AMENDMENT TWO TO THE
MOLINA HEALTHCARE OF TEXAS, INC.
HOSPITAL SERVICES AGREEMENT
Health Benefit Exchange

THIS HEALTH BENEFIT EXCHANGE AMENDMENT TO THE HOSPITAL SERVICES AGREEMENT ("Amendment") is made and entered by and between Molina Healthcare of Texas, Inc. ("Health Plan") and **Dallas County Hospital District, dba Parkland Health & Hospital System, a political subdivision of the State of Texas and Hospital District of Dallas County, Texas** ("Provider").

A. **Whereas**, Health Plan and Provider have entered into a Hospital Services Agreement, or other corresponding health care services agreement or contract, as may have been amended from time to time ("Agreement"); and

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

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

1. Section 2.10 **Claims Payment**, subsection b, **Compensation**, is deleted and replaced with the following subsection c:

   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-1 – Compensation Schedule for Molina Texas Medicaid and CHIP products and Attachment D-2- Compensation Schedule for Molina Health Benefit Exchange Product as applicable. Provider shall accept such compensation in accordance with the Attachment D-1 and Attachment D-2, applicable copayments, deductibles, and coordination of benefits collections as payment in full for services provided under this Agreement. Health Plan shall adjudicate (pend, pay or deny) Clean Claims within thirty (30) days from the date the claim is received for Members enrolled in Health Plan's Star or Star Program, Star+Plus or Star+Plus Program, Children's Health Insurance Program, and Children's Health Insurance Program Perinatal Program. For any Clean Claims that are not adjudicated within thirty (30) days, Health Plan shall pay eighteen percent (18%) interest calculated annually for Members enrolled in Health Plan's Star or Star Program, Star+Plus or Star+Plus Program, Children's Health Insurance Program, and Children's Health Insurance Program Perinatal Program. However, duplicate claims filed prior to the expiration of thirty-one (31) days are not subject to any interest payment if not processed within thirty (30) days for Members enrolled in Health Plan's Star or Star Program, Star+Plus or Star+Plus Program, Children's Health Insurance Program, and Children's Health Insurance Program Perinatal Program.

2. Section 2.13 **Compliance with Applicable Law** (or equivalent section of the Agreement) is amended by adding the following subsection f:

    f. For Covered Services rendered to Members enrolled in a Molina Health Benefit Exchange Product, Provider shall use commercially reasonable efforts to comply with all statutory and regulatory requirements applicable to the Health Benefit Exchange, including the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, and referred to collectively as the Affordable Care Act; regulations at 45 CFR Parts 153, 155, and 156; Title 6, Chapter 843 of the Texas Insurance Code; and Title 28, T.A.C. §11.901.

3. Section 5.3 **Entire Agreement** (or equivalent section of the Agreement) is deleted and replaced with the following:

    5.3 **Entire Agreement.** This Agreement, together with Attachments, Amendments and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. Additionally, as to the Medicaid and CHIP products offered by Health Plan and listed in Attachment C, the UMCC is incorporated herein by reference and this Agreement shall be the guiding and controlling document when interpreting the terms in the event of a conflict between the Provider Manual, UMCC and this Agreeement. 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.

4. Section 5.13 **Attachments** (or equivalent section of the Agreement) is amended to add the following to the list of Attachments which are part of the Agreement:

    "Attachment D-1-Compensation Schedule for Molina Texas Medicaid and CHIP products"

    "Attachment D-2-Compensation Schedule for Molina Health Benefit Exchange Product"

    "Attachment I-Molina Health Benefit Exchange Product Requirements"

5. Section 5.14 is added as follows:

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

6. All cross-references to Attachment D-1 and D-2 in the Agreement not specifically addressed by this Amendment are revised as follows:

   "Attachment D, Attachment D-1, or Attachment D-Compensation Schedule for Molina Health Benefit Exchange Product, as applicable"

7. Attachment B, **Definitions** , is amended by adding the following defined terms:

   "**Health Benefit Exchange** means the federal health benefit exchange established for Texas pursuant to the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, and referred to collectively as the Affordable Care Act; and regulations at 45 CFR Parts 153, 155, and 156."

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

8. Attachment C (Products/Benefits Inventory) is amended by adding the following product:

   "Molina Health Benefit Exchange Product."

9. Attachment D-1 and D-2 Compensation Schedule for Molina Health Benefit Exchange Product, attached hereto, is added.

10. Attachment I-Molina Health Benefit Exchange Requirements, attached hereto, is added.

11. Any reference to UMCC or UMCM in the Agreement shall be applicable to the Molina Health Benefit Exchange Product, unless stated otherwise by this Amendment, determined to be a violation of state or federal law or regulations related to the Molina Health Benefit Exchange Product, