periodic schedule consistent with industry standards, but no less than annually, will be set forth in the delegated services addendum/agreement.
21. Health Plan will provide a process for the Subcontractor to identify deficiencies or areas of improvement and to take necessary corrective action. If Health Plan identifies deficiencies or areas for improvement, Health Plan and the Subcontractor shall take corrective action.
22. The Commonwealth, CMS, HHS Inspector General, the Comptroller General or their designee have a right to audit, evaluate and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor’s contractor, that pertain to any aspect of services and activities performed, determination of amounts payable under the contract with the Commonwealth, or for reasonable possibility of Fraud or similar risk. Subcontractor will make its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to Medicaid Members available. The right to audit through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.
23. Subcontractor will notify the Health Plan throughout the term of the Agreement of any new or existing litigation.
24. In addition to the remedies set forth elsewhere in this Agreement, including, if applicable, the delegated services addendum/agreement, Health Plan may revoke a Subcontract if the Subcontractor does not fulfill its obligations. Subcontractor shall also be subject to penalties as set forth in Appendix B “Remedies for Violation, Breach, or NonPerformance of Contract,” as set forth in the Commonwealth Government Contract. Additionally, Health Plan may revoke delegation or imposition other sanctions if the Subcontractor’s performance is inadequate and if the Subcontractor does not provide data or information upon request.
25. Subcontractor will report suspected Fraud and Abuse be reported to Health Plan.
26. Subcontractor agrees to indemnify, defend and hold harmless the Commonwealth, its officers, agents, and employees, and each and every Member from any liability ever arising in connection with this Commonwealth Government Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor. Subcontractor further covenants and agrees that in the event of a breach of the Subcontract by Health Plan, termination of the Subcontract, or Insolvency of Health Plan, each Subcontractor shall provide all services and fulfill all of its obligations pursuant to the Subcontract for the remainder of any month for which the Department has made payments to Health Plan, and shall fulfill all of its obligations respecting the transfer of Members to other providers, including record maintenance, access and reporting requirements all such covenants, agreements, and obligations of which shall survive the termination of the Agreement.
27. **Utilization Management.** Consistent with 42 CFR sections 438.6(h) and 422.208, compensation to individuals or entities that conduct utilization management activities will not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to a Member.
28. **Accounting.** Subcontractor shall maintain their accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted system of accounting. The accounting system shall clearly document all financial transactions between the Health Plan and Subcontractor. These transactions shall include, but not be limited to, Claims payment, refunds and adjustment of payments.
29. **Legal Notice.** Subcontractor shall provide written notice to Health Plan of any legal action or notice listed upon receiving notice of: (i) any action, proposed action, lawsuit, or counterclaim filed against the Subcontractor related in any way to this Agreement; (ii) any administrative or regulatory action, or proposed action, respecting the business or operations of Subcontractor related in any way to this Agreement; (iii) any notice received from the DOI or the Cabinet for Health and Family Services; (iv) any claim made against the Subcontractor having the potential to result in litigation related in any way to this Agreement; (v) the filing of a petition in bankruptcy by or against Subcontractor or the insolvency of Subcontractor; and (vi) the payment of a civil fine or conviction of any person who has an ownership or controlling interest in Subcontractor or who is an agent or managing employee of Subcontractor, of a criminal offense related to that person’s involvement in an program under Medicare, Medicaid, or Title XX of the Act, or of Fraud, or unlawful manufacture, distribution, prescription or dispensing of a controlled substance, as specified in 42 USC 1320a-7.
30. **HIPAA.** Subcontractor agrees to abide by the rules and regulations regarding the confidentiality of Protected Health Information (“PHI”) as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 C.F.R. Parts 160 and 164. Subcontractor is required to abide by the same statutes and regulations regarding confidentiality of PHI as Health Plan.
31. **Confidentiality.** Subcontractor will comply with the confidentiality provisions as set forth in the Commonwealth Government Contract. Subcontractor shall comply with the provisions of the Privacy Act of 1974 and instruct its employees to use the same degree of care as it uses with its own data to keep confidential information concerning client data, the business of the Commonwealth, its financial affairs, its relations with its citizens and its employees, as well as any other information which may be specifically classified as confidential by the Commonwealth in writing. All Federal and State Regulations and Statutes related to confidentiality shall be applicable to Subcontractor. Subcontractor shall have an appropriate agreement with its employees, and any subcontractor employees, to that effect, provided however, that the foregoing will not apply to: (i) information which the Commonwealth has released in writing from being maintained in confidence; (ii) information which at the time of disclosure is in the public domain by having been printed an published and available to the public in libraries or other public places where such data is usually collected; or (iii) information, which, after disclosure, becomes part of the public domain as defined above, thorough no act of the contractor.
32. **Kentucky Equal Employment Opportunity Act.** To the extent applicable to this Agreement, the following provision applies to subcontractors as defined by Commonwealth Law. The Equal Employment Opportunity Act of 1978 (“Act”) applies to Commonwealth government projects with an estimated value exceeding $500,000. Subcontractor shall comply with all terms and conditions of the Act.
33. **Executive Order 11246.** To the extent applicable to this Agreement, the following provisions apply to subcontractors as defined by Federal Law. During the performance of this contract, subcontractor agrees as follows:
34. Subcontractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, gender identity, or national origin. Subcontractor will take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, sexual orientation, gender identity, or national origin. Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Subcontractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of this nondiscrimination clause
35. Subcontractor will, in all solicitations or advancements for employees placed by or on behalf of subcontractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, or national origin.
36. Subcontractor will not discharge or in any other manner discriminate against any employee or applicant for employment because such employee or applicant has inquired about, discussed, or disclosed the compensation of the employee or applicant or another employee or applicant. This provision shall not apply to instances in which an employee who has access to the compensation information of other employees or applicants as a part of such employee’s essential job functions discloses the compensation of such other employees or applicants to individuals who do not otherwise have access to such information, unless such disclosure is in response to a formal complaint or charge, in furtherance of an investigation, proceeding, hearing, or action, including an investigation conducted by the employer, or is consistent with subcontractor’s legal duty to furnish information.
37. Subcontractor will send to each labor union or representative of workers with which he has a collective bargaining agreement or other contract or understanding, a notice, to be provided by the agency contracting officer, advising the labor union or workers’ representative of subcontractor’s commitments under Section 202 of Executive Order No. 11246 of September 24, 1965, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
38. Subcontractor will comply with all provisions of Executive Order No. 11246 of Sept. 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.
39. Subcontractor will furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to his books, records, and accounts by the contracting agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.
40. In the event of subcontractor’s noncompliance with the nondiscrimination clauses of this contract or with any of such rules, regulations, or orders, this contract may be cancelled, terminated, or suspended in whole or in part and subcontractor may be declared ineligible for further Government contracts in accordance with procedures authorized in Executive Order No. 11246 of Sept. 24, 1965, and such other sanctions may be imposed and remedies invoked as provided in Executive Order No. 11246 of September 24, 1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.
41. Health Plan will include the provisions of paragraphs (a) through (h) in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. Subcontractor will take such action with respect to any subcontract or purchase order as may be directed by the Secretary of Labor as a means of enforcing such provisions including sanctions for noncompliance: Provided, however, that in the event subcontractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction, subcontractor may request the United States to enter into such litigation to protect the interests of the United States. [Sec. 202 amended by EO 11375 of Oct. 13, 1967, 32 FR 14303, 3 CFR, 1966–1970 Comp., p. 684, EO 12086 of Oct. 5, 1978, 43 FR 46501, 3 CFR, 1978 Comp., p. 230, EO 13665 of April 8, 2014, 79 FR 20749, EO 13672 of July 21, 2014, 79 FR 42971]

