WELLCARE PARTICIPATION AMENDMENT

THIS WELLCARE PARTICIPATION AMENDMENT (“Amendment”) is made and entered into effective October 1, 2011, by and between COMMONWEALTH HEALTH CORPORATION d/b/a CENTER CARE (hereinafter, “Center Care”) and ___________________ (hereinafter, “Provider”).

WHEREAS, Center Care and Provider are parties to a Provider Agreement (as amended, the “Agreement”) under which Provider provides or arranges for the provision of health care items and services to beneficiaries of health plans sponsored by Center Care’s contracted payers;

WHEREAS, WellCare Health Insurance of Illinois, Inc. d/b/a WellCare of Kentucky (“Health Plan”) sponsors managed care plans (“WellCare Plans”) pursuant to government programs in the Commonwealth of Kentucky;

WHEREAS, Center Care and Health Plan have entered into a payer agreement for Center Care to provide Covered Services to Members of WellCare Plans through Center Care’s participating provider network;

WHEREAS, Center Care and Provider desire to enter into this Amendment to set forth terms and conditions specific to Provider’s participation in participating provider networks for WellCare Plans pursuant to the Agreement;

NOW THEREFORE, in consideration of the mutual premises herein, Center Care and Provider agree as follows:

1. With respect to WellCare Plans, Center Care and Provider agree to the terms and conditions set forth in Attachment A, attached hereto and made a part of this Amendment.

2. Except as amended by this Amendment, the Agreement remains in full force and effect.

IN WITNESS WHEREOF, the undersigned have caused this Amendment to be duly executed as of the date first written above, with the intent to be legally bound.

COMMONWEALTH HEALTH CORPORATION Provider

d/b/a CENTER CARE

By: ___________________________ By: ___________________________

Print Name: _____________________ Print Name: _____________________

Title: ___________________________ Title: ___________________________

Date: ___________________________ Date: ___________________________

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1. **Participation in Kentucky Medicaid Contract.** Subject to and in accordance with the terms and conditions of the Agreement, including this Amendment, Provider shall participate in WellCare Plans under the Kentucky Medicaid Contract (as such term is defined below). Center Care and Provider agree that Health Plan, pursuant to this Amendment, is an intended third-party beneficiary under the Agreement.

2. **Compensation.** Compensation for Covered Services provided to Members shall be the lesser of the Provider’s billed charges, or the following, less Member deductibles, copayments or coinsurance where applicable:
   a. **100%** percent of Health Plan’s Medicaid rate schedule, based on the Kentucky Cabinet for Health and Family Services’ Department for Medicaid Services’ (“Department”) Medicaid fee schedule on the date the Covered Services are rendered, as adjusted pursuant to this section.
   b. Payment of compensation is subject to coordination of benefits and subrogation activities and adjustments.
   c. Health Plan shall process claims and pay or deny a clean claim within 30 days of its receipt of the clean claim. The date of receipt of a clean claim shall be the date Health Plan receives the clean claim electronically, or for paper claims as indicated by Health Plan’s date stamp on the clean claim. The date of payment shall be the date of the electronic funds transfer, check or other form of payment.
   d. Health Plan may automatically update Health Plan’s Medicaid rate schedules without notice to Provider to include successor code numbers for the same services or delete retired codes, as such are revised or implemented by the Department. Health Plan will include in Health Plan’s Medicaid rate schedules those Covered Services and corresponding rates that are not included in the Kentucky Medicaid rate schedule.
   e. If the Department changes its Medicaid fee schedule, Health Plan will implement and prospectively apply changes to Health Plan’s Medicaid rate schedules based on the Department’s changes (i) on the Department’s effective date, if the Department publishes the rate change at least 45 days prior to their effective date, or (ii) if the publication date is less than 45 days before the Department’s effective date, Health Plan will implement and prospectively apply the changes no more than 45 days after the date the Department publishes the rate change. Health Plan will not retrospectively apply increases or decreases to Health Plan’s Medicaid rate schedule to any claims that have already been paid.

3. **Definitions.** Capitalized terms that are not defined in this Amendment shall be as defined in the Agreement, provided that if an identical term is defined in the Agreement and this Amendment, the definition in this Amendment shall control with respect to WellCare Plans.
   a. “Cabinet” means the Kentucky Cabinet for Health and Family Services.
   b. “Commonwealth” or “State” means the Commonwealth of Kentucky.
c. “Emergency Medical Condition” means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.[907 KAR 1:320(7)]

d. “Emergency Services” or “Emergency Care” means (i) covered inpatient and outpatient services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; or (ii) emergency ambulance transport.[907 KAR 1:320(6)]

e. “Finance” means the Kentucky Cabinet for Finance and Administration.

f. “Kentucky Medicaid Contract” means a contract between the Commonwealth and Health Plan for Health Plan to provide or arrange for the provision of health care items and services to enrollees in the Kentucky managed care programs for Medicaid or Children’s Health Insurance Program (“CHIP”), as amended from time to time, including any requests for proposal issued by the Commonwealth and incorporated into such a contract, including RFP 758 1100000276 (“RFP”), or Health Plan’s response thereto, as amended from time to time.

g. Items and services that are “Medically Necessary” or a “Medical Necessity” are those that are (i) reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy; (ii) appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice; (iii) provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care provider, or for cosmetic reasons; (iv) provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided; (v) needed, if used in reference to an emergency medical service, to exist using the prudent layperson standard; (vi) provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in Federal laws and regulations for individuals under twenty-one (21) years of age; and (vii) sufficient in amount, duration, and scope to reasonably achieve its purpose, subject to appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. [907 KAR 3:130(2)(1)(b); 907 KAR 1:320(13)]

h. “Member” means an individual enrolled in a benefit plan issued by Health Plan pursuant to a Kentucky Medicaid Contract.

i. “Primary Care Services” means health care items or services available from primary care physicians within the scope of their medical or professional licenses or certifications, and shall include primary care items and services required by Plan Requirements, which may include (i) assuring the timeliness of urgent, emergent, sick and preventive care to Members; (ii) conducting initial health assessments of new Members when such assessments are Covered Services under the applicable Service Agreement; (iii) informing Members of specific health care needs that require follow-up; (iv) instructing Members on measures they may take to promote their own health; (v) providing the coordination necessary for the referral of Members to specialists; or (vi) monitoring and follow-up of care provided by other providers for diagnosis and treatment.
j. “Specialty Physician Services” means health care items and services within the scope of a particular medical specialty.

4. If there is inconsistent or contrary language between this Amendment and any other part of the Agreement, the provisions of this Amendment shall prevail with respect to WellCare Plans.

5. Provider may freely communicate with Members about their treatment regardless of benefit coverage limitations.

6. Emergency Services. Provider shall not be required to seek prior authorization for Emergency Care before the Member has been stabilized. Once a Member who receives Emergency Care is stabilized, Provider shall seek prior authorization for post-stabilization care services for the Member in accordance with Plan Requirements.

   a. Member Hold Harmless. Provider may not, under any circumstance, including: (i) nonpayment of moneys due the Provider by Health Plan, (ii) insolvency of Health Plan, or (iii) breach of the provider agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member, dependent of a 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 noncovered services. [KRS § 304.17A-527(1)(a)]
   b. Continuity of Care. If the Agreement or payer agreement is terminated for any reason, other than a quality of care issue or fraud, Provider shall continue to provide services and Health Plan shall continue to reimburse Provider in accordance with the agreement until the Member or 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. [KRS § 304.17A-527(1)(b)]
   c. Survivorship. The foregoing hold harmless clause and continuity of care clause shall survive the termination of the Agreement. [KRS § 304.17A-527(1)(c)]
   d. For WellCare Plans, Center Care will, upon request of Provider, provide or 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 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. [KRS § 304.17A-527(1)(d)]
   e. If Provider enters into any subcontract agreement with another provider to provide their licensed health care services to a Member or dependent of the Member of WellCare Plans where the subcontracted provider will bill Health Plan or Member directly for the subcontracted services, the subcontract agreement must meet all requirements of KRS subtitle 304.17A and all such subcontract agreements shall be filed with the commissioner in accordance with this paragraph. [KRS § 304.17A-527(1)(e)]
f. As used in this section, unless the context requires otherwise: (1) “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 (2) “participating provider” means a physician licensed under KRS Chapter 311, an advanced practice registered nurse licensed under KRS Chapter 314, a psychologist licensed under KRS Chapter 319, or an optometrist licensed under KRS Chapter 320 that has entered into an agreement with an insurer to provide health care services.

i. If Center Care makes a material change to an agreement it has entered into with a participating provider for the provision of health care services for WellCare Plans, Center Care shall provide the participating provider with at least ninety (90) days’ written notice of the material change. The notice shall include a description of the material change and a statement that the participating provider has the option to withdraw from the agreement prior to the material change becoming effective pursuant to the following paragraph of this section.

ii. A participating provider who opts to withdraw following notice of a material change pursuant to the foregoing paragraph of this section shall send written notice of withdrawal to Center Care no later than forty-five (45) days prior to the effective date of the material change.

iii. If Center Care makes a change to an agreement that changes an existing prior authorization, precertification, notification, or referral program, or changes an edit program or specific edits, Center Care shall provide notice of the change to the participating provider at least fifteen (15) days prior to the change.

8. Kentucky Medicaid Contract Requirements. [Cites are to applicable sections of Kentucky Contract]

   a. Neither Provider, nor any individual who has a direct or indirect ownership or controlling interest of 5% or more of 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 Provider or who directly or indirectly conducts the day-to-day operation of Provider) is an entity or individual (1) 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)); or (2) 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 (3) 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 Balanced Budget Act or under a Commonwealth health care program. [4.6]

   b. Health Plan retains the right to approve, suspend or terminate any provider selected by Center Care. [5.3E]

   c. Provider shall comply with the requirements of 42 CFR 438, as applicable. [5.3F]

   d. During the term of this Agreement, Provider agrees as follows:

      i. Provider will not discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. Provider 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 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. Provider 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.

ii. Provider will, in all solicitations or advancements for employees placed by or on behalf of the contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex or national origin.

iii. Provider 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 the Provider’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.

iv. Provider will comply with all applicable provisions of Executive Order No. 11246 of Sept. 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.

v. Provider 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.

vi. In the event of Provider’s noncompliance with the nondiscrimination clauses of this Agreement or with any of such rules, regulations, or orders, this Agreement may be cancelled, terminated, or suspended in whole or in part and Provider 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.

vii. Provider will include the provisions of this section (c) 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. Provider 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 Provider becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction, Provider may request the United States to enter into such litigation to protect the interests of the United States. [6.3]

e. The Equal Employment Opportunity Act of 1978, KRS 45.560 – 45.640 applies to all State government projects with an estimated value exceeding $500,000. Provider shall comply with all terms and conditions of the Act. [6.3G]

f. Provider shall comply with the following laws:

i. Title VI of the Civil Rights Act of 1964 (Public Law 88-352);
ii. Rules and regulations prescribed by the United States Department of Labor in accordance with 41 CFR Part 60-741; and


g. Access to Premises.

i. Upon reasonable notice, Provider shall allow duly authorized agents or representatives of the Commonwealth or federal government or the independent external quality review organization required by Section 1902(a)(30)(c) of the Social Security Act, 42 U.S. Code Section 1396a(a)(30), access to Provider’s premises during normal business hours to inspect, audit, investigate, monitor or otherwise evaluate the performance of Provider and/or its subcontractors. Provider and/or its subcontractors shall forthwith produce all records, documents, or other data requested as part of such review, investigation, or audit.

ii. In the event right of access is requested under this section, Provider or its subcontractor shall provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the Commonwealth, federal, or external quality review personnel conducting the audit, investigation, or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of the Provider’s or its subcontractors’ activities. Provider will be given twenty (20) business days to respond to any findings of an audit made by Finance, the Department or their agent before the findings are finalized. Provider shall cooperate with Finance, the Department or their agent as necessary to resolve audit findings. All information obtained will be accorded confidential treatment as provided under applicable laws, rules and regulations. [6.6]

h. Hold Harmless Provisions.

i. Provider will indemnify, defend and hold harmless the Commonwealth, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with this Agreement for the payment of any debt of or the fulfillment of any obligation of the Provider.

ii. Provider further covenants and agrees that in the event of a breach of this Agreement by Center Care, termination of this Agreement, or insolvency of the Health Plan or Center Care, Provider shall provide all services and fulfill all of its obligations pursuant to this Agreement 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 Kentucky Medicaid Contract and this Agreement. [7.1]

i. Health Plan may monitor the quality of services rendered to Members, in accordance with the terms of the Kentucky Medicaid Contract. [7.2F]

j. Center Care and Provider represent the Agreement contains no provision that provides incentives, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services. [7.2G]
k. The Commonwealth is the intended third-party beneficiary of this Agreement and, as such, the Commonwealth is entitled to all remedies entitled to third-party beneficiaries under law. [7.2I]

l. Provider shall submit encounter records in the format specified by the Department so that Health Plan can meet the Department’s specifications required by the Kentucky Medicaid Contract. [7.2J]

m. This Agreement incorporates all provisions of the Kentucky Medicaid Contract to the fullest extent applicable to the service or activity to be performed under the Agreement, 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 Finance and the Department, and all standards governing the provision of Covered Services and information to Members, all Quality Assessment/Performance Improvement (“QAPI”) program requirements, all record keeping and reporting requirements, all obligations to maintain the confidentiality of information, all rights of Finance, 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. [7.2K]

n. Provider shall report suspected fraud and abuse to Health Plan. Reports may be made anonymously through Health Plan’s fraud hotline at (866) 678-8355. [7.2P]

o. Finance shall have the right to invoke against Provider any remedy set forth in the Kentucky Medicaid Contract, including the right to require the termination of any provider agreement, for each and every reason for which it may invoke such a remedy against Health Plan or require the termination of the Kentucky Medicaid Contract. [7.4]

p. Acknowledgement of Federal Funding. Claims, data and other information submitted to Health Plan pursuant to this Agreement may be used, directly or indirectly, for purposes of obtaining payments from Federal or State governments under Federal health care programs, and payments that Provider receives under this Agreement may be, in whole or in part, from Federal funds. Provider shall, upon request of Health Plan, certify, based on its best knowledge, information and belief, that all data and other information directly or indirectly reported or submitted to Health Plan pursuant to this Agreement is accurate, complete and truthful. [8.4]

q. In no event shall the Commonwealth, Finance, the Department or Member be liable for the payment of any debt or fulfillment of any obligation of Health Plan, Center Care or Provider to any subcontractor, supplier, out-of-network provider or any other party, for any reason whatsoever, including the insolvency of Health Plan, Center Care or Provider. Provider agrees that any subcontract will contain a hold harmless provision. [14.2]

r. Provider is prohibited from directly receiving payment or any type of compensation from the Member, except for Member co-pays or deductibles from Members for providing Covered Services. Member co-pay, co-insurance or deductible amounts cannot exceed amounts specified in 907 KAR 1:604. [15.2]

s. Provider will report/submit all encounter records in an accurate and timely fashion. [17.1]

t. The following applies if Provider is a primary care provider: Providershall connect to the Kentucky Health Information Exchange within one year of the effective date of its provider agreement or other schedule as determined by the Department. Health Plan encourages all other
Providers in Health Plan’s Participating Provider network to establish connectivity with the Kentucky Health Information Exchange. [18]

u. Provider shall cooperate and participate in Health Plan’s QAPI activities. QAPI program activities of Provider, if separate from Health Plan’s QAPI activities, shall be integrated into the overall QAPI program. Requirements to participate in QAPI activities, including submission of complete encounter record, are hereby incorporated into this Agreement and Provider subcontracts and employment agreements. [19.3]

v. Consistent with 42 CFR sections 438.6(h) and 422.208, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to a Member. [20.6]

w. Provider’s service locations shall meet all requirements of the Americans with Disabilities Act, and all Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures which are applicable to health care facilities. [22.1]

x. Provider shall comply with Plan Requirements related to Member rights and responsibilities. [22.6]

y. Provider shall comply with Plan Requirements related to Member medical records, advance directives and grievances and appeals. [27.6-27.8]

z. A provider cannot enroll in Health Plan’s Participating Provider network if the provider has active sanctions imposed by Medicare or Medicaid or CHIP, if required licenses and certifications are not current, if money is owed to the Medicaid program, or if the Office of the Attorney General has an active fraud investigation involving the provider or the provider otherwise fails to satisfactorily complete the credentialing process. Health Plan shall obtain access to the National Practitioner Database as part of their credentialing process in order to verify a provider’s eligibility for network participation. [28.3]

aa. Provider shall have a Medicaid number assigned by the Department as a condition to participating in Health Plan’s Participating Provider networks under Kentucky Medicaid Contract. [28.5]

bb. Any Provider who engages in activities that result in suspension, termination, or exclusion from the Medicare or Medicaid program shall be terminated from participation in WellCare Plans effective as of the date of such suspension, termination or exclusion. [28.6]

c. If coverage of any Medicaid service provided by Provider requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be properly completed according to the appropriate Kentucky Administrative Regulation. Provider shall retain the form in the event of audit and a copy shall be submitted to the Department upon request. [30.1]

dd. Provider shall not bill a Member for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under this Agreement. According to the Kentucky Medicaid Contract, any Provider who knowingly and willfully bills a Member for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if Health Plan becomes insolvent. [30.4]
ee. The following applies if Provider is a primary care provider: Provider shall have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavior health problems and disorders. [33.7]

ff. The following applies if Provider provides behavioral health services: Provider shall ensure that all Members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within fourteen (14) days from the date of discharge. Provider will contact Members who have missed appointments within twenty-four (24) hours to reschedule appointments. [33.8]

gg. Provider shall comply with Plan Requirements and laws designed to prevent or ameliorate fraud, waste, and abuse, including applicable provisions of Federal criminal law, the False Claims Act (31 USC §§ 3729 et. seq.), and the anti-kickback statute (section 1128B(b) of the Social Security Act). Health Plan shall be entitled to audit Provider with respect to compliance issues, including their compliance programs, and require them to address compliance issues through education, counseling or corrective action plans. [36]

hh. Provider shall maintain its 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 Health Plan and Provider. These transactions shall include, but not be limited to, claims payment, refunds and adjustment of payments. [37.14]

ii. Provider shall comply with requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against Federal health care programs as described in the Kentucky Medicaid Contract and 42 CFR part 455 subpart B (Program Integrity: Medicaid). [37.15]

jj. Provider shall provide access to the medical record 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. Additionally, when a Member changes primary care providers, the medical records or copies of medical records shall be forwarded by Provider to the new primary care provider or Health Plan within ten (10) days from receipt of request. Primary care providers shall have Members sign a release of medical records before a medical record transfer occurs. [38.1]

kk. Provider shall comply with Plan Requirements and laws relating to confidentiality of Member information. [38.2]

ll. Provider shall provide written notice to Health Plan, so that Health Plan may meet its obligation to notify Finance pursuant to the terms of the Kentucky Medicaid Contract, of any legal action or notice listed below, within two (2) days following the date Provider becomes aware of:

i. Any action, proposed action, lawsuit or counterclaim filed against Provider, related in any way to the Kentucky Medicaid Contract;

ii. Any administrative or regulatory action, or proposed action, respecting the business or operations of Provider, related in any way to the Kentucky Medicaid Contract;

iii. The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider; and
iv. The payment of a civil fine or conviction of any person who has an ownership or controlling interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person’s involvement in a program under Medicare, Medicaid, or Title XX of the Social Security Act, or of fraud, or unlawful manufacture, distribution, prescription or dispensing of a controlled substance, as specified in 42 USC 1320a-7.

A complete copy of all documents, filings or notices shall accompany the notice to Health Plan. A complete copy of all further filings and other documents generated in connection with any such legal action shall be provided to Health Plan within five (5) days following the date Provider receives such documents. [40.1]

mm. Provider shall abide by the rules and regulations regarding the confidentiality of protected health information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164. [40.12]

9. Kentucky RFP Requirements. [Cites are to applicable sections of RFP]

a. Provider shall make all of its books, documents, papers, provider records, medical records, data, surveys and computer databases (collectively “Records”) available for examination and audit by the Department, the Attorney General of the Commonwealth of Kentucky, the Kentucky Department of Insurance, authorized federal or Commonwealth personnel, or the authorized representatives of the governments of the United States and the Commonwealth of Kentucky including, without limitation, any employee, agent, or subcontractor of the Department, Cabinet, CMS, or the Department’s fiscal agent.

Access shall be at the discretion of the requesting authority and shall be either through on site review of records or by submission of records to the office of the requesting authority. Any records requested shall be produced immediately for on-site reviews or sent to the requesting authority by mail within fourteen (14) days following a request. All records shall be provided at the sole cost and expense of Provider including, without limitation, any costs associated with making excerpts or transcripts, copying, reproducing, shipping and/or mailing of records. The Department shall have unlimited rights to use, disclose, and duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by Provider. [RFP § 030.090.170]

b. Provider 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 to Health Plan. All Federal and State regulations and statutes related to confidentiality shall be applicable to Provider. Provider shall have an appropriate agreement with its 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 and 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, through no act of Provider.

Provider shall have an appropriate agreement with its subcontractors extending these confidentiality requirements to all subcontractors’ employees. [RFP § 40.115]