AMENDMENT NUMBER 1 TO
MOLINA HEALTHCARE OF TEXAS
HOSPITAL SERVICE AGREEMENT

This Amendment to the Hospital Services Agreement (the "Amendment") is made and entered into by and between Molina Healthcare of Texas, Inc. a Texas Corporation ("Health Plan") and Dallas County Hospital District DBA Parkland Health and Hospital Systems, a political subdivision of the State of Texas and Hospital District of Dallas County Texas ("Provider"), to be effective as of March 1, 2012:

RECITALS

A. The parties have previously entered into that certain Hospital Service Agreement dated February 9, 2011 (the "Agreement").

B. The parties hereby agree to amend the Agreement in accordance with the terms and conditions of this Amendment.

NOW, THEREFORE, in consideration of the promises, covenants and warranties stated herein, Health Plan and Provider agree as follows:

Section 2.2d is hereby deleted in its entirety and shall be replaced with the following

2.2d Prior Authorization. Provider shall use commercially reasonable effort to verify eligibility of Members prior to rendering services. Except as otherwise provided below, prior to admitting any Member as an inpatient, Provider shall obtain the prior authorization from Health Plan in accordance with agreement unless the situation is one involving the delivery of Emergency Services. Except as otherwise provided below, for Emergency Services that result in an admission, Provider shall use commercially reasonable effort to notify Health Plan or its agent within two (2) business days of admission and shall request authorization from Health Plan. For non-emergent services, regardless of whether prior authorization was received, Provider shall materially cooperate and participate in Health Plan's notification procedures described in this agreement for all inpatient admissions (acute, rehabilitation, mental health and SNF) and Provider shall notify Health Plan of any admission within a maximum of two (2) business days of admission.
The following exceptions apply:

i. Obstretic (OB) Services (inclusive of both mother and child admission), shall not require authorization until after the 5th day of admission. Provider will provide a list of OB admissions via report within two (2) business days of admission.
ii. If extenuating circumstances exist that are outside of the control of Provider where Provider cannot provide notice or request the authorization of Health Plan within the time periods set set forth herein, (e.g. where Provider was not made aware that a patient was a Health Plan Member or the Member's eligibility was made retrospectively effective) then Provider will not be denied payment or penalized for late notification.
iii. Outpatient services shall not require authorization by Health Plan for reimbursement to Provider.

iv. Inpatient admissions that resulted in a one day length of stay will be reviewed by Health Plan for Medical Necessity utilizing Interqual criteria. The admission will either be authorized as Inpatient or if determined not to be Medically Necessary as a inpatient level of care then the Observation level of care shall be paid if present on the claim; provider however that if the Observation level of care was not deemed Medically Necessary then the claim shall be paid as an ER claim.

v. Expedited clinical appeals will be a nurse to nurse review. If the parties cannot agree upon the results of the appeal at this level, then the appeal will move to a physician to physician review. If the parties are still unable to agree upon the results of an appeal, the parties will move to an independent review in accordance with Texas HHSC guidelines. Health Plan may deny an clinical appeal if after three (3) business days of Provider's acknowledgementand receipt of a request from Health Plan for clinical information , such clinical information is not provided to Health Plan. Health Plan will not accept telephonic appeals Furthermore, Provider may always file appeals in accordance with Section 2.10.m of the Agreement.

1. Attachment C (Products/Programs) is hereby deleted in its entirety and shall be replaced with a new Attachment C (Products/Programs) attached hereto and incorporated herein.

2. Attachment D (Compensation Schedule) is hereby deleted in its entirety and shall be replaced with a new Attachment D (Compensation Schedule) attached hereto and incorporated herein.

2. Use of Defined Terms. Capitalized terms utilized in this Amendment shall have the same meanings ascribed to such terms in the Agreement.

3. Agreement Remains in Full Force and Effect. Except as specifically amended by this Amendment, the Agreement shall continue in full force and effect.

IN WITNESS WHEREOF, the parties hereto have agreed to and executed this Amendment by their duly authorized officers as of the Effective Date set forth by Health Plan below.

Parkland Health & Hospital System ***Molina Healthcare of Texas, Inc***

Provider Signature:		Molina Signature:	
Signatory Name (Printed):	JAMES F DOUGLAS	Signatory Name (Printed):	ZARINA SHOCKLEY-SPARLING
Signatory Title (Printed):	EVP & COO	Signatory Title (Printed):	REGIONAL VP
Signature Date:	7 March 2012	Signature Date:	3-14-12
		Effective Date:	March 1, 2012

ATTACHMENT C
Products/Programs

Provider hereby elects to participate as a panel provider for each of the Health Plan products indicated below.

