AMENDMENT TO MOLINA HEALTHCARE OF WASHINGTON, INC.

HOSPITAL SERVICES AGREEMENT

THIS AMENDMENT TO THE HOSPITAL SERVICES AGREEMENT ("Amendment") is made and entered by and between Molina Healthcare of Washington, Inc. ("Health Plan")(formerly QualMed Washington Health Plan, Inc.) and Harborview Medical Center ("Provider").

A. **Whereas,** Provider is a component of UW Medicine, a clinical enterprise of the University of Washington, an institution of higher education and agency of the state of Washington, consisting of the following components: University of Washington Medical Center, Harborview Medical Center, Northwest Hospital & Medical Center, Valley Medical Center, UW Physicians, the University of Washington School of Medicine, UW Neighborhood Clinics, and Airlift Northwest (collectively, "UW Medicine Component Units");

B. **Whereas,** Health Plan and Provider entered into a Hospital Services Agreement, effective February 26, 1996 as amended from time to time ("Agreement"); and

C. **Whereas,** Provider agrees to contract with Health Plan for Health Plan's Health Benefit Exchange products;

Now therefore, in consideration of the rights and obligations contained herein, Health Plan and Provider agree to amend the Agreement as follows:

1. Article 6 **Compensation and Payment**, subsection 6.1 is deleted and replaced with the following subsection 6.1:

   6.1 **Compensation.** Health Plan shall pay Provider for Clean Claims for Covered Services provided to Members, including Emergency Services, in accordance with applicable law and regulations and in accordance with the compensation schedule set forth in Attachment A and D-X, as applicable.

2. Article 6 **Compensation and Payment**, subsection 6.6, is deleted and replaced with the following subsection 6.6:

   6.6 **Co-payment, Deductibles and Co-Insurance.** Provider is responsible for collection of co-payments, deductibles and co-insurance, if any, provided for in the Member's Health Plan product. Medicaid Members, and those Members with dual coverage under the Medicare and Medicaid program ("Medi-Medi" beneficiaries), have no cost sharing including co-payments, deductibles or co-insurance when the State, Health Plan or another payor such as a Medicaid managed care plan is responsible for paying such amounts, and Provider agrees to accept payment from Health Plan as payment in full or bill the appropriate State source for any cost sharing that is covered by Medicaid.

3. Article 6 **Compensation and Payment**, subsection 6.10, is deleted and replaced with the following subsection 6.10:

6.10 **No Billing of Members.** Except as specifically provided for in this section, Provider agrees to seek payment from only Health Plan or a Capitated Provider for all Covered Services provided to a Member. In no event, including but not limited to, nonpayment by Health Plan or a Capitated Provider, insolvency by Health Plan or a Capitated Provider, or breach of the Agreement, shall Provider, or any person acting on Provider's behalf, bill, charge, collect a deposit or surcharge from, seek compensation from, or have any other recourse against a Member, or a person acting on the Member's behalf, for Covered Services provided pursuant to this Agreement. This prohibition does not apply to the following:

i. When a Member has dual coverage, Provider may bill both payors consistent with the coordination of benefits provision in Article 7.

ii. Provider may bill a Member for any applicable co-payment, deductible or co-insurance obligation in accordance with Article 6.

iii. Provider may seek payment from Member for services that are not Covered Services under the terms of this Agreement provided the payment is not for otherwise Covered Services which Health Plan determines not to have been Medically Necessary or in keeping with Health Plan's Utilization Review and Management Program and provided the Member signs a written waiver that meets the following criteria:

(a) The waiver notifies the Member that the medical service is a non-Covered Service;

(b) The waiver notifies the Member of the medical service being provided and the date(s) of service;

(c) The waiver notifies the Member of the approximate cost of the medical service; and

(d) The waiver is signed by the Member prior to receipt of the medical service.

4. Article 16 **Applicable Law** is amended by adding the following subsection 16.1:

16.1 For Covered Services rendered to Members enrolled in a Molina Health Benefit Exchange Product, Medicaid statutes and regulations referenced in this Agreement are inapplicable, and Provider shall comply with all statutory and regulatory requirements of the Washington Health Benefit Exchange Act, including the 2012 regular session laws, chapter 87 Affordable Care Act Implementation and regulations adopted pursuant to RCW 43.71.

5. Article 12 **Miscellaneous** is amended by adding the following subsection 12.5:

12.5 **Fraud and Abuse Reporting** Provider acknowledges that fraud, waste and abuse in the delivery of healthcare services is a significant concern to the State, federal government, and Health Plan. As such, Provider agrees to comply with RCW 48.135, concerning Insurance Fraud Reporting. Additionally, Provider agrees to notify Health Plan's compliance officer of all incidents or occasions of suspected fraud, waste or abuse involving services provided to any Member. Provider agrees to report a suspected incident of fraud, waste or abuse within ten (10) business days of the date Provider first becomes aware of, or is on notice of, such activity. The obligation to report suspected fraud, waste or abuse shall apply whether the suspected conduct was perpetrated by Provider, Provider's employee, agent, or subcontractor, or Member. Provider agrees to establish policies and procedures for identifying, investigating, and taking appropriate corrective action against suspected fraud, waste or abuse. Upon request by Health Plan or the State, Provider shall confer with the appropriate State agency prior to or during any investigation into suspected fraud, waste or abuse. For purposes of this section, the terms fraud and abuse shall have the same meaning as provided for in 42 CFR §455.2.

6. Article 12 **Miscellaneous**, subsection 12.1, is deleted and replaced with the following subsection 12.1:

12.1 **Entire Agreement.** This Agreement, together with Attachments, Amendments and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. Additionally, as to the Medicaid products offered by Health Plan, the contract between the Washington Department of Social and Health Services and the Health Plan shall be the guiding and controlling document when interpreting the terms of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement are of no force or effect.

7. Article 12 **Miscellaneous** is amended by adding the following subsection 12.7:

12.7 **Conflict with Health Plan Product.** Nothing in this Agreement modifies any benefits, terms or conditions contained in the Member's Health Plan product. In the event of a conflict between this Agreement and the benefits, terms, and conditions of the Health Plan product, the benefits, terms or conditions contained in the Member's Health Plan product shall govern.

8. All cross-references to Attachment A in the Agreement not specifically addressed by this Amendment are revised as follows:

"Attachment A or Attachment D-X, as applicable"

9. Article 1, **Definitions**, is amended by adding the following defined terms:

"**Health Benefit Exchange** means the Washington health benefit exchange established in RCW 43.71.020, et seq., the Health Benefit Exchange Act.

"**Molina Health Benefit Exchange Product** means those health benefit programs offered and sold by Health Plan to individuals who obtain health coverage through the Washington Health Benefit Exchange.

10. Attachment D-X, (Compensation Schedule-Molina Health Benefit Exchange Program), attached hereto, is added.

11. Attachment B, Participating Provider Contract Form, is amended by adding the following section (l):

(l). **Required Provisions (Health Care Service Plans)** Upon termination of this Agreement without cause, Provider will continue to render Covered Services to Members until the earliest of the following: (1) the date Covered Services being rendered to Member by Provider are completed or medically appropriate provisions have been made by Health Plan for another provider to assume responsibility for providing such Covered Services; or (2) sixty (60) days following notice to the Member of Provider's contract termination. The provision of such Covered Services and the reimbursement to Provider for such Covered Services shall be subject to all applicable terms of this Agreement on the same basis as Covered Services provided during the term of this Agreement.

12. There are no performance, bonus or special compensation programs applicable to the Molina Health Benefit Exchange Program. Any such additional compensation requires a written amendment to this Agreement.

15. Health Plan and Provider recognize that this Amendment and/or the Agreement may require further amendments in the event that any federal, state or local agency, administration, board or other governing body requires changes to this Amendment or Agreement as a condition of approval. Health Plan shall be entitled to revise this Amendment and the Agreement without the written agreement of Provider upon thirty (30) days prior written notice to Provider, if an additional amendment is being effected by Health Plan to comply with any federal, state or local agency, administration, board or other governing body request and/or regulatory requirement regarding the Health Benefit Exchange, such amendment shall be effective as of the effective date set forth in the amendment. Notwithstanding the above, Health Plan shall be entitled to amend the Agreement upon less than thirty (30) days prior written notice if a shorter notice period is required in order to comply with such federal, state or local agency, administration, board or other governing body request or regulatory requirement.

14. Effective Date. This Amendment shall become effective on the date this Amendment is signed by Health Plan, and renew with and under the terms of the Agreement.

15. Use of Defined Terms. Unless otherwise defined in this Amendment, capitalized terms utilized in this Amendment will have the same meaning(s) ascribed to such terms in the Agreement.

16. No Other Modifications. Except as provided herein, the terms and conditions of the Agreement shall remain the same, in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment by their officers thereunto duly authorized.

Provider Name		Molina Healthcare of ~~Washington~~, Inc.	
By:	Eileen Whalen	By:	
			Bela Biro
Its:	Executive Director	Its:	President
Date:	6/6/13	Date:	6-10-13

ATTACHMENT D-X
Compensation Schedule

MOLINA HEALTH BENEFIT EXCHANGE PROGRAM

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with the Molina Health Benefit Exchange Product program, 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:

Molina Health Benefit Exchange Product:

Inpatient Services:
Covered Services shall be paid at an amount equivalent to one hundred sixty percent (160%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date(s) of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date(s) of service, payment shall be at two hundred percent (200%) of the prevailing Medicaid Fee-For-Service Program allowable Inpatient rates, as of the date(s) of service. Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider's revised rate be that through its own research or notification from Provider or State.

Outpatient Services:
Covered Services shall be paid at an amount equivalent to one hundred sixty percent (160%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date(s) of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date(s) of service, payment shall be at two hundred percent (200%) of the prevailing Medicaid Fee-For-Service Program allowable Outpatient payment rates, as of the date(s) of service. Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider's revised rate be that through its own research or notification from Provider or State.