MOLINA Contract Administration

■ New Contract
❑ Amendment
❑ Settlement Agreement
❑ Letter of Agreement
❑ Other _____

Contract Cover Sheet

JUL 21 2011

❑ New Provider ■ Existing Provider

MHC **For Provider Services & Contracting Use Only**

CONTRACT ENTITY: St Mary Medical Center - Apple Valley

TAX ID: 95-1914489

Effective Date of Contract: 09/01/2011

SENT DATE: (if hand delivered enter delivery date):

RECEIVED DATE: (returned for countersignature): 07/21/2011

COUNTY: ☐ Los Angeles ☒ Inland Empire ☐ Sacramento ☐ San Diego

CONTRACT TYPE: ☐ Group/IPA ☐ PCP ☒ Hospital ☐ Ancillary ☐ Specialist

Contract Negotiator:

☐ Shronda Bethany ☐ John Arce-Ignacio ☐ Milaine Isaac ☐ Lanette Cody ☒ Dolores Olague-Swanson
☐ Sabra Matovsky ☐ David Church ☐ Adriana Cuellar ☐ Linda Baez ☐ Other _____

Product Line & Rates

☒ MEDI-CAL	☒ HEALTHY FAMILIES	☒ MMO	☒ MMOP
☐ _____ PMPM	☐ _____ PMPM	☐ _____ PMPM	☐ _____ PMPM
☐ _____ % Medi-Cal FFS*	☐ _____ % Medi-Cal FFS*	☐ _____ FFS RATES*	☐ _____ FFS RATES*
☐ _____ % M-CARE FFS*	☐ _____ % M-CARE FFS*	*Default Comp.: _____	*Default Comp.: _____
*Default Comp.: _____	*Default Comp.: _____	☒ CUSTOM (refer to contract)	☒ CUSTOM (refer to contract)
☒ CUSTOM (refer to contract)	☒ CUSTOM (refer to contract)		

Configuration Required: ☐ NO ☒ YES-Date CCRF submitted to MHC Business Applications Dept: July 27, 2011

☐ **Contract Proofing Checklist fully completed and attached**
(N/A for Settlements, or Amendments that do not require both parties signature)

Provider Services & Contracting Sign-Off:

Contract Negotiator or Manager: _____ Contracting Director: Maggie Holl

For Contract Administration Use Only

CATS Tracking Number:		#12452
CCRF completed/closed:	☑ YES, Date:	9.25.11
Contract sent to Molina signatory for countersignature:	☑ YES, Date:	7.21.11
Contract received fully executed:	☑ YES, Date:	8.4.11
PIM Notified (if applicable):	☑ YES, Date:	8.29.11
PIM Update Completed (if applicable):	☑ YES, Date:	9.8.11
Update approp. Master List (IPA, Primary Care, Specialty, Hospital, Ancillary):	☑ YES, Date:	10.11.11
Return one contract back to Provider with welcome letter:	☑ YES, Date:	10.11.11
Contract Uploaded to CAD SharePoint:	☑ YES, Upload Date:	10.20.11
Contract Uploaded to Emptoris:	☑ YES, Upload Date:	10.20.11
Emptoris Contract ID:		5837

Cover Sheet Reviewed By: Rekesha Tillis 7/21/11 **Contract Administration Manager:** 7.21.11

Notes:

MOLINA

Contract Proofing Checklist

CONTRACT ENTITY: St. Mary Medical Center – Apple Valley EFFECTIVE DATE: 09/01/2011

TAX ID: 95-1914489

CONTRACT TYPE: ☐ IPA ☐ PCP ■ Hospital ☐ Specialty ☐ Ancillary

For New Agreements & Model K's – All verifications are required (1-18) unless noted otherwise.

For Amendments – Items 1-10 are required unless noted otherwise.

For all other documents, refer to Contract Proofing Checklist - Verification Reference Sheet for listing of required verifications by document type.

#	QA 1 ✓	QA 2 ✓	VERIFICATIONS QA1 Performed By Provider Services & Contracting | QA2 Performed By Contract Administration
1	■	☑	Non-Emptoris Contract and/or Non Standard Provisions: ■ NO ☐ YES-approval documentation attached.
2	■	☑	Minimum of one complete set of original agreements/amendments are signed by provider.
3	■	☑	No unauthorized changes to contract language entered by provider, e.g., strike-out, white-out, other annotations.
4	■	☑	Contract Cover Sheet attached. And, if applicable: Product Lines and Rates information matches w/contract.
5	■	☑	Attached a copy of the cover letter sent with proposed agreement to provider, and any other key correspondence for contract file as provided by Provider Contracting & Services.
6	■	☑	Non Standard Compensation negotiated: ☐ NO ■ YES-approval documentation attached. *(N/A for amendments that do not contain compensation section).*
7	■	☑	Product/Programs and Compensation Schedule are consistent - rates have been negotiated for all designated lines of business, and vice versa. *(N/A for amendments that do not contain this section).*
8	■	☑	All pages of Compensation Schedule are initialed *(N/A for amendments that do not contain this section).*
9	■	☑	Disclosure Form is fully completed and signed. *(N/A for amendments that do not contain this section).*
10	■		Negotiated product line(s) is consistent with provider type and/or physician practice restrictions. *(N/A for amendments that do not contain Product Lines section).*
11	■	☑	Provider Identification Sheet is fully completed and signed.
12	■	☑	Certificate of Ownership is fully completed and signed.
13	■	☑	W-9 attached / Legal Entity Name is the same on W-9, Agreement, Cover Sheet & Proofing Checklist.
14	■	☑	CPPA/HDO Application(s) submitted to Credentialing Dept (*if applicable*): Date submitted: # of apps:
15	☐	☐	Provider Data Form (PDF) and/or Group Roster attached (*New Agreements - PCP & Specialists*).
16	☐		Hospital/facility privileges consistent with contracted network of hospitals/facilities *(New Agreements- PCP & Specialists).*
17	☐		Hospital privileges consistent with PDF and credentialing form *(New Agreements-Direct PCP & Specialists).*
18	☐		Due Diligence IPA Pre-contractual Application complete and submitted to Provider Compliance Department *(IPA only).* Date submitted:

All required verifications performed as indicated above.

QA 1 – Contract Negotiator or Manager
(Signature and date): [signature] 7/20/11

QA 2 – Contract Administration
(Signature and date): Jekeisha Ellis 8/4/2011

***FOR CONTRACT ADMINISTRATION USE ONLY**

☐ QA REJECTION By: _____ Date: _____

Rejection Reason:

Approved By Contract Administration Manager:

MOLINA HEALTHCARE OF CALIFORNIA

HOSPITAL SERVICES AGREEMENT

This Hospital Services Agreement ("Agreement") is entered by and between Molina Healthcare of California, a California corporation ("Health Plan"), and ST MARY MEDICAL CENTER - APPLE VALLEY.

RECITALS

A. Health Plan arranges for the provision of certain health care services to Members pursuant to contracts with various government sponsored health programs. Health Plan intends to participate in additional government sponsored health programs and offer other health products as the opportunities become available.

B. Health Plan arranges for the provision of certain health care services to Members by entering into provider service agreements with individual physicians, groups of physicians, individual practice associations, hospitals, clinics, ancillary health providers, and other health providers.

C. Provider is licensed to render hospital inpatient and outpatient services and desires to provide such services to Health Plan's Members in connection with Health Plan's contractual obligations to provide and/or arrange for Health Care Services for Health Plan's Members.

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

ARTICLE ONE - DEFINITIONS

1.1 Provider means the health care professional(s), or entity(ies) identified in Attachment A to this Agreement.

1.2 Capitalized words or phrases in this Agreement shall have the meaning set forth in Attachment B.

ARTICLE TWO - PROVIDER OBLIGATIONS

2.1 **Serving as a Panel Provider.** Provider shall provide hospital inpatient and/or outpatient services to Members for the products specified in Attachment C. Provider agrees that its facility information may be used in Health Plan's provider directories, promotional materials, advertising and other informational material made available to the public and Members. Facility information includes, but is not limited to, name, address, telephone number, hours of operation, and services.

Provider shall promptly notify Health Plan of any changes in this practice information.

2.2 **Standards for Provision of Care.**

a. **Provision of Covered Services.** Provider shall provide Covered Services to Members, within the scope of Provider's license, in accordance with this Agreement, Health Plan's policies and procedures, the terms and conditions of the Health Plan product which covers the Member, and the requirements of any applicable government sponsored program.

b. **Standard of Care.** Provider shall provide Covered Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements.

c. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel and administrative services shall be at a level and quality as necessary to perform Provider's duties and responsibilities under this Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act.

d. **Prior Authorization.** Provider shall verify eligibility of Members prior to rendering services. Prior to admitting any Member as an inpatient or outpatient, Provider shall obtain the prior authorization of Health Plan in accordance with Health Plan's Provider Manual unless the situation is one involving the delivery of Emergency Services. For Emergency Services that result in an admission, Provider shall notify Health Plan or its agent within twenty-four (24) hours of admission and shall request authorization from Health Plan prior to the provision of any post-stabilization care. For non-emergent services, regardless of whether prior authorization was received, Provider shall cooperate and participate in Health Plan's notification procedures described in the Provider Manual for all inpatient admissions (acute, rehabilitation, mental health and SNF) including admissions resulting from an outpatient visit, and Provider shall notify Health Plan of any admission within twenty-four (24) hours of admission.

e. **Contracted Providers.** Except in the case of Emergency Services or upon prior authorization of Health Plan, Provider shall use only those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan ("Participating Providers").

f. **Prescriptions.** Except with respect to prescriptions and pharmaceuticals ordered for in-patient hospital services, Provider shall abide by Health Plan's drug formularies and prescription policies, including those regarding the

prescription of generic or lowest cost alternative brand name pharmaceuticals. Provider shall obtain prior authorization from Health Plan if Provider believes a generic equivalent or formulary drug should not be dispensed. Provider acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.

g. **Availability of Services.** Provider shall make Covered Services available twenty-four (24) hours a day, seven (7) days a week. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

h. **Hospital Services** are those Plan benefits to include short term inpatient or outpatient general hospital services including room with customary furnishings and equipment, meals (including special diets as medically necessary), general nursing care, use of operating room and related facilities, intensive care unit and services, emergency services, drugs, including drugs to be dispensed at time of emergency room visit in amount sufficient to last until such time Member can reasonably be expected to fill a prescription, medications, biological, anesthesia and oxygen services, ambulatory care services, diagnostic laboratory and x-ray services, special duty nursing as medically necessary, physical therapy, respiratory therapy, administration of blood and blood products, and diagnostic, therapeutic and rehabilitative services as appropriate, and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

2.3 **Standards for Hospital Providers.**

a. **Hospital Providers.** Provider shall have a sufficient number of Hospital Providers to provide Covered Services and meet the needs of Health Plan and its Members as determined by Health Plan's Quality Improvement Program and in accordance with state and federal law. Provider shall be responsible for the Covered Services provided by Hospital Providers.

b. **Contract with Hospital Providers.** Provider's contract with its Hospital Providers shall be in writing and shall bind Hospital Providers to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance and billing of Members for Covered Services.

c. **Hospital Provider Information.** Upon request, Provider shall provide Health Plan with a complete list of its Hospital Providers, together with the provider specific information required by Health Plan for credentialing and for administration of its health programs.

d. **Restriction, Suspension or Termination of Hospital Provider(s).** Provider shall immediately restrict, suspend or terminate Hospital Providers(s) from providing Covered Services to Members in the following circumstances: (i) the Hospital Provider(s) ceases to meet the licensing/certification requirements or other professional standards as specified in this Article; or (ii) Health Plan or Provider reasonably determine that there are serious deficiencies in the quality of care of the applicable Hospital Provider(s) which affects or could adversely affect the health or safety of Members.

e. **Staffing Privileges.** Provider agrees to use its best efforts to arrange staff privileges or other appropriate access for Health Plan's contracted providers, Health Plan's medical directors 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. Individual providers must apply for staff privileges.

f. **Notification.** Provider shall notify Health Plan within five (5) business days of becoming aware of any of its Hospital Provider(s) who cease to meet the licensing/certification requirements or other professional standards as described in this Agreement. Provider will notify Health Plan within five (5) business days should any disciplinary or other action of any kind be initiated against any Health Plan contracted provider, medical director or hospitalist provider which could result in any suspension, reduction or modification of his/her hospital privileges. Provider's notification to Health Plan shall state Provider's actions taken against the Hospital Provider or Health Plan provider. If Provider fails to act as required by this Article with respect to any of its Hospital Provider(s) or Health Plan reasonably determines and provides documentation to Provider that there are serious deficiencies in the professional competence, conduct, or quality of care of the Hospital Provider which could adversely affect the health and safety of Members, Health Plan shall have the right to prohibit such Hospital Provider(s) from continuing to provide Covered Services to Members.