STAR- **STAR or STAR Program** means the State of Texas Access Reform program and is administered through HMOs throughout the State of Texas. HHSC contracts with HMOs to provide, arrange, and coordinate preventive, primary, and acute care covered services to non-disabled, low-income children and families, and pregnant women, SSI and SSI- related adults and children who do not receive Medicare, pursuant to Title XIX of the Social Security Act and Texas Administrative Code, Title !, Part 15, Chapter 353.

CHIP HMO - **Children's Health Insurance Program** or **CHIP** means the health insurance program authorized and funded pursuant to Title XXI, Social Security Act (42 U.S.C. §§ 1397aa-1397jj) and administered by HHSC. (UMCC Att. A, Article 2. Definitions).

STAR+PLUS - **STAR+PLUS or STAR+PLUS Program** means the State of Texas Medicaid managed care program in which HHSC contracts with HMOs to provide, arrange, and coordinate preventive, primary, acute and long term care Covered Services to adult persons with disabilities and elderly persons age 65 and over who qualify for Medicaid through the SSI program and/or the MAO program. Children under age 21, who qualify for Medicaid through the SSI program, may voluntarily participate in the STAR+PLUS program. (UMCC Att. A, Article 2. Definitions)

CHIP PERINATE - **CHIP Perinatal Program** means the State of Texas program in which HHSC contracts with HMOs to provide, arrange for, and coordinate Covered Services for enrolled CHIP Perinate and CHIP Perinate Newborn Members. Although the CHIP Perinatal Program is part of the CHIP Program, for Contract administration purposes it is identified independently in this Contract. An HMO must specifically contract with HHSC as a CHIP Perinatal HMO in order to participate in this part of the CHIP Program. (UMCC Att. A, Article 2. Definitions).

Medicare Advantage (Molina Medicare Options)

Medicare Advantage-Special Needs Plan (Molina Medicare Options Plus)

ATTACHMENT D
Compensation Schedule

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

STAR, CHIP HMO, CHIP PERINATE, and STAR+PLUS: Covered Services shall be paid at in the amount set forth below:

Inpatient Services:

Covered Services shall be paid one hundred ten percent (110%) of Hospital's Standard Dollar Amount in accordance with the State of Texas Medicaid DRG reimbursement methodology in effect on the date of service;provided however that:

- Hospital inpatient services will not be subject to outlier payment adjustments with the exception of Neonatal DRGs (790-794); and
- Neonatal DRGs that meet the criteria for exceptionally high costs or exceptionally long lengths of stay will be reimbursed in accordance to the Texas Medicaid outlier methodology; and
- The 30 day Spell of Illness condition shall not apply

Outpatient Services:

Covered Services shall be paid at one hundred ten percent (110%) of the payable rate as defined below for the applicable service.

- Radiology services shall be paid at 110% of the then current Texas Medicaid Radiology Fee Schedule
- Labatory services shall be paid at 110% of the then current Texas Medicaid Interim Cost-to-Charge ratio less the Texas Medicaid high volume provider discount
- ASC/HASC services shall be paid at 110% of the then current Texas Medicaid ASC Grouper rate following the then current Texas Medicaid methodology
- Professional services shall be reimbursed at 110% of the then current Texas Medicaid Fee Schedule for professional services
- All other services shall be reimbursed at 110% of the then current Texas Medicaid Interim Cost-to-Charge ratio not reduced by any outpatient reduction factor

Notwithstanding the above, payment for for certain Covered Services where there is no payment rate in the State of Texas Medicaid Fee-For-Service Program fee schedule as of the date(s) of service, shall be paid at Provider's then current Interim Cost to Charge Ratio.

Network Access Assurance Payment:

In the event that HHSC allocates Network Access Assurance Payment or other similar payments to the Health Plan that have historically been paid or that are derived from amounts intended for payment to Provider for either hospital or professional services, the Health Plan will assure one

hundred percent (100%) of those funds are paid to the Provider within thirty (30) days of the Health Plan receiving such funds.

Medicare Advantage (Molina Medicare Options) and MA-SNP (Molina Medicare Options Plus): Covered Services shall be paid at an amount equivalent to one hundred and five (105%) of the Medicare Fee-For-Service Program allowable payment rates (adjusted for locality or geography), as of the date of service.