**ATTACHMENT E**

**Medicare Advantage**

**Laws and Government Program Requirements**

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the Medicare Advantage Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. 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 for the Medicare Advantage Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to the Medicare Advantage Product.

1. **Definitions.**
2. **Completion of Audit** means a completion of audit by The U.S. Department of Health and Human Services (“HHS”), the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or Related Entity.
3. **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between a Medicare Advantage Organization (or applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider for health and administrative services.
4. **Final Contract Period** means the final term of the contract between CMS and the Medicare Advantage Organization.
5. **First Tier Entity** means any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the Medicare Advantage program.
6. **Medicare Advantage Organization** means a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the Medicare Advantage contract requirements.
7. **Related Entity** means any entity that is related to the Medicare Advantage Organization by common ownership or control and; (i) performs some of the Medicare Advantage Organization's management functions under contract or delegation; (ii) furnishes services to Medicare enrollees under an oral or written agreement; or (iii) leases real property or sells materials to the Medicare Advantage Organization at a cost of more than $2,500 during a contract period.
8. **Right to Audit.** HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the First Tier Entity, Downstream Entity, and Related Entity, through ten (10) years from the final date of the Final Contract Period of the contract entered into between CMS and the Medicare Advantage Organization or from the date of completion of any audit, whichever is later.
9. **Right to Audit Directly from FDR.** HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under Section 1.2, of this attachment, directly from any First Tier Entity, Downstream Entity, and Related Entity. For records subject to review under Section 1.2, except in exceptional circumstances, CMS will provide notification to the Medicare Advantage Organization that a direct request for information has been initiated.
10. **Confidentiality.** Provider will comply with the confidentiality and Member record accuracy requirements, including: (i) abiding by all Laws regarding confidentiality and disclosure of medical records, or other health and enrollment information; (ii) ensuring that medical information is released only in accordance with applicable Law, or pursuant to court orders or subpoenas; (iii) maintaining the records and information in an accurate and timely manner; and (iv) ensuring timely access by Members to the records and information that pertain to them.
11. **Hold Harmless.** Members will not be held liable for payment of any fees that are the legal obligation of the Medicare Advantage Organization.
12. **Cost Sharing.** For all Members eligible for both Medicare and Medicaid, Members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (i) accept the Health Plan payment as payment in full; or (ii) bill the appropriate State source.
13. **Delegation.** Any services or other activity performed in accordance with a contract or written agreement by Provider ora Downstream Entity of Provider must be consistent and comply with the Medicare Advantage Organization's contractual obligations.
14. **Prompt Payment.** Health Plan will pay Provider for Clean Claims for Covered Services, that are determined to be payable, in accordance with Laws, Government Program Requirements, and this Agreement. Health Plan will make such payment within sixty (60) days.
15. **Compliance with Medicare Laws.** Provider will comply with all applicable Medicare Laws, regulations, and CMS instructions.
16. **Benefit Continuation.** Provider agrees to provide for continuation of Member health care benefits: (i) for all Members, for the duration of the period for which CMS has made payments to Health Plan for Medicare services; and (ii) for Members who are hospitalized on the date Health Plan’s contract with CMS terminates, or, in the event of insolvency, through discharge
17. **Accountability.** Health Plan may only delegate activities or functions to a First Tier Entity or Downstream Entity in a manner that is consistent with the requirements set forth in Health Plan’s contractual obligations.
18. **Reporting**. Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310.

**ATTACHMENT F**

**Medicare-Medicaid Program**

**Laws and Government Program Requirements**

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the MMP Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. 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 for the MMP Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to MMP Product.

[Placeholder, to be populated at a later date.]

**ATTACHMENT G**

**Molina Marketplace**

**Laws and Government Program Requirements**

This attachment sets forth applicable Laws and Government Program Requirements or other provisions necessary to reflect compliance for the Molina Marketplace Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. 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 for the Molina Marketplace Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to Molina Marketplace Product.

**Article One**

1. **Definitions.** The following definitions apply only in this attachment:
2. **Delegated Entity** means any party that enters into an agreement with a qualified health plan (“QHP”) issuer to provide administrative services or health care services to qualified individuals and their dependents.
3. **Downstream Entity** means any party that enters into an agreement with a Delegated Entity or with another downstream entity for purposes of providing administrative or health care services related to the agreement between the Delegated Entity and the QHP issuer. The term is intended to reach the entity that directly provides administrative services or health care services to qualified individuals and their dependents.

Consistent with the above definitions, Provider is a Delegated Entity and Health Plan is a QHP issuer.

1. **Health Plan Accountability.** Notwithstanding any relationship Health Plan may have with Provider, as Delegated Entity, and any Downstream Entity, Health Plan maintains responsibility for its compliance, as well as the compliance of the Provider and any Downstream Entity, with all applicable standards enumerated at 45 CFR 156.340(a). (45 CFR 156.340(a))
2. **Delegated Entity and Downstream Entity Compliance.** If any of Health Plan’s issuer activities and obligations, in accordance with 45 CFR 156.340(a), are delegated to Provider, then Provider, as Delegated Entity, agrees to the following. Provider further agrees that it will require the same of any Downstream Entities. (45 CFR 156.340(b))
   1. **Standards for Downstream and Delegated Entities.** The Agreement, including, when applicable, any delegated services attachment/addendum, specifies the delegated activities and reporting responsibilities. (45 CFR 156.340(b)(1))
   2. **Revocation of Delegated Activities.** In the event the United States Department of Health and Human Services (“HHS”) or Health Plan determines, in its sole discretion, that Provider or any Downstream Entity have not performed the delegated activities and reporting obligations satisfactorily, consistent with applicable standards enumerated at 45 CFR 156.340(a), then the delegated activities and reporting obligations shall be revoked. The foregoing does not preclude the employment of other remedies in lieu of revocation of the delegated activities or reporting responsibilities if deemed appropriate by HHS or Health Plan, as applicable. (45 CFR 156.340(b)(2))
   3. **Compliance with Laws.** Provider will perform such activities and obligations in compliance with all applicable laws and regulations relating to the standards specified in 45 CFR 156.340(a). (45 CFR 156.340(b)(3))
   4. **Right to Audit.** Provider and any Downstream Entity shall permit access to the relevant Health Insurance Marketplace authority, the Secretary of HHS, and the Office of the Inspector General, or their designees, to evaluate through audit, inspection, or other means, Provider’s or Downstream Entity’s books, contracts, computers, or other electronic systems, including medical records and documentation, relating to Health Plan’s obligations in accordance with the standards enumerated at 45 CFR 156.340(a), as applicable, until ten (10) years from the final date of the Agreement period. (45 CFR 156.340(b)(4)-(5))
3. **Privacy** **and Security of Personally Identifiable Information.** Provider must adhere to privacy and security standards and obligations to which Health Plan has agreed to in its contract or agreement with the Health Insurance Marketplace authority. (45 CFR 155.260(b)(2)(v))
4. **Consolidated Appropriations Act of 2021.** The Consolidated Appropriations Act of 2021, Section 201, prohibits Health Plan from entering into a contract with Provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict Health Plan from: (i) providing provider-specific cost or quality of care information or data to referring providers, plan sponsors, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage; (ii) electronically accessing de-identified claims and encounter data for each participant, beneficiary, or enrollee; or (iii) sharing such information, consistent with applicable privacy Laws. Notwithstanding anything to the contrary in this Agreement, Provider agrees that Health Plan is in compliance with this provision with respect to this Agreement and nothing in this Agreement will prohibit Health Plan from complying with this provision.

**Article Two**

1. **Timely Payment of Claims.** Health Plan will pay Provider for Clean Claims for Covered Services that are determined to be payable and make determinations on Clean Claims in accordance KRS 304.17A-702.
2. **Standards for Provider Participation.**
3. Health Plan has mechanisms in place for soliciting and acting upon applications for provider participation in the Marketplace Product in a fair and systematic manner. These mechanisms, at a minimum, include: (i) allowing all providers who desire to apply for participation in the Marketplace Product an opportunity to apply at any time during the year; and (ii) making criteria for provider participation in the Marketplace Product available to all applicants.
4. Health Plan will abide by the following: (i) Health Plan will inform a Provider of the Health Plan’s removal and withdrawal policy at the time the Health Plan contracts with the Provider to participate in Health Plan’s Participating Provider network for the Marketplace Product, and when changed thereafter; (ii) if a Provider’s participation will be terminated or withdrawn prior to the date of the termination of the contract as a result of a professional review action, Health Plan and Provider will comply with the standards in 42 U.S.C. sec. 11112; and (iii) if the Health Plan finds that Provider represents an imminent danger to an individual Member or to the public health, safety, or welfare, the medical director shall promptly notify the appropriate professional state licensing board.

**ATTACHMENT H**

**Provider Identification Sheet**

When Provider includes multiple entities that may bill Health Plan with different Tax Identification Numbers (“TIN”), Provider must supply each Legal Name and TIN. Each Legal Name and TIN must exactly match the corresponding tax form (i.e. W-9) that Provider supplies to Health Plan in order for Provider to be eligible to receive compensation under this Agreement.

|  |
| --- |
| Legal Name – Matching the applicable tax form (i.e. W-9, Line 1) |
| Tax ID Number – As listed on corresponding tax form |
| NPI – That corresponds to the Tax ID Number |
| IRS 1099 Address – If different than Mailing Address |

|  |
| --- |
| Legal Name – Matching the applicable tax form (i.e. W-9, Line 1) |
| Tax ID Number – As listed on corresponding tax form |
| NPI – That corresponds to the Tax ID Number |
| IRS 1099 Address – If different than Mailing Address |

|  |
| --- |
| Legal Name – Matching the applicable tax form (i.e. W-9, Line 1) |
| Tax ID Number – As listed on corresponding tax form |
| NPI – That corresponds to the Tax ID Number |
| IRS 1099 Address – If different than Mailing Address |

|  |
| --- |
| Legal Name – Matching the applicable tax form (i.e. W-9, Line 1) |
| Tax ID Number – As listed on corresponding tax form |
| NPI – That corresponds to the Tax ID Number |
| IRS 1099 Address – If different than Mailing Address |

Continuation pages are acceptable to collect additional information.

**ATTACHMENT** **I**

**Coronavirus** **Disease** **Requirements**

This attachment sets forth applicable Coronavirus Disease (“COVID”) requirements which are required to be included by Law as stated below. This attachment will be automatically modified to conform to subsequent changes to Law. 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. Any purported modification or any provision in this attachment that is inconsistent with Law will not be effective and will be interpreted in a manner that is consistent with the applicable Law. For the avoidance of doubt, this attachment applies to the Medicare Advantage Product and the Medicare-Medicaid Product.

1. **Executive** **Order** **14042**. Ensuring Adequate COVID-19 Safety Protocols for Federal Contractors for Subcontractors Over the Simplified Acquisition Threshold of Two Hundred and Fifty Thousand Dollars ($250,000).
2. **Definition**. As used in this section, “United States or its outlying areas” means:
3. The fifty States;
4. The District of Columbia;
5. The commonwealths of Puerto Rico and the Northern Mariana Islands;
6. The territories of American Samoa, Guam, and the United States Virgin Islands; and
7. The minor outlying islands of Baker Island, Howland Island, Jarvis Island, Johnston Atoll, Kingman Reef, Midway Islands, Navassa Island, Palmyra Atoll, and Wake Atoll.
8. **Authority**.This clause implements Executive Order 14042, Ensuring Adequate COVID Safety Protocols for Federal Contractors, dated September 9, 2021 (published in the Federal Register on September 14, 2021, 86 FR 50985).
9. **Compliance**.Provider, a subcontractor, shall comply with all guidance, including guidance conveyed through Frequently Asked Questions, as amended during the performance of this Agreement, for contractor or subcontractor workplace locations published by the Safer Federal Workforce Task Force (“Task Force Guidance”) at [https:/www.saferfederalworkforce.gov/contractors/](https://urldefense.com/v3/__https:/www.saferfederalworkforce.gov/contractors/__;!!DOw_8Fim!bHpWlxtZS16NYYDqlhjgcN_f2rkoVBhuW_TV3OzCF3HSOhM9EOleD5PQDgupoHrpFSrEDw$).
10. **Subcontracts**. Provider shall include the substance of this clause, including this paragraph (d), in subcontracts at any tier that exceed the simplified acquisition threshold, as defined in Federal Acquisition Regulation 2.101 on the date of subcontract award, and are for services, including construction, performed in whole or in part within the United States or its outlying areas.