2.4 **Nondiscrimination.**

a. **Enrollment.** Provider shall not differentiate or discriminate in providing Covered Services to Members 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 shall render Covered Services to Members in the same location, in the same manner, in accordance with the same standards, and within the same time availability regardless of payor.

b. **Employment.** Provider shall not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure,

terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical, sensory or mental disability unrelated to the individual's ability to perform the duties of the particular job or position.

2.5 **Recordkeeping.**

a. **Maintaining Member Medical Records.** Provider shall maintain a medical record for each Member to whom Provider renders health care services. Provider shall open each Member's medical record upon the Member's first encounter with Provider. The Member's medical record shall contain all information required by state and federal law, generally accepted and prevailing professional practice, applicable government sponsored health programs, and all Health Plan policies and procedures. Provider shall retain all such records for at least ten (10) years.

b. **Confidentiality of Member Health Information.** Provider shall comply with all applicable state and federal laws, Health Plan's policies and procedures, government sponsored program requirements regarding privacy and confidentiality of Members' health information and medical records, including mental health records. Provider shall not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or medical records without obtaining appropriate authorization to do so. This provision shall not affect or limit Provider's obligation to make available medical records, encounter data and information concerning Member care to Health Plan, any authorized state or federal agency, or other Providers of health care upon authorized referral.

c. **HIPAA.** To the extent Provider is considered a covered entity under the Health Insurance Portability and Accountability Act ("HIPAA"), Provider shall comply with all provisions of HIPAA including, but not limited to, provisions addressing privacy, security, and confidentiality.

d. **National Provider Identification ("NPI").** In accordance with applicable statutes and regulations of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Provider shall comply with the Standard Unique Identifier for Health Care Provider regulations promulgated under HIPAA (45 CFR Section 162.402, et seq.) and use only the NPI to identify HIPAA covered health care providers in standard transactions. Provider shall obtain an NPI from the National Plan and Provider Enumeration System ("NPPES") for itself or for any subpart of the Provider. Provider shall make best efforts to report its NPI and any subparts to Health Plan. Provider shall report any changes in its NPI or subparts to Health Plan within thirty (30) days of the change. Provider shall use its NPI to identify itself on all claims and

encounters (both electronic and paper formats) submitted to Health Plan.

e. **Delivery of Patient Care Information.** Provider shall promptly deliver to Health Plan, upon request and/or as may be required by state or federal law, Health Plan's policies and procedures, applicable government sponsored health programs, Health Plan's contracts with the government agencies, or third party payers, any information, statistical data, encounter data, or patient treatment information pertaining to Members served by Provider, including but not limited to, any and all information requested by Health Plan in conjunction with utilization review and management, grievances, peer review, HEDIS Studies, Health Plan's Quality Improvement Program, or claims payment. Provider shall further provide direct access at reasonable times to said patient care information as requested by Health Plan or as required by any governmental agency or any appropriate state and federal authority having jurisdiction over Health Plan. Health Plan shall have the right to withhold compensation from Provider in the event that Provider fails or refuses to promptly provide any such information to Health Plan.

f. **Member Access to Health Information.** Provider shall give Health Plan and Members access to Members' health information including, but not limited to, medical records and billing records, in accordance with the requirements of state and federal law, applicable government sponsored health programs, and Health Plan's policies and procedures.

2.6 **Program Participation.**

a. **Participation in Grievance Program.** Provider shall participate in Health Plan's Grievance Program and shall cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries.

b. **Participation in Quality Improvement Program.** Provider shall participate in Health Plan's Quality Improvement Program and shall cooperate with Health Plan in conducting peer review and audits of care rendered by Provider.

c. **Participation in Utilization Review and Management Program.** Provider shall participate in and comply with Health Plan's Utilization Review and Management Program, including all policies and procedures regarding prior authorizations, and shall cooperate with Health Plan in audits to identify, confirm, and/or assess utilization levels of Covered Services.

d. **Participation in Credentialing.** Provider shall participate in Health Plan's credentialing and re-credentialing process and shall satisfy, throughout the term of this Agreement, all credentialing and re-credentialing criteria established by the Health Plan. Provider shall immediately notify Health Plan

of any change in the information submitted or relied upon by Provider to achieve credentialed status. If Provider's credentialed status is revoked, suspended or limited by Health Plan, Health Plan may at its discretion terminate this Agreement and/or move Members to another hospital.

e. **Provider Manual.** Provider shall comply and render Covered Services according to contracted services within agreement and in accordance with the contents, instructions and procedures set forth in Health Plan's Provider Manual, which may be amended from time to time. Health Plan's Provider Manual is incorporated in this Agreement by this reference.

f. **Health Education/Training.** Provider shall participate in and cooperate with Health Plan's Provider education and training efforts as well as Member education and efforts. Provider shall also comply with all Health Plan health education, cultural and linguistic standards, policies, and procedures, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers, the state, or federal government. Provider shall promptly deliver to medical staff, all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Covered Services to Members.

2.7 **Promotional Activities.** At the request of Health Plan, Provider shall (a) display Health Plan promotional materials in its offices and facilities as practical, and (b) shall cooperate with and participate in all reasonable Health Plan's marketing efforts. Provider shall not use Health Plan's name in any advertising or promotional materials without the prior written permission of Health Plan.

2.8 **Licensure and Standing.**

a. **Licensure.** Provider warrants and represents that it is appropriately licensed as a general acute care hospital to render health care services. Provider shall provide evidence of licensure to Health Plan upon request. Provider shall maintain its licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Provider shall immediately notify Health Plan of any change in Provider's licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Provider.

b. **Unrestricted Status.** Provider warrants and represents that it has not been convicted of crimes as specified in Section 1128 of the Social Security Act (42 U.S.C. 1320a-7), excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of Section 1128, entered into a contractual relationship with an entity convicted of a crime specified in Section 1128, or taken any other action that would prohibit it from participation in Medicaid and/or state health care programs.

c. **Malpractice and Other Actions.** Provider shall give immediate notice to Health Plan of: (a) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (b) any criminal investigations or proceedings against Provider; (c) any convictions of Provider for crimes involving moral turpitude or felonies; and (d) any civil claim asserted against Provider that may jeopardize Provider's financial soundness.

d. **Liability Insurance.** Provider shall maintain premises and professional liability insurance in coverage amounts appropriate for the size and nature of Provider's facility and the nature of Provider's health care activities. 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 shall deliver copies of such insurance policies to Health Plan within five (5) business days of a written request by Health Plan.

2.9 **Claims Payment.**

a. **Submitting Claims.** Provider shall promptly submit to Health Plan claims for Covered Services rendered to Members. All claims shall be submitted in a form acceptable to and approved by Health Plan, and shall include any and all medical records pertaining to the claim if requested by Health Plan or otherwise required by Health Plan's policies and procedures. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted by Provider to Health Plan within one hundred and twenty (120) days of providing the Covered Services that are the subject of the claim shall not be eligible for payment, and Provider hereby waives any right to payment therefor.

b. **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 D. Provider shall accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for services provided under this Agreement. Provider shall not balance bill Members for any Covered Services.

c. **Co-payments and Deductibles.** Provider is responsible for collection of co-payments and deductibles, if any.

d. **Coordination of Benefits.** Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Provider shall make reasonable inquiry of Members to learn whether 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, and Provider shall

immediately notify Health Plan of said entitlement. In the event that coordination of benefits occurs, Provider shall 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 Attachment D.

e. **Payments which are the Responsibility of a Capitated Provider.** Provider agrees that if Provider is or becomes a party to a subcontract or other agreement with a provider contracted with Health Plan, who receives a global capitation from Health Plan for both professional and facility services and is responsible for arranging for Covered Services through subcontract arrangements ("Capitated Provider"), that Provider shall look to the Capitated Provider, and not Health Plan, for payment of Covered Services provided to Members that are covered by Health Plan's agreements with such Capitated Providers.

2.10 **Claims Review.**

a. **Emergency Room.** For admissions through the Emergency Room in which there is: (a) a direct admission to Provider's intensive care units for the provision of Emergency Services, (b) a direct transfer to Provider's operating room for the provision of Emergency Services, or (c) an authorization by Health Plan or its agents for the provision of post-stabilization care, Health Plan will not retrospectively deny payment for the day of admission. For all other services, including those admissions through the Emergency Room that resulted in a one (1) day admission, Health Plan reserves the right to retrospectively review such claims to determine if such services were Medically Necessary and may deny payment for any such services which do not constitute Covered Services. Notwithstanding the foregoing, Provider is not required to obtain authorization from Health Plan prior to the provision of Emergency Services and care necessary to stabilize a Member's emergency medical condition. Health Plan will not retrospectively deny payment for any services rendered by Provider in good faith pursuant to the prior authorization of Health Plan.

b. **Authorized Services.** Health Plan is responsible for the authorization of medical services provided to Members. If Provider has obtained concurrent or prior authorization for a Covered Service provided to a Member, Health Plan will not retrospectively deny payment for such authorized Covered Service, unless Provider's claim and/or medical record for such services do not support the specific services and/or level of care authorized by Health Plan. Health Plan shall conduct medical management throughout the course of treatment. Provider acknowledges that initial and subsequent authorizations shall be obtained as necessary.

c. **Reporting Requirements.** Provider's failure to comply with Health Plan's requirements regarding Provider's identification and reporting of institutional and outpatient services, admissions, and/or related services to Health Plan or to obtain authorization as required may result in non-payment to Provider for all days and charges until the day that notification is received and services are authorized.

d. **Offset.** In the event that Health Plan determines that a claim has been overpaid or paid in duplicate, or that funds were paid which were not provided for under this Agreement, Provider shall make repayment to Health Plan within thirty (30) working days of written notification by Health Plan of the overpayment, duplicate payment, or other excess payment. In addition to any other contractual or legal remedy, Health Plan may recover the amounts owed by way of offset or recoupment from current or future amounts due Provider by giving Provider not less than thirty (30) working days notice in which to exercise Provider's appeal rights under this Agreement. As a material condition to Health Plan's obligations under this Agreement, Provider agrees that the offset and recoupment rights set forth herein shall be deemed to be and to constitute rights of offset and recoupment authorized in state and federal law or in equity to the maximum extent legally permissible, and that such rights shall not be subject to any requirement of prior or other approval from any court or other governmental authority that may now or hereafter have jurisdiction over Health Plan and/or Provider.

e. **Claims Review and Audit.** Provider acknowledges Health Plan's right to review Provider's claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to, current UB manual and editor, current CPT and HCPCS coding, CMS billing rules, CMS bundling/unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS multiple procedure billing rules, and FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Provider acknowledges Health Plan's right to conduct such review and audit on a line-by-line basis or on such other basis as Health Plan deems appropriate, and Health Plan's right to exclude inappropriate line items to adjust payment and reimburse Provider at the revised allowable level. Provider also acknowledges Health Plan's right to conduct utilization reviews to determine medical necessity and to conduct post-payment billing audits. Provider shall 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 shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Health Plan's policies and data to determine the appropriateness of the billing, coding and payment.

2.11 **Compliance with Applicable Law.** Provider shall comply with all applicable state and federal laws governing the delivery of Covered Services to Members

including, but not limited to, title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation act of 1973; the Balanced Budget Act of 1997; and the Americans with Disabilities Act:

a. Provider acknowledges that this Agreement and all Covered Services rendered pursuant to this Agreement are subject to state licensing statutes and regulations set forth in Attachment E.

b. Provider acknowledges that all Covered Services rendered in conjunction with the state Medicaid program are subject to the additional provisions set forth in Attachment F, the effect of which provisions is limited solely to activities and Covered Services related to the state Medicaid program.

c. Provider acknowledges that all Covered Services rendered in conjunction with the Medicare program are subject to the Medicare provisions set forth in Attachment H, the effect of which provisions is limited solely to activities and Covered Services related to the Medicare program.

2.12 **Provider Non-solicitation Obligations.** Provider shall not unilaterally assign or transfer patients served under this Agreement to another hospital without the prior written approval of Health Plan. Nor shall Provider solicit or encourage Members to select another health plan for the primary purpose of securing financial gain for Provider. Nothing in this provision is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities.

2.13 **Fraud and Abuse Reporting.** Provider shall report to Health Plan's compliance officer all cases of suspected fraud and/or abuse, as defined in Title 42, of the Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) state working days of the date when Provider first becomes aware of, or is on notice of, such activity. Provider shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medicaid program. Upon the request of Health Plan and/or the state, Provider shall consult with the appropriate state agency prior to and during the course of any such investigations.

2.14 **Advance Directive.** Provider shall document all patient records with respect to the existence of an Advance Directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other appropriate laws.

2.15 **Reciprocity Agreements.** Provider shall cooperate with Health Plan's Participating Providers and affiliates of Health Plan and agrees to provide Covered Services to Members enrolled in various government sponsored health

programs and other health products, and various government sponsored health programs and other health products of affiliates, and to assure reciprocity of health care services. Without limiting the foregoing, if any Member receives services or treatment constituting Covered Services from Provider and a capitated Participating Provider is financially responsible for such services, such Participating Provider shall be solely responsible for compensating Provider for any Covered Services provided by the Provider in accordance with the applicable Payments which are the Responsibility of a Capitated Provider provisions of this Agreement. Payment by the Participating Provider shall be at; (i) the rates agreed by the Participating Provider and Provider, or (ii) if there is no applicable agreement, at the lesser of Provider's billed charges or an amount equivalent to one hundred percent (100%) of the governing rates provided by applicable State and Federal Law specific to the Member's enrolled benefit plan (i.e. Medicaid, Medicare, etc) in place at the time services are rendered, or (iii) at the election of the Participating Provider, at the rates set forth in this Agreement. Provider agrees that the applicable provisions of the Compensation section of this Agreement shall continue to be binding upon Provider, especially in that Provider shall not balance bill Members for any Covered Services. Provider shall comply with the procedures established by Health Plan or its affiliates and this Agreement for reimbursement of such services or treatment. Provider shall not encourage Members to receive Covered Services from non-Participating Providers. Breach of this section shall constitute breach of a material term of the Agreement and will give rise to cause for termination of this Agreement pursuant to the applicable Termination with Cause provisions of this Agreement. Provider shall abide by all provisions of this Agreement relating to non-billing of Members with respect to all services and treatment subject to this reciprocity arrangement.

ARTICLE THREE - HEALTH PLAN'S OBLIGATIONS

3.1 **Compensation.** Health Plan shall pay Provider in accordance with the terms and conditions of this Agreement and the compensation schedule set forth in Attachment D.

3.2 **Member Eligibility Determination.** Health Plan shall maintain data on Member eligibility and enrollment. Health Plan shall promptly verify Member eligibility at the request of Provider.

3.3 **Prior Authorization Review.** Health Plan shall timely respond to requests for prior authorization and/or determination of Covered Services.

3.4 **Medical Necessity Determination.** Health Plan's determination with regard to Medically Necessary services and scope of Covered Services, including determinations of level of care and length of stay benefits available under the Member's health program shall govern. The primary concern with respect to all medical determination shall be in the interest of the Member.

3.5 **Provider Directory.** Health Plan will provide Members with access to Health Plan's Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan contracted providers.

3.6 **Provider Services.** Health Plan will maintain a Provider Manual describing Health Plan's policies and procedures, Covered Services, limitations and exclusions, and coordination of benefits information. Health Plan will maintain a Provider Services Department available to educate Provider regarding Health Plan's policies and procedures.

3.7 **Medical Director.** Health Plan will employ a physician as medical director who shall be responsible for the management of both the; (i) medical, and (ii) medically-related scientific and technical, aspects of Health Plan.

ARTICLE FOUR - TERM AND TERMINATION

4.1 **Term.** This Agreement shall commence on the effective date indicated by Health Plan on the signature page of this Agreement ("Effective Date") and shall continue in effect for one year; thereafter, it shall automatically renew for successive one (1) year terms unless and until terminated by either party in accordance with the provisions of this Agreement or in accordance with applicable provisions set forth in the attachments.

4.2 **Termination without Cause.** This Agreement may be terminated without cause by either party on at least ninety (90) days written notice to the other party.

4.3 **Termination with Cause.** In the event of a breach of any 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(s) that the other party has breached the Agreement. The party receiving the notice of termination shall 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 good faith 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 provided the notice of termination shall have the right to immediately terminate this Agreement.

4.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, Health Plan may immediately terminate this Agreement and transfer Member(s) to another provider by giving notice to Provider in the event of any of the following:

a. Provider's license or certificate to render health care services is limited, suspended or revoked, or disciplinary proceedings are commenced against

Provider by the state licensing authority;

b. Provider fails to maintain insurance required by this Agreement;

c. Provider loses credentialed status;

d. Provider 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 is appointed by appropriate authority;

e. Health Plan determines that Provider's facility and/or equipment is insufficient to render Covered Services to Members;

f. Provider is excluded from participation in Medicare and state health care programs pursuant to Section 1128 of the Social Security Act or otherwise is terminated as a provider by any state or federal health care program;

g. Provider engages in fraud or deception, or knowingly permits fraud or deception by another in connection with Provider's obligations under this Agreement.

h. Health Plan determines that health care services are not being properly provided, or arranged for, and that such failure poses a threat to Members' health and safety.

ARTICLE FIVE - GENERAL PROVISIONS

5.1 **Indemnification.** Each party shall 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 and/or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

5.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor shall 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 the provisions of this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained shall prevent any of the parties from entering into similar arrangements with other parties. Each of the parties shall maintain separate and independent management and shall be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor shall be construed to create, any right in any third party, including but not limited to Health Plan's Members. Nor shall any third party

have any right to enforce the terms of this Agreement.

5.3 **Entire Agreement.** This Agreement, together with Attachments 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. The contract between the state and the Health Plan is incorporated herein by reference and 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.

5.4 **Severability.** If any 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 shall remain in full force and effect and shall in no way be affected, impaired, or invalidated as a result of such decision.

5.5 **Non-exclusivity.** This Agreement shall not be construed to be an exclusive Agreement between Health Plan and Provider. Nor shall it be deemed to be an Agreement requiring Health Plan to refer Members to Provider for health care services.

5.6 **Amendment.** Health Plan may, without Provider's consent, amend this Agreement to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement upon forty-five (45) business days' notice to Provider unless a shorter timeframe is necessary for compliance. Health Plan may otherwise materially amend this Agreement only after forty-five (45) business days prior written notice to Provider and only if mutually agreed to by the parties as evidenced by the amendment being executed by each party hereto.

5.7 **Assignment.** Provider may not assign, transfer, subcontract or delegate, 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 Health Plan and Provider and their respective successors in interest and assigns. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment.

5.8 **Arbitration.** Any claim or controversy arising out of or in connection with this Agreement shall be resolved, to the extent possible, within forty-five (45) days through informal meetings and discussions held in good faith between appropriate representatives of the parties. Any remaining claim or controversy shall be settled by binding arbitration administered by the American Arbitration Association ("AAA") in accordance with its Commercial Arbitration Rules then in effect by a single arbitrator in Long Beach, CA; provided, however, that binding arbitration shall not be utilized to adjudicate matters that primarily involve review of Provider's professional competence or professional conduct, and shall not be

available as a mechanism for appeal of any determinations made as to such matters. If possible, the arbitrator shall be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care. The parties shall conduct a mandatory settlement conference at the initiation of arbitration, to be administered by AAA. The arbitrator shall have no authority to provide a remedy or award damages that would not be available to such prevailing party in a court of law, nor shall the arbitrator have the authority to award punitive damages. Each party shall bear its own costs and expenses, including its own attorneys' fees, and shall bear an equal share of the arbitrator's and administrative fees of arbitration. The parties agree to accept any decision by the arbitrator 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. Arbitration must be initiated within one year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered with reasonable diligence; otherwise it shall be deemed waived. The use of binding arbitration shall not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

5.9 **Attachments.** Each of the Attachments identified below is hereby made a part of this Agreement

Attachment A – Provider Identification Sheet
Attachment B – Definitions
Attachment C – Products/Programs
Attachment D – Compensation Schedule
Attachment E – Licensing Provisions
Attachment F – Medicaid Program Provisions
Attachment G – Acknowledgment of Receipt of Provider Manual
Attachment H – Medicare Program Provisions
Attachment I – Disclosure Form
Attachment J – Certificate of Ownership

5.10 **Notice.** All notices required or permitted by this Agreement shall be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, with postage prepaid, or by Federal Express or other overnight courier that guarantees next day delivery, or by facsimile transmission, and shall be deemed sufficiently given if served in the manner specified in this Section. The addresses below shall be the particular party's address for delivery or mailing of notice purposes:

If to Health Plan:
Molina Healthcare of California
200 Oceangate, Suite 100, Long Beach, California, 90802
Attention: President/CEO

If to Provider:

ST MARY MEDICAL CENTER - APPLE VALLEY
18300 Highway 18, Apple Valley, CA, 92307, USA
Attention: Director, Network Development,

The parties may change the names and addresses noted above through written notice in compliance with this Section. Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the United States Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

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SIGNATURE AUTHORIZATION

IN WITNESS WHEREOF, the parties hereto have agreed to and executed this Agreement by their officers thereunto duly authorized as of the Effective Date set forth by Health Plan below. The individual signing below on behalf of Provider acknowledges, warrants, and represents that said individual has the authority and proper authorization to execute this Agreement on behalf of Provider and its constituent providers, if any, and does so freely with the intent to fully bind Provider, and its constituent providers, if any, to the provisions of this Agreement.

St Mary Medical Center
18300 Highway 18, Apple Valley, CA, 92307

Molina Healthcare of California

Provider Signature:		Molina Signature:	
Signatory Name (Printed):	EDWARD WOW	Signatory Name (Printed):	Teri Lauenstein
Signatory Title (Printed):	CFO	Signatory Title (Printed):	VP Network Management & Operations
Signature Date:	7/19/2011	Signature Date:	8/2/11
		Effective Date:	(To be completed by Health Plan) 9-1-11

ATTACHMENT A

Provider Identification Sheet

Mark applicable category(ies) below. For those Providers representing multiple health care professional(s) or entity(ies), please check all the categories that apply.

_____ Primary Care Physician _____

_____ Specialist: type _____

_____

_____ Group/IPA (a list of constituent members with their License and DEA numbers is attached and incorporated herein)

__X__ Hospital X Acute Care _____

_____ Ancillary Provider: type _____

_____

_____ Pharmacy _____

_____ Other: type _____

Please enter "N/A" for the following if not applicable or not available:

Provider Name	ST MARY MEDICAL CENTER - APPLE VALLEY	Billing Address: _____
Telephone No.	760-242-2311	
Facsimile No.		
Email Address		
Tax I.D. No.	95-1914489	Physical Address (if different than above): 18300 Highway 18, Apple Valley, CA, 92307, USA
License No.		
NPI (or UPIN if NPI not yet designated)	NPI: 1910109186 UPIN: _____	
DEA No.		

(Use continuation pages if multiple providers under common ownership will submit bills under this Agreement)

I, the undersigned, am authorized to and do hereby verify the accuracy of the foregoing Provider information.

Provider Signature:	Mesrak Gessesse
Signatory Name (Printed):	MESRAK GESSESSE
Signatory Title (Printed):	DIRECTOR OF NETWORK DEVELOPM
Signature Date:	7/28/11

ATTACHMENT A
Provider Identification Sheet (Continuation Page)

Use one or more continuation pages as necessary when multiple providers under common ownership (the Provider is signing on behalf of all of them) are expected to bill Health Plan under more than one TIN and/or billing address. Please enter "N/A" for the following if not applicable or not available:

Provider Name		Billing Address:	
Telephone No.		Street	
Facsimile No.		City	
Email Address		State, Zip	,
Tax I.D. No.		Physical Address:	
License No.		Street	
NPI (or UPIN if NPI not yet designated)	NPI: UPIN:	City	
DEA No.		State, Zip	,

Provider Name		Billing Address:	
Telephone No.		Street	
Facsimile No.		City	
Email Address		State, Zip	,
Tax I.D. No.		Physical Address:	
License No.		Street	
NPI (or UPIN if NPI not yet designated)	NPI: UPIN:	City	
DEA No.		State, Zip	,

Provider Name		Billing Address:	
Telephone No.		Street	
Facsimile No.		City	
Email Address		State, Zip	,
Tax I.D. No.		Physical Address:	
License No.		Street	
NPI (or UPIN if NPI not yet designated)	NPI: UPIN:	City	
DEA No.		State, Zip	,

Provider Name		Billing Address:	
Telephone No.		Street	
Facsimile No.		City	
Email Address		State, Zip	,
Tax I.D. No.		Physical Address:	
License No.		Street	
NPI (or UPIN if NPI not yet designated)	NPI: UPIN:	City	
DEA No.		State, Zip	,

ATTACHMENT B

Definitions

1. **Advance Directive** is a Member's written instructions, recognized under state law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under state law. Examples of Advance Directives are living wills and durable powers of attorney for health care.

2. **Agreement** means this Provider Services Agreement, all Attachments, and incorporated documents or materials.

3. **Claim** means an invoice for services rendered to a Member by Provider, submitted in a format approved by Health Plan, and with all service and encounter information required by Health Plan.

4. **Clean Claim** means a claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

5. **CMS** means the Centers for Medicare and Medicaid Services, an administrative agency of the United States Government, responsible for administering the Medicare program.

6. **CMS Agreement** means the Medicare Advantage contract between Health Plan and CMS.

7. **Covered Services** means those health care services that are Medically Necessary, are within the normal scope of practice and licensure of Provider, and are benefits of the Health Plan product or a Health Plan affiliate's product which covers the Member.

8. **Emergency Services are Covered Services** necessary to evaluate or stabilize a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so as to cause a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in: (a) placement of the Member's health (or the health of the Member's unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. For Health Plan's Medicaid / Medi-Cal members, Emergency Services also includes any services defined as emergency services under 42 C.F.R. §438.114.

9. **Grievance Program** means the procedures established by Health Plan to timely address Enrollee and Provider complaints or grievances.

10. **Health Plan** means Molina Healthcare of California

11. **HEDIS Studies** means Health Employer Data and Information Set.

12. **Hospital Provider** are hospital-based physicians and independent licensed non-physician health care professionals who are employed by, contract with, or on the medical staff of Provider to provide Covered Services to Members.

13. **IPA** means Independent Practice Association.

14. **Medically Necessary** means those medical services and supplies which are provided in accordance with professionally recognized standards of practice which are determined to be: (a) appropriate and necessary for the symptoms, diagnosis or treatment of the Member's medical condition; (b) provided for the diagnosis and direct care and treatment of such condition; (c) not furnished primarily for the convenience of the Member, the Member's family, the treating provider, or other provider; (d) furnished at the most appropriate level which can be provided consistent

with generally accepted medical standards of care; and (e) consistent with Health Plan policy.

15. **Medicare** means the Hospital Insurance Plan (Part A) and the Supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.

16. **Medicare Advantage** means the managed care program established by the Medicare Modernization Act of 2003 to serve Medicare-eligible beneficiaries. Medicare Advantage plans generally cover Part A and Part B services and may also include Part D services.

17. **Medicare Advantage Special Needs Plan (MA-SNP)** means the managed care program established by the Medicare Modernization Act of 2003 which allows health plans to create specialized plans for beneficiaries who are eligible for Medicare and Medicaid.

18. **Member(s)** means a person(s) enrolled in one of Health Plan's benefit products or a Health Plan affiliate's benefit product and who is eligible to received Covered Services.

19. **Provider** means the person(s) and/or entity identified in Attachment A to this Agreement. Where Provider is a Group/IPA or Hospital, Provider means and includes all constituent physicians, allied health professionals and staff persons who provide health care services to Members by and/or through the Group/IPA or Hospital. All of said persons are bound by the terms of this Agreement.

20. **Provider Manual** means the compilation of Health Plan policies, procedures, standards and specimen documents, as may be unilaterally amended or modified from time to time by Health Plan or mutually amended or modified from time to time by the parties, that have been compiled by Health Plan for the use and instruction of Provider, and to which Provider must adhere.

21. **Quality Improvement Program** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.

22. **Utilization Review and Management Program** means the policies, procedures and systems developed by Health Plan for monitoring the utilization of Covered Services by Members, including but not limited to under-utilization and over-utilization.

23. **Utilization Management Reduction Amount** means that amount by which payments otherwise owing to Provider are reduced in the event that Provider is de-delegated responsibility for utilization management.

ATTACHMENT C

Products/Programs

Provider hereby elects to participate as a panel provider for each of the following Health Plan products as offered and applicable.

1. Medi-Cal Primary Care Case Manager
2. Medi-Cal Prepaid Health Plan
3. Medi-Cal Geographic Managed Care
4. Medi-Cal Two-Plan Model
5. Healthy Families
6. Medicare Advantage (Molina Medicare Options)
7. MA-SNP (Molina Medicare Options Plus)
8. Other Products - Provider agrees that Health Plan may from time to time add additional products for which provider agrees to participate as a contracted provider

Health Plan shall maintain any applicable benefit and Covered Services descriptions in its Provider Manual.

ATTACHMENT D

Compensation Schedule

St Mary Hospital Medical Center
Effective September 1, 2011 – August 31, 2013

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

SERVICE DESCRIPTION	MEDI-CAL	HEALTHY FAMILIES	MEDICARE
INPATIENT			
Medical/Surgical/Pediatrics	$1400 per diem	$1,442 per diem	100% DRG
DOU/Telemetry	$1525 per diem	$1,571 per diem	
NICU II, III, IV / ICU /CCU	$2200 per diem	$2,266 per diem	
OB Normal Delivery	$2900 2 day case rate, LOC thereafter	$2900 2 day case rate, LOC thereafter	
OB C-Section Delivery	$4000 3 day case rate, LOC thereafter	$4000 3 day case rate LOC thereafter	
NICU I / Boarder Baby	$450 per diem	$464 per diem	
Cardiac Catheterization – 1 day then LOC	$2500 1 day then LOC	$2675 1 day then LOC	
Cardiac Pacemaker Implant	$4000 1 day then LOC	$4120 1 day then LOC	
Cardiac Surgery (1-6 day case rate) then LOC	$14,000 case rate	$14,420 case rate	
Angioplasty/PTCA	$2850 2 day case rate then LOC	$2936 2 day case rate then LOC	
Additional days	LOC	LOC	
OUTPATIENT SERVICES			
Emergency Room / All other Outpatient Services	100% Medi-Cal Fee Schedule	110% Medi-Cal Fee Schedule	100% Medicare Fee Schedule
Outpatient Surgery	100% Medi-Cal Fee Schedule	110% Medi-Cal Fee Schedule	100% APC
Unlisted Procedures	30% of Medicare	30% of Medicare	30% of BC
EXCLUSIONS: Inpatient Implants – Rev Codes: 275, 276, 278	20% BC	20% BC	20% BC

8/1/11
8/2/11

ARTICLE ONE – ALL OTHER PROGRAM RATES

Compensation Terms for all other Health Plan's Members not designated above (the "All Other Rates").

a. **All Other Rates.** The following rates shall apply for Covered Services rendered to Members assigned to Health Plan's programs not otherwise designated above.

b. **Inpatient Covered Services.** Covered Services shall be paid at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for locality or geography), as of the date of service.

c. **Outpatient Covered Services.**

(1) **Ambulatory / Outpatient Surgery Covered Services.** Covered Services shall be paid at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for locality or geography), as of the date of service.

(2) **Emergency Room Covered Services (All Levels).** Covered Services shall be paid at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for locality or geography), as of the date of service.

(3) **All Other Outpatient Covered Services.** Covered Services shall be paid at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for locality or geography), as of the date of service.

d. **Hospital Providers.** Covered Services shall be paid at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for locality or geography), as of the date of service.

ARTICLE TWO – NOTATIONS

2.1 Capitalized terms utilized in this Attachment, which are not otherwise defined in this Attachment, if any, shall have the same meaning set forth in the definitions to this Agreement.

2.2 Unless otherwise set forth above, the stipulated Hospital Provider payment rates shall apply to all Professional Clean Claims submitted by Hospital Providers.

ATTACHMENT D-1

Health Plan and Provider hereby agree to the terms and conditions relating to 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.

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; (i) adjust compensation payments and rates as set forth below ("Adjustment to Compensation"), and (ii) recoup from Provider a reprocessing fee of ten dollars ($10) for each claim Health Plan in its sole discretion determines must be reprocessed by Health Plan as a result of the CDM Increase. Health Plan may recoup any adjustments to compensation and reprocessing fees by way of offset against Provider's claim payments.

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.

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 (3) for each twelve (12) month period following the first anniversary of the Effective Date of this Agreement (the "CDM Limit").

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.

Adjustment to Compensation Examples.

Compensation adjustment calculations for first twelve (12) months following the Effective Date:

- Provider's CDM Increase: 9%
- Compensation Payment Rate: 30% of Provider's CDM
- Compensation Adjustment Calculation = 0.30 / 1.09 = 27.52% of Provider's CDM

Compensation adjustment calculations for each twelve (12) month period following the first anniversary after the Effective Date:

- Provider's CDM Increase: 9%
- CDM Limit: 3%
- Compensation Payment Rate: 30% of Provider's CDM
- Compensation Adjustment Calculation = 1.03 / 1.09 x 0.30 = 28.35% of Provider's CDM.

ATTACHMENT E

REQUIRED PROVISIONS

(Health Care Service Plans)

The following provisions are required by (i) federal statutes and regulations applicable to Health Plan, or (ii) state statutes and regulations applicable to health care service plans. Any purported modifications to these provisions inconsistent with such statutes, regulations, and agreements shall be null and void.

DMHC Provisions

1. In the event that Health Plan fails to pay Provider for Covered Services, the Member or subscriber shall not be liable to Provider for any sums owed by Health Plan. Provider shall not collect or attempt to collect from a Member or subscriber any sums owed to Provider by the Health Plan. Provider may not and will not maintain any action at law against a Member or subscriber to collect sums owed to the Provider by Health Plan. (Health and Safety Code section 1379)

2. To the extent that any of Health Plan's quality of care review functions or systems are administered by Provider, Provider shall deliver to Health Plan any information requested in order to monitor or require compliance with Health Plan's quality of care review system. (Rule 1300.51, J-5)

3. Provider is responsible for coordinating the provision of Health Care Services to Members who select Provider if Provider is a primary care physician. (Rule 1300.67.1(a))

4. Provider shall maintain Member medical records in a readily available manner that permits sharing within Health Plan of all pertinent information relating to the health care of Members. (Rule 1300.67.1(c))

5. Provider shall maintain reasonable hours of operation and make reasonable provisions for after-hour services. (Rule 1300.67.2(b))

6. To the extent Provider has any role in rendering Emergency Services, Provider shall make such Emergency Services available and accessible twenty-four (24) hours a day, seven days a week. (Rule 1300.67.2(c))

7. Provider shall participate in Plan's system for monitoring and evaluating accessibility of care including but not limited to waiting times and appointment availability, and addressing problems that may develop. Provider shall timely notify Health Plan of any changes to address or inability to maintain Health Plan's access standards. (Rule 1300.67(f))

8. Health Plan is subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended (Chapter 2.2 of Division 2 of the Health and Safety Code), and the Regulations promulgated hereunder (subchapter 5.5 of Chapter 3 of Title 28 of the California Code of Regulations). Any provision of the aforementioned statutes or regulation that is required to be in this Agreement shall bind the Health Plan whether or not expressly set forth in this Agreement. (Rule 1300.67.4(a)(9))

9. Upon the termination of this Agreement, Health Plan shall be liable for Covered Services rendered by Provider (other than for copayments as defined in subdivision (g) of Section 1345 of the Health and Safety Code) to a subscriber or Member who retains eligibility under the applicable plan contract or by operation of law under the care of Provider at the time of termination of the Agreement until the services being rendered to the subscriber or Member by Provider are completed, unless the Health Plan makes reasonable and medically appropriate provision for the assumption of services by a contracting provider. (Health and Safety Code section 1373.96) (Rule 1300.67.4(a)(10))

10. Any written communications to Members that concern a termination of this agreement shall comply with the notification requirements set forth in Health and Safety Code section 1373.65(f)

11. Provider shall maintain all records and provide all information to the Health Plan or the DMHC as may be necessary for compliance by the Health Plan with the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended and any regulations promulgated thereunder. To the extent feasible, all such records shall be located in this state. Provider shall retain such records for at least two years: this obligation shall not terminate upon termination of the Agreement, whether by rescission or otherwise. (Health and Safety Code section 1381) (Rule 1300.67.8(b))

12. Provider shall afford Health Plan and the DMHC access at reasonable times upon demand to the books, records and papers of Provider relating to health services provided to Members and subscribers, to the cost thereof, to payments received by Provider from Members and subscribers of the Health Plan (or from others on their behalf), and, unless Provider is compensated on a fee-for-services basis, to the financial condition of Provider. Provider shall promptly deliver to Health Plan, any financial information requested by Health Plan for the purpose of determining Provider's ability to bear capitation or other applicable forms of risk sharing compensation. (Rule 1300.67.8(c))

13. Provider shall not and is hereby prohibited from demanding surcharges from Members for Covered Services. Should Health Plan receive notice of any such surcharges by Provider, Health Plan may take any action it deems appropriate including but not limited to demanding repayment by Provider to Members of any surcharges, terminating this Agreement, repaying surcharges to Members and offsetting the cost of the same against any amounts otherwise owing to Provider. (Rule 1300.67.8(d))

14. Upon Health Plan's request, provider shall report all co-payments paid by Members to provider. (Health and Safety Code section 1385)

15. To the extent that any of Health Plan's quality assurance functions are delegated to Provider, Provider shall promptly deliver to Health Plan all information requested for the purpose of monitoring and evaluating Provider's performance of those quality assurance functions. (Rule 1300.70)

16. Provider may utilize Health Plan's Provider Dispute Resolution Process by phoning or writing the Provider Services Department, Molina Medical Centers, Third Floor, One Golden Shore Drive, Long Beach, CA 90802 (800) 526-8196, ext. 1249. The Provider Dispute Resolution Process, however, does not and cannot serve as an appeal process from any fair hearing proceeding held pursuant to Health and Safety Code Section 809, et. seq. Please see the Provider Manual for more information regarding the dispute resolution process. (Health and Safety Code Section 1367(h).) (Rule 1300.71.38)

17. Provider shall display in each reception and waiting area a notice informing Members how to contact their health plan, file a complaint with their plan, obtain assistance from the DMHC, and seek an independent medical review. (Rule 1300.67.8(f))

18. Provider shall provide grievance forms and assist Members in filing grievances. Provider shall cooperate with Health Plan in responding to Member grievances and requests for independent medical reviews. (Rule 1300.68(b))

19. In the event a Member seeks and obtains a recovery from a third party or a third party's insurer for injuries caused to that Member, and only to the extent permitted by the Member's evidence of coverage and by California law, Provider may have the right to assert a third party lien for and to recover from the Member the reasonable value of Covered Services provided to the Member by Provider for the injuries caused by the third party. Health Plan shall similarly have the right to assert a lien for and recover for payments made by Health Plan for such injuries. Provider shall cooperate with Health Plan in identifying such third party liability claims and in providing such information. Pursuit and recovery of under third party liens shall be conducted in accordance with California Civil Code section 3040.

20. The Provider Manual may be unilaterally amended or modified by Health Plan to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement upon forty-five (45) business days' notice to Provider unless a shorter timeframe is necessary for compliance. Health Plan may otherwise materially amend the Provider Manual only after forty-five (45) business days prior written notice to Provider and only if mutually agreed to by the parties as evidenced by the amendment being executed by each party.

21. Notwithstanding any other provision in this Agreement, if Health Plan or Health Plan's capitated provider is not the primary payer under coordination of benefits, Provider may submit claims to Health Plan or Health Plan's capitated provider within ninety (90) days from the date of payment or date of contest, denial or notice from the primary payer. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted by Provider to Health Plan within ninety (90) days from the date of payment or date of contest, denial or notice from the primary payer shall not be eligible for payment, and Provider hereby waives any right to payment therefore.

22. Notwithstanding any other provision in this Agreement, if Health Plan or Health Plan's capitated provider denies a claim because it was filed beyond the claim filing deadline, Health Plan will, upon Provider's submission of a provider dispute pursuant to Title 28, California Code of Regulations, section 1300.71.38 and the demonstration of good cause for the delay, accept, and adjudicate the claim according to California Health & Safety Code section 1371 or 1371.35, which ever is applicable, and the California Code of Regulations.

ATTACHMENT F

DHCS Provisions

The following provisions apply exclusively to Covered Services provided and activities engaged in pursuant to Medicaid Program:

1. All Medicaid covered services are set forth in Attachment C and the Provider Manual as set forth in this Agreement. (Rule 53250(c)(1))

2. This Agreement shall be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the Health Plan. (Rule 53250(c)(2))

3. This Agreement shall become effective upon approval by the Department of Health Care Services ("DHCS") in writing, or by operation of law where the DHCS has acknowledged receipt of this Agreement and has failed to approve or disapprove the Agreement within 60 days of receipt. (Rule 53250(c)(3))

4. Amendments to this Agreement shall be submitted to the DHCS, for prior approval, at least thirty (30) days before the effective date of any proposed changes governing compensation, services or term. Proposed changes which are neither approved nor disapproved by the DHCS, shall become effective by operation of law thirty (30) days after the DHCS has acknowledged receipt, or upon the date specified in the Amendment, whichever is later. (Rule 53250(c)(3))

5. Provider agrees to submit all reports required and requested by Health Plan, in a form acceptable to Health Plan. (Rule 53250(c)(5))

6. Provider shall make all of its books and records, pertaining to the goods and services furnished under the terms of this Agreement, available for inspection, examination or copying:

a. By the DHCS, the United States Department of Health and Human Services, the DMHC, and the Department of Justice;

b. At all reasonable times, at Provider's place of business or at such other mutually agreeable location in California;

c. In a form maintained in accordance with the general standards applicable to such book or record keeping;

d. For a term of at least five years from the close of the fiscal year in which the date of service occurred, in which the record or data was created or applied, and for which the financial record was created;

e. Including all encounter data for a period of at least five years. (Rule 53250(e)(1))

7. Provider agrees to notify the DHCS in the event that this Agreement is amended or terminated. Notice to the DHCS shall be considered given when properly addressed and deposited in the United States Postal Service as First Class Registered Mail, postage attached. (Rule 53250(e)(4))

8. Provider shall maintain and make available to the DHCS, upon request, copies of all subcontracts and shall ensure that all subcontracts are in writing and require that subcontractors:

a. Make all applicable books and records available at all reasonable times for inspection, examining or copying by the DHCS, the U.S. Department of Health and Human Services, the DMHC, and the Department of Justice;

b. Retain such books and records for a term of at least five years from the fiscal year in which the date of service occurred, in which the record or data was created or applied, and for which the financial record was created. (Rule 53250(e)(3))

9. Provider agrees that any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the DHCS in those instances where prior approval by the DHCS is required. (Rule 53250(e)(5))

10. Provider agrees to hold harmless both the State of California and Health Plan members in the event that Health Plan cannot or will not pay for services performed by Provider pursuant to this Agreement. (Rule 53250(e)(6))

11. Provider shall assist Health Plan in the transfer of care in the event Health Plan's Two-Plan Model Contract with the DHCS expires or terminates. Providers shall assist Health Plan in the transfer and care in the event this Agreement expires or terminates for any reason.

12. Provider shall not attempt recovery in circumstances involving casualty insurance, tort liability or workers' compensation. Provider shall report to the DHCS within ten (10) days after discovery any circumstances which may result in casualty insurance payments, tort liability payments, or workers' compensation award. (Rule 53222(b))

13. Provider shall disclose the names of the officers and owners of Provider, stockholders owning more than ten percent (10%) of the stock issued by Provider, if any, and major creditors holding more than five percent (5%) of the debt of Provider. For that purpose, Provider shall use the Disclosure Form made available by Health Plan. (W&I Code section 14452(a))

14. Provider acknowledges that Health Plan bears significant risk by assuming financial responsibility for all in-patient hospitalization expenditures, including expenditures for services connected with the period of hospitalization. (Rule 53251(c) & (e))

15. Non-Discrimination Clause. During the performance of this Agreement, Provider and Provider's subcontractors will not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including cancer), age (over 40), marital status, and denial of family care leave. Provider and Provider's subcontractors will ensure the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. Provider and Provider's subcontractors will comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, et. seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285.0, et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990(a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Provider and Provider's subcontractors as the case may require will give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

16. Provider agrees to arrange for the provision of interpreter services for Members at all provider sites.

17. Nothing in this Agreement shall be interpreted in any manner to terminate or diminish Health Plan's independent obligations to the State of California under one or more of its contracts with the Department of Health Care Services.

Upon request by DHCS, Provider shall timely gather, preserve and provide to DSHS, in the form and manner specified by DHCS, any information specified by DHCS, subject to lawful privileges, in Provider's possession, related to threatened or pending litigation by or against DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all

reasonable efforts to immediately notify DHCS and Health Plan of any subpoenas, document production requests, or requests for records, received by Provider related to Health Plan's contract with DHCS. Provider shall be reimbursed by DHCS for the services necessary to comply with this requirement under the reimbursement terms specified in Health Plan's contract with DHCS.

ATTACHMENT G

Acknowledgement of Receipt of Provider Manual

Provider hereby acknowledges receipt of Health Plan's Provider Manual.

Date of receipt: 7/28/11

Initials of authorized representative of Provider: MG

ATTACHMENT H

MEDICARE PROGRAM REQUIREMENTS---HEALTH CARE SERVICES

This Attachment H sets forth Medicare program requirements that are hereby incorporated into contracts and/or agreements with Providers covering the provision of health care services. The Agreement and this attachment shall be automatically modified to conform to subsequent amendments to Medicare program requirements. In the event of any inconsistency between the terms of this attachment and the Agreement, the terms of this attachment shall control.

1. **Downstream Compliance**. Provider agrees to require all of its downstream, related entity(s), and transferees that provide any services benefiting Health Plan's Medicare enrollees to agree in writing to all of the terms provided herein.

2. **Right to Audit**. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under Health Plan's contract with CMS, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 422.504(e)(3), 422.504(e)(4) and 422.504(i)(2)(ii)).

3. **Confidentiality**. Provider shall comply with the confidentiality and enrollee record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13)).

4. **Hold Harmless/Cost Sharing**. Provider agrees that under no circumstance shall a Member be liable to the Provider for any sums owed by Health Plan to the Provider. Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the State or another payor such as a Medicaid Managed Care Plan is responsible for paying such amounts. Provider

agrees to accept payment from Health Plan as payment in full, or bill the appropriate responsible party, for any Medicare part A and B cost sharing that is covered by Medicaid. (42 CFR 422.504(g)(1)(i)).

5. **Delegation**. Health Plan may only delegate activities or functions to a first tier, downstream, or related entity, in a manner that is consistent with the provisions. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement shall be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(3)(iii) and 422.504(i)(4)).

6. **Prompt Payment**. Health Plan and Provider agree that Health Plan shall pay all clean claims for services that are covered by Medicare within sixty (60) days of the date such claim is delivered by Provider to Health Plan and Health Plan determines such claim is complete/clean. Any claims for services that are covered by Medicare that are not submitted to Health Plan within six (6) months of providing the services that are subject of the claim shall not be eligible for payment, and Provider hereby waives any right to payment therefor. Health Plan reserves the right to deny any claims that are not in accordance with the Medicare Claims Processing Manual and Medicare rules for billing. (42 CFR 422.520(b)).

7. **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. (42 CFR 504(a)(8)).

8. **Accountability**. Health Plan may only delegate activities or functions to a first tier, downstream, or related entity, in a manner that is consistent with the provisions. (42 CFR 422.504(i)(3)(ii)).

9. **Compliance with Medicare Laws and Regulations**. Provider shall comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v)).

10. **Benefit Continuation.** Provider agrees to provide for continuation of enrollee 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 an insolvency, through discharge. (42 CFR 422.504(g)(2)(i), 422.504(g)(2)(ii) and 422.504(g)(3).

ATTACHMENT I

DISCLOSURE FORM

(Welfare and Institutions Code Section 14452 (a))

Name of Subcontractor ST MARY MEDICAL CENTER

The undersigned hereby certifies that the following information regarding ST MARY MEDICAL CENTER (the "Organization") is true and correct as of the date set forth below.

1. Officers/Directors General Partners: Alan Garret, Ed Wong, David O'brien
2. Co-Owner(s): —
3. Stockholders owning more than ten percent (10%) of the stock of the Organization: St. Joseph Health System
4. Major creditors holding more than five percent (5%) of Organization's debt: Various investors via tax exempt bond issuances.
5. Form of Organization (Corporation, Partnership, Sole Proprietorship, Individual): Corporation
6. If not already disclosed above, is Organization, either directly or indirectly, related to or affiliated with the Contracting Health Plan? Explain:

Date: 7/19/11

By: Shawn T Curtis

Print Name: SHAWN T. CURTIS

Title: Director of Finance

ATTACHMENT J

CERTIFICATE OF OWNERSHIP

I, _____ , an authorized representative of ST MARY MEDICAL CENTER, do certify that, to the best of my knowledge, the individuals or entities listed below have a five percent or more ownership, direct or indirect, or control interest in the aforementioned entity as defined under 42 U.S. C. Section 1320 a 3 (2). This form is to be submitted annually to the organization contracting with the Managed Risk Medical Insurance Board for the Healthy Families Program and/or Access to Infants and Mothers Program.

Name of Individual/Entity	Employer Identification Number	Social Security Number

☐ No one is listed because there are no individuals or entities with a five (5%) percent or more interest

☐ No one is listed because the plan is under government ownership.

☐ No one is listed because the provider of services is a non-profit, public benefit corporation for which there are no outside controlling interests.

_____ _____

Signature of Authorized Representative and Title Date

Business Analyst/Configuration

CCRF Cover Sheet

*CCRF Description: St. Mary Med. Ctr. Apple Valley

*CCRF Owner: Maggie Hallon

Region/Dept: ☐LA ☐SD ☑IE ☐SAC ☐BA ☐Admin/Other

*CCRF Status: ☐Rejected ☐Pending ☑Open ☑Work in Progress ☐Closed

*Date Received in Business Applications: 7/26/11

*Review Completion Date by Suma: 7/27/11

*CCRF Draft Review: _____ (If Needed)

***Submission Date to MHI Configuration**: 7/27/11 (Time if after 2:00pm)_____

***CCRF Tracker Info:**

*MC/HF # 14487 *M-Care# 14489 *TCIM# ~

*MHI E.T.A. 8-10-11 *MHI E.T.A. 8-10-11 *MHI E.T.A. _____

*Ext. E.T.A. 9-25-11 *Ext. E.T.A. 7/27/11 *Ext. E.T.A. _____

*ARF Ref# _____

***MHI Configuration Completion Date**: MC/HF 9-26-11 M-Care 9-6-11

*Submission to PIM: 9-6-11 *PIM Completion Date: 9-8-11

*Submission to MHC Cont Admin: 10-5-11

*MHI Configuration Analyst(s): Veronica Gutierrez

*Type of Update: Contracts

*LOB: ☑M-CAL ☐H-FAM ☑Medicare ☐LA Care Health Plan

*Category: ☑New ☐Amendment ☐Clean-Up ☐Other

*BA QA Completion Date: 10-3-11 *BA Signature: [signature]

*TCIM/ARF Validated by submitter: _____ *Date Validated: _____

*Fee Schedule Validated by submitter: _____ * Date Validated: _____

*Impact: ☑Quality ☐Financial

MHC-Business Applications

JUL 26 11

Received

St Mary Med Ctr - Apple Valley

MOLINA HEALTHCARE

Configuration Change Request Form (CCRF)

Section I – General Information

State: CA

LOB: Medicaid and Medicare **Other:** Healthy Families

Effective Date of Change: September 1, 2011

Priority of Request: Medium

Section II – Type of Request

Request Type: Contracts **Other:**

Nature of Request: NEW

Explanation for Retroactive Request:

Section III – Request Description

Description of Proposed Change:

New contract to pay at custom fee schedule. Compensation schedule is attached.

Section IV – Required Information for Benefit Requests

Benefit Plan name:

Section V – Required Information for Contract Requests

Contract name:

Does the contract change require changes to Provider affiliation? No

What is the net result of contract changes on finalized claims? No Impact

Section VI – Required Information for Fee Schedule Requests

Number of Fee Schedule requests in this CCRF:

Fee Schedule name:

QNXT Name	Excel File Name

Section VII – Required Information for MRDT Requests

MRDT Table name:

QNXT Name	Excel File Name

Section VIII – Required Approvals

Health Plan Primary Approval: Maggie Holl Date: 7-21-11

Health Plan Secondary Approval: [signature] Date: 7/27/11

Section IX – Exception Approvals

CFO Approval: _____ Date: _____

Corporate Sr Executive: _____ Date: _____

Jon Doyle

From: Dolores Olague-Swanson
Sent: Monday, August 15, 2011 3:21 PM
To: MHC BA Department; Marco Avila
Subject: RE: SMMC - Apple Valley NPI number

St Mary Medical Center – Apple Valley NPI #'s.

Outpatient NPI #= 1710109186
Inpatient NPI # = 1669456299

From: MHC BA Department
Sent: Monday, August 15, 2011 1:58 PM
To: Dolores Olague-Swanson
Subject: SMMC - Apple Valley NPI number

Hi Dolores,

The CIM team has asked me to verify the provider to be attached to this new contract for purposes of going through MHI Testing. In my review I have noticed that the NPI# does not match between QNXT (1710109186) and the contract (1910109186). Please verify the NPI# and follow through with Marco's area.

Thanks
Jon

Jon Doyle | Molina Healthcare of California | Business Applications | 200 Oceangate, Suite 100 | Long Beach, CA. 90802
T: 562.499.6191 or 800.526.8196 x127844 - F: 562.951.1500
Jon.Doyle@molinahealthcare.com

Jon Doyle

From: Maggie Hollon
Sent: Thursday, September 01, 2011 4:42 PM
To: MHC BA Department; Jon Doyle
Cc: Dolores Olague-Swanson; Suma Verghese; Veronica Rodriguez
Subject: FW: SMMC - Apple Valley
Attachments: St. Mary Medical Center Apple Valley 9-1-11.pdf

Categories: CURRENT WORK

Thanks Jon and Dolores.

Jon, pls proceed with the configuration for St. Mary Apple Valley with the default for unlisted procedures to be configured to be paid at "zero".

From: MHC BA Department
Sent: Thursday, September 01, 2011 1:51 PM
To: Dolores Olague-Swanson
Cc: Maggie Hollon; Suma Verghese; Veronica Gutierrez
Subject: RE: SMMC - Apple Valley

Dolores – Thank you for the notification. I wanted to get back to you on the notes that you provided in regards to the issues that were found.

It is not configurable in this contract to allow Unlisted Procedures at 30% of Medicare with a 30% of BC default.

I understand that as an organization we want to move towards standardization of using a 30% of Medicare default when a value is not found in the Medi-Cal FS, and that language is normally a standard paragraph in our contracts, however; I don't see it in the paperwork that I was given.

Due to the structure of this contract, we are faced with finding a workaround to configure a 0% default when using both a 100% Medi-Cal and 30% Medicare Fee Schedules.

OUTPATIENT SERVICES	MEDI-CAL	HEALTHY FAMILIES
ER/OP SURG/ALL OTHER OP SVCS	100% of M-Cal FS	110% M-Cal FS
Unlisted Procedures	30% of Medicare FS	30% of Medicare FS

Please let our department know if for some reason the page with default language is simply missing from the CCRF.
Jon

From: Dolores Olague-Swanson
Sent: Thursday, September 01, 2011 10:31 AM
To: Dolores Olague-Swanson; Jon Doyle
Cc: Maggie Hollon; Suma Verghese; Crystal Nicolai
Subject: RE: SMMC - Apple Valley

CCRF submitted to ignore lesser than language for Maggie's signature today. Thanks - Dolores

---

From: Dolores Olague-Swanson
Sent: Wednesday, August 31, 2011 3:07 PM
To: Jon Doyle

Cc: Maggie Hollon; Suma Verghese
Subject: RE: SMMC - Apple Valley

Jon – see comments below.

From: Jon Doyle
Sent: Wednesday, August 31, 2011 10:05 AM
To: Dolores Olague-Swanson
Cc: Maggie Hollon; Suma Verghese
Subject: SMMC - Apple Valley

Hi Dolores –

CIM is waiting for my response to Cycle 1 testing of this contract. Please review and get back to me ASAP so we can move through the remaining two test cycles. I've attached a spreadsheet showing the QNXT "unlisted" procedure code grouping along with an explanation from Encoder Pro and the CPT book.

Cycle 1 testing is showing that OP services are paying per contract, but you have indicated to me that our interpretation of Unlisted Procedures is not the same as what you had intended. Unlisted procedures to be paid at 30% of Medicare for Medi-Cal and HFP. No Medicare amount then to pay at 30%BC

Please provide your feedback on the following:

1. There is no "default" language in this contract for any of the OP services. If a value is not found in a Fee Schedule the allowed amount will be zero. The default is 30% of Medicare for Medi-Cal/HFP. 30% of BC for Medicare = Standard default for all agreements.
2. QNXT is configured to allow 30% of Medicare for OP Unlisted Services. Unlisted Services are generally those CPT codes that end in 99 or have a descriptor that indicate that the procedure is By Report. These services will most likely NOT have a value in the Medicare Fee Schedule.
3. QNXT is configured to allow the lesser of billed or contracted rate as per the contract. The QNXT limitation is that it determines this by line rather than by total billed. A CCRF will be submitted to "ignore lesser than language".

Continuation of testing is waiting your response.

Thanks
Jon

Jon Doyle | Molina Healthcare of California | Business Applications | 200 Oceangate, Suite 100 | Long Beach, CA. 90802
T: 562.499.6191 or 800.526.8196 x127844 - F: 562.951.1500
Jon.Doyle@molinahealthcare.com

Jon Doyle

From: MHC PIM
Sent: Thursday, September 08, 2011 3:08 PM
To: MHC BA Department; Marco Avila
Subject: RE: St Mary Medical Center Apple Valley

Categories: Jon

This has been processed.

From: MHC BA Department
Sent: Thursday, September 01, 2011 3:42 PM
To: Marco Avila; MHC PIM
Subject: St Mary Medical Center Apple Valley
Importance: High

Marco,
Please have your team complete the affiliations for this new contract effective 9/1/11.

ST MARY MEDICAL CENTER, TIN 951914489

Terminate the affiliations to these contracts 08/31/11
HOSP – NON PAR – HF – SAINT MARY MEDICAL CTR – APPLE VALLEY (QMXCT04229)
HOSP – NON PAR – MC - *SO CAL – NON TERTIARY (QMXCT07470)

Create new affiliations to these contracts on 09/01/11
HOSP – PAR – HF – ST MARY MED CTR APPLE VALLEY (QMXCT09399)
HOSP – PAR – MC – ST MARY MED CTR APPLE VALLEY (QMXCT09400)

Please return notification when this has been completed.

Thanks
Jon

From: Veronica Gutierrez
Sent: Thursday, September 01, 2011 3:11 PM
To: MHC BA Department; Jon Doyle
Cc: Bory Chhun; Allan Saena; Wendy Sgaggero
Subject: RE: St Mary Medical Center Apple Valley

As requested here are the contract headers for this facility:

QMXCT09399 HOSP - PAR - HF - ST MARY MED CTR APPLE VALLEY
QMXCT09400 HOSP - PAR - MC - ST MARY MED CTR APPLE VALLEY

Thanks,
Veronica

From: Wendy Sgaggero
Sent: Thursday, September 01, 2011 2:59 PM
To: Veronica Gutierrez; Jon Doyle
Cc: Bory Chhun; Allan Saena
Subject: RE: St Mary Medical Center Apple Valley

Veronica, Please create both contr t headers in production, so that the ay attach the provider. This will eliminate claim adjustments. Please send out the information. Thanks, Wendy

---

From: Veronica Gutierrez
Sent: Thursday, September 01, 2011 2:07 PM
To: Jon Doyle
Cc: Bory Chhun; Wendy Sgaggero; Allan Saena
Subject: RE: St Mary Medical Center Apple Valley

Jon,

Wendy, Allan and myself got together to discuss the suggestion of not have a selection of any UCR Schedule at the header level; we can leave it blank but the default will be reading at the fee table at the Program Level.

I'm waiting for Sean's report to validate how many of the "unlisted" codes have actual rates in the fee schedules that we are using in this contract. As soon as we receive this information we will let you know so we can proceed to make the best viable configuration.

From: MHC BA Department
Sent: Wednesday, August 31, 2011 3:05 PM
To: Veronica Gutierrez
Cc: Wendy Sgaggero
Subject: RE: St Mary Medical Center Apple Valley

Veronica,

- OP Unlisted procedures is processing as the contract specifies.

1. Dolores has indicated in my discussion with her that the expectation may be different.

- The contractual reference to allow Lesser Of billed charges or the contracted amounts is processing as the contract specifies.

2. Dolores has indicated in my discussion with her that processing line by line is a QNXT limitation and that Lesser Of should compare total billed to contracted rate.

- The LOC build-outs are not scoring as intended.

3. Please place a Manual Pend on these terms

Jon

From: Veronica Gutierrez
Sent: Thursday, August 25, 2011 5:28 PM
To: MHC BA Department
Cc: Jon Doyle; Wendy Sgaggero
Subject: St Mary Medical Center Apple Valley

Jon - attached are the results of the internal testing of this contract, please take a look at them and let us know how you would like to proceed.

The majority of the claims have passed but the ones listed in **red** have issues. These claims are failing due the different LOC provided to the patient within a **specific procedure**; for example, claim # 11166606417 where member was in ICU for 3 days and then transferred to CCU for 4 days.

System prices:
Line 1 *CARDIAC PACEMKR IMPLANT 1 DAY then LOC (ICU/CCU) 4,000 + 4,400 (2,200 per diem) = 8,400

Line 2 *CARDIAC PACEMKR IMP' 'NT 1 DAY then LOC (DOU/TELE) 4,000 + ' '75 (1,525.per diem) = 8,575
Line 2 is pricing $8,575 instead o' $6,100.

You can see the same situation in these other claims 11109613923 & 11174606708. Would the terms restricted to specific procedures codes be pended for manual review to prevent overpayment?

I have also included claims listed in **blue** and **purple,** system is hitting the correct terms but pricing $0.00 since the service codes billed don't have a rate either in the CA MEDI-CAL PHYSICIAN FEE SCHEDULE-CUSTOM for the **OP SERVICES/SURGERY/ER* and 30% MEDICARE FEE SCHEDULE - #99 SOCA for ****OP UNLISTED PROCEDURES.***

Please let me know if you have questions...

Thanks,
Veronica

Jon Doyle

From: MHC PIM
Sent: Thursday, September 08, 2011 5:06 PM
To: MHC BA Department
Subject: RE: St Marys Medical Center - Ignore Billed Charges

This has been processed.

From: MHC BA Department
Sent: Tuesday, September 06, 2011 12:39 PM
To: MHC PIM
Cc: Jennifer Anderson
Subject: RE: St Marys Medical Center - Ignore Billed Charges
Importance: High

Please affiliate St Mary Medical Center – Apple Valley (TIN 951914489) to the following NEW contract in MAPD.
CA – HOSP – PAR – ST MARY MED CTR (QMXCT09230) effective 09/01/11.

Please return verification when this is completed.

Thank you
Jon

From: Jennifer Anderson
Sent: Tuesday, September 06, 2011 12:18 PM
To: Jon Doyle
Subject: FW: St Marys Medical Center - Ignore Billed Charges
Importance: High

Jon, looks like this hospital is still setup as nonpar in the MAPD environment. The contract previously created was never assigned to the hospital. I will note the change to the ignore billed charges language when the CCRF is assigned but wanted to bring this to your attention.

CA - HOSP - PAR - ST MARY MED CTR

Jennifer Anderson
Sr Configuration Analyst, CIM-Medicare
Molina Healthcare, Inc.
562.480.7017 (66)
Jennifer.Anderson@molinahealthcare.com

From: MHC BA Department
Sent: Tuesday, September 06, 2011 12:08 PM
To: CCRF/ARF Submission
Cc: Wendy Sgaggero; Allan Saena; Veronica Gutierrez; Jennifer Anderson
Subject: St Marys Medical Center - Ignore Billed Charges
Importance: High

CCRF Attached.
St Mary's Medical Center – Apple Valley

Thanks

Jon

From: Ernest Quinones
Sent: Tuesday, September 06, 2011 10:51 AM
To: MHC BA Department
Cc: Jennifer Anderson
Subject: FW: St Marys Medical Center - Ignore Billed Charges
Importance: High

Approved.

Ernie Quiñones

Director - Medicare Corporate Operations

Molina Healthcare

888-562-5442 ext. 142132

(562) 519-5664 (mobile)

Ernest.Quinones@Molinahealthcare.com

From: MHC BA Department
Sent: Tuesday, September 06, 2011 9:40 AM
To: Ernest Quinones
Cc: Jennifer Anderson
Subject: St Marys Medical Center - Ignore Billed Charges
Importance: High

Please approve CCRF for Medicare

Thanks
Jon

Jon Doyle | Molina Healthcare of California | Business Applications | 200 Oceangate, Suite 100 | Long Beach, CA. 90802
T: 562.499.6191 or 800.526.8196 x127844 - F: 562.951.1500
Jon.Doyle@molinahealthcare.com

Jon Doyle

From: Veronica Gutierrez
Sent: Monday, September 26, 2011 7:41 AM
To: MHC BA Department
Cc: Jon Doyle; Wendy Sgaggero; Allan Saena
Subject: CLOSED: CA MCaid/HF K2 CIM Tracking 14487 CT St. Mary Medical Center Apple Valley - Eff 09-01-11 Recd 07-27-11

This CCRF has been completed as requested base on the below information; the FS will be updated with a new CCRF as you has also indicated.

QMXCT09400 HOSP - PAR - MC - ST MARY MED CTR APPLE VALLEY
QMXCT09399 HOSP - PAR - HF - ST MARY MED CTR APPLE VALLEY

Please review these contracts in production and advise if changes are needed. This should be audited via report for 60 days to determine additional changes.

Thanks,
Veronica

From: MHC BA Department
Sent: Monday, September 19, 2011 4:32 PM
To: Veronica Gutierrez; Wendy Sgaggero; Allan Saena
Subject: RE: CA MCaid K2 14487 Contract New-St. Mary Medical Center Apple Valley UAT 1762

Veronica,

- Cycle 2 of testing is approved and the contract can be moved to production.

OP UNLISTED - We are waiting for all Medicare FS CCRFs to be completed. Then we will validate the FS MEDICARE LOCALITY #99 NOCAL FACILITY – PAR rates in QNXT against Palmetto to be sure that the rates are correct. We will then submit a CCRF to have a 100% Custom FS made from this, and then it can be attached to the term with the Pay% set to 30.

Jon

From: Veronica Gutierrez
Sent: Monday, September 19, 2011 11:33 AM
To: MHC BA Department
Cc: Jon Doyle; Wendy Sgaggero; Nancy Vasquez
Subject: FW: CA MCaid K2 14487 Contract New-St. Mary Medical Center Apple Valley UAT 1762

Jon, the cycle 2 of this facility testing is complete. Please review it an advise if this is approve by the Health Plan in order to move it to production.

Thanks,
Veronica

From: Nancy Vasquez
Sent: Friday, September 16, 2011 4:14 PM
To: Veronica Gutierrez; Jon Doyle
Cc: Maria del sol Gomez; Wendy Sgaggero; >>> MHI Claims Systems Testing
Subject: RE: CA MCaid K2 14487 Contract New-St. Mary Medical Center Apple Valley UAT 1762

Hi Veronica,

Attached are the Cycle 2 results for review and approval. As previously discussed the scenario's for the two items listed below have been deferred as we could not achieve the expected results. Please provide HP approval so that we can close the UAT.

- For ER/OP services if there is not are rate in the fee schedule the system will price 0.00.
- For the Case Rates scenarios that are not pricing correctly, the terms were pended for manual review so the examiner will need to price properly.

Thank you,

Nancy

From: Veronica Gutierrez
Sent: Friday, September 16, 2011 9:33 AM
To: Nancy Vasquez; >>> MHI Claims Systems Testing; Jon Doyle
Cc: Maria del sol Gomez; Wendy Sgaggero
Subject: RE: CA MCaid K2 14487 Contract New-St. Mary Medical Center Apple Valley UAT 1762

Nancy,

The HP reviewed the scenarios you mentioned below and an update was performed in the system as I did indicate the case rate terms were pended for manual review.

For ER/OP services if there is not are rate in the fee schedule the system will price 0.00.
For the Case Rates scenarios that are not pricing correctly, the terms were pended for manual review so the examiner will need to price properly.

Jon,
Could you please confirm?

Thanks,
Veronica

From: Nancy Vasquez
Sent: Friday, September 16, 2011 8:53 AM
To: Veronica Gutierrez; >>> MHI Claims Systems Testing
Cc: Maria del sol Gomez; Wendy Sgaggero
Subject: RE: CA MCaid K2 14487 Contract New-St. Mary Medical Center Apple Valley UAT 1762

Hi Veronica,

We haven't received any response or direction on the failed scenario's from the HP. Please see my responses below in purple.

- ER/OP Services claims had service lines which did not pay at 100% of Medi-Cal fee schedule. Yes, this is a fee schedule issue, if there is not a rate establish for a particular service, the system will price $0.00 since this contract does not have a default percent specified for services without a rate in the fee schedule. We have notified this to the HP and we will wait for their directions. We can defer these scenario's and it will be up to the HP to move this into production.
- Case rate scenario's are not appropriately paying. Yes, the system is applying the reimbursement base on the term selected per line; **this occurs when patient has treated at different LOCs during the entire hospital stay**, generating a payment for the first day on each line and then the LOC. We have notified this issue to HP and we will wait for them to provide directions. We may have to pend these contract terms for manual review. If this cannot be configured, we can defer these scenario's as well and document that these are pending with edit 225. However, there will need to be some

communication to the productio manager and/or the learning team to prov the examiners with guidelines for this contract.

Based on your response we will update the scenario's and submit the final testing spreadsheet for HP approval today

Thanks and I do apologize for not getting back to you sooner.

Nancy

From: Veronica Gutierrez
Sent: Thursday, September 15, 2011 3:33 PM
To: Nancy Vasquez; >>> MHI Claims Systems Testing
Cc: Maria del sol Gomez; Wendy Sgaggero; Julie Szathmary
Subject: RE: CA MCaid K2 14487 Contract New-St. Mary Medical Center Apple Valley UAT 1762

Hi Nancy, I want to follow up on this, I just need an estimate time of completion of the UAT in order to provide this information to the HP and also to coordinate our next steps.

Your assistance is appreciated.

Thanks,
Veronica

From: Veronica Gutierrez
Sent: Wednesday, September 14, 2011 5:00 PM
To: Nancy Vasquez
Cc: Maria del sol Gomez; Wendy Sgaggero
Subject: RE: CA MCaid K2 14487 Contract New-St. Mary Medical Center Apple Valley UAT 1762

Hi Nancy, any update on this? Thanks...

From: Veronica Gutierrez
Sent: Tuesday, September 13, 2011 8:12 AM
To: Nancy Vasquez
Cc: Maria del sol Gomez; Wendy Sgaggero
Subject: RE: CA MCaid K2 14487 Contract New-St. Mary Medical Center Apple Valley UAT 1762

Good Morning Nancy,

Would you be able to provide an estimate time of completion of the cycle 2? I need to provide the HP this information.

Thanks for your assistance,

Veronica

From: Veronica Gutierrez
Sent: Wednesday, September 07, 2011 12:37 PM
To: >>> MHI Claims Systems Testing
Cc: Nancy Vasquez; Maria del sol Gomez; Julie Szathmary; Wendy Sgaggero; Jon Doyle
Subject: FW: CA MCaid K2 14487 Contract New-St. Mary Medical Center Apple Valley UAT 1762

Hi Nancy,

Please proceed with the cycle 2 testing this contract, HP has revised the results and a few updates were performed to this contract such as the LOC terms that have been pended for Manual Review due to inappropriate pricing when patient is move from one level of care to a different level of care. Also the O/P terms are set up to price per contract with 0% default.

If you have any questions please let us know.

Thanks,
Veronica

From: Veronica Gutierrez
Sent: Monday, August 29, 2011 7:34 AM
To: Nancy Vasquez
Cc: >>> MHI Claims Systems Testing; Wendy Sgaggero; Maria del sol Gomez
Subject: RE: CA MCaid K2 14487 Contract New-St. Mary Medical Center Apple Valley UAT 1762

Thanks Nancy, I have reviewed your findings and added my comments to the spreadsheet. You can also find my comments below.

Thanks,
Veronica

From: Nancy Vasquez
Sent: Friday, August 26, 2011 5:18 PM
To: Veronica Gutierrez
Cc: >>> MHI Claims Systems Testing; Wendy Sgaggero; Maria del sol Gomez
Subject: RE: CA MCaid K2 14487 Contract New-St. Mary Medical Center Apple Valley UAT 1762

Hi Veronica,

Testing has been completed. Below is a summary of fails. Attached are the results for your review.

- Medical, surgical and pediatric claims are not paying at correct Per Diem. Appears to be a minor typo. Yes, this has been corrected, please re-adjudicate these claims, they should now show the correct amount.

- Claims: 11238G00005 and 11238G00007 paid correctly. However, please review as it is firing Edit 135. Claim payment amount exceeds the maximum allowed. However, not to exceed amount language was not found in hardcopy contract. Yes, the max allowed edit 135 is related to the max amount allow by HP to price. Yes, this is the max amount allow by the HP to price any claim, this is not related to Stop Loss apply to a particular contract.

- Cardiac Pacemaker claims are not paying correctly. Yes, the system is applying the reimbursement base on the term selected per line; **this occurs when patient has treated at different LOCs during the entire hospital stay,** generating a payment for the first day on each line and then the LOC. We have notified this issue to HP and we will wait for them to provide directions. We may have to pend these contract terms for manual review.

- Cardiac Surgery claims are not paying correctly. Yes, same as above.

- ER/OP Services claims had service lines which did not pay at 100% of Medi-Cal fee schedule. Yes, this is a fee schedule issue, if there is not a rate establish for a particular service, the system will price $0.00 since this contract does not have a default percent specified for services without a rate in the fee schedule. We have notified this to the HP and we will wait for their directions.

- Unlisted procedures did not pay at 30% of Medicare. Yes, same as above.

Thank you,
Nancy

From: Veronica Gutierrez
Sent: Wednesday, August 17, 2011 11:55 AM
To: >>> MHI Claims Systems Testing
Cc: Nancy Vasquez
Subject: FW: CA MCaid K2 14487 Contract New-St. Mary Medical Center Apple Valley-Eff 09-01-11 recd 07-27-11 due 08-10-11

Hello,

Submitting St Mary Medical Center Apple Valley contract for testing; contract is currently configured in "*CA QNXT 3.4 SP 6 – Configuration*" environment. If you have any questions please let us know.

Contract ID: TQMCT04491
Contract Description: ****HOSP - PAR - ST MARY MED CTR APPLE VALLEY
Effective Date: 11/01/10
LOB: San Bernardino, Riverside, Los Angeles

Note: Only 1 contract has been created for this testing since only the contract rates are different from MC and HF

Thanks,
Veronica

From: Joyce Reid **On Behalf Of** CCRF/ARF Submission
Sent: Wednesday, July 27, 2011 1:05 PM
To: Jon Doyle; MHC BA Department
Cc: Wendy Sgaggero; Allan Saena; Veronica Gutierrez; Jennifer Anderson
Subject: CA MCaid K2 14487 Contract New-St. Mary Medical Center Apple Valley-Eff 09-01-11 recd 07-27-11 due 08-10-11

Jon
K2 CCRF Tracking **14487**
Your request has been accepted. Your tracking number: 14487

Joyce A. Reid
Data Specialist II
TCIM/Configuration Dept
Molina Healthcare Inc/Hughes Way Pod A
ph#562-435-3666 x117888
Joyce.Reid@MolinaHealthCare.Com

From: MHC BA Department
Sent: Wednesday, July 27, 2011 12:19 PM
To: CCRF/ARF Submission
Cc: MHC BA Department; Jon Doyle; Wendy Sgaggero; Allan Saena; Veronica Gutierrez
Subject: CCRF--St. Mary Medical Center Apple Valley

Please see approval below, thank you.

From: Ernest Quinones
Sent: Wednesday, July 27, 2011 10:56 AM
To: MHC BA Department

Cc: Jennifer Anderson
Subject: FW: St. Mary Medical Center - Apple Valley

Approved.

Ernie Quiñones

Director - Medicare Corporate Operations

Molina Healthcare

888-562-5442 ext. 142132

(562) 519-5664 (mobile)

Ernest.Quinones@Molinahealthcare.com

From: MHC BA Department
Sent: Wednesday, July 27, 2011 9:14 AM
To: Ernest Quinones
Cc: Jennifer Anderson; MHC BA Department
Subject: FW: St. Mary Medical Center - Apple Valley

Please review for approval in MAPD.
Thank you
Jon

From: Maggie Hollon
Sent: Tuesday, July 26, 2011 5:41 PM
To: Suma Verghese
Cc: Jon Doyle; Deletha Foster; MHC BA Department; Dolores Olague-Swanson
Subject: FW: St. Mary Medical Center - Apple Valley

1 more thing I forgot:

Is there already a tested and configured hospital service grouping for Implants? Thanks again.

From: Maggie Hollon
Sent: Tuesday, July 26, 2011 5:36 PM
To: Suma Verghese
Cc: Jon Doyle; Deletha Foster; MHC BA Department; Dolores Olague-Swanson
Subject: FW: St. Mary Medical Center - Apple Valley

Hi Suma, thanks to you/your team for working on this contract – can you pls confirm whether the exclusions on attached are configurable? Thanks.

From: Maggie Hollon
Sent: Thursday, July 21, 2011 2:10 PM
To: MHC BA Department; Jon Doyle; Deletha Foster; Suma Verghese
Cc: Dolores Olague-Swanson; Lanette Cody; Sue Roth; Lori Cadle; Albert de Anda
Subject: St. Mary Medical Center - Apple Valley

Albert will be routing the contract through the formal process/channels once the contract is fully executed; but wanted to share with you that the St. Mary Medical Center – Apple Valley hospital contract has been completed and signed by the hospital – see attached CCRF & Rate pages.

Jon Doyle

From: Maggie Hollon
Sent: Friday, July 29, 2011 2:31 PM
To: Jon Doyle
Subject: FW: SMMC/Molina contract

From: Maggie Hollon
Sent: Friday, July 29, 2011 2:27 PM
To: 'Mesrak Gessesse'
Cc: Dolores Olague-Swanson
Subject: RE: SMMC/Molina contract

Thank you Mesrak. Will do.

From: Mesrak Gessesse [mailto:Mesrak.Gessesse@stjoe.org]
Sent: Friday, July 29, 2011 2:17 PM
To: Maggie Hollon
Cc: Dolores Olague-Swanson
Subject: RE: SMMC/Molina contract

Ok Maggie please let us include those codes unto the contract under exclusions and we both will initial them. Thanks

---

From: Maggie Hollon [mailto:Margaret.Hollon@MolinaHealthCare.Com]
Sent: Friday, July 29, 2011 2:10 PM
To: Mesrak Gessesse
Cc: Dolores Olague-Swanson
Subject: RE: SMMC/Molina contract

Thanks Mesrak:

We concur with you on 275, 276, and 278 only:
(275-Pacemaker, 276-IntraOcular Lens, and 278-Other Implants)

274 is prosthetics/orthotics (does not meet the clinical definition nor billing definition of an implant per our physicians/nurses here at Molina as well as the National Uniform Billing Committee, UB-04 Data Specifications Manual:

Definition of Implantables: That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing a radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic, diagnostic purposes.

277 = take home oxygen, not meet the definition of implants.

279 = other supplies

Just don't want us to have any claims disputes. I believe this issue was discussed between you and Dolores which led to the contract exclusions of "implants" from inpatient per diems to be paid at 20% of billed charges (the contract does not state that prosthetics/orthotics/supplies are excluded and we would not have been able to agree to these exclusions).

Not trying to be a pain, unfortunately I'm getting a lot of frowns from my leadership re the implant exclusions agreed to in this contract. Not to worry, we absolutely look forward to all of the positives and benefits of this contract and will continue to work side-by-side with you Mesrak to facilitate a continued positive relationship that you have created Mesrak and we very much appreciate you !

From: Mesrak Gessesse [mailto:Mesrak.Gessesse@stjoe.org]
Sent: Friday, July 29, 2011 1:49 PM
To: Maggie Hollon
Cc: Dolores Olague-Swanson
Subject: RE: SMMC/Molina contract

Maggie:
Sorry we keep missing each other
Exclusions include all implants – REV CODES 274 - 279

July 1, is when we have our annual charge master increase.
Let me know if you need any more clarifications.
Thanks

From: Maggie Hollon [mailto:Margaret.Hollon@MolinaHealthCare.Com]
Sent: Friday, July 29, 2011 12:50 PM
To: Mesrak Gessesse
Cc: Dolores Olague-Swanson
Subject: RE: SMMC/Molina contract

Hello Mesrak, per my voicemail, we are seeking concurrence from you as to the specific hospital inpatient implants are represented in the exclusions – was this exclusion intended for all of the cardiac implants only?

Pls let us know the date of St. Mary Apple Valley last chargemaster change? Does St. Mary Apple Valley update chargemaster one time per year?

Thanks again and we appreciate all of your help and support,

Maggie

From: Maggie Hollon
Sent: Wednesday, July 27, 2011 4:48 PM
To: 'Mesrak Gessesse'
Cc: Dolores Olague-Swanson
Subject: RE: SMMC/Molina contract

Hi Mesrak,

Hope all is well. I want to thank both you and Dolores again for all of your diligent efforts on the new contract. Mesrak, I left you a quick non-urgent voicemail. Maybe we'll get a chance to talk live in the next few days or so. Attached are two pages from the contract we received from you that need signature – once you've secured signature, you can PDF back to me. A copy of Molina's Provider Manual is available on our website.

Want to request concurrence from you regarding what codes represent the Implants in the Exclusions part of the contract so as to avoid any potential disputes in the future. I'll be sending you a list of the codes that represent hospital implants for your review.

Thanks and we'll talk soon,

Maggie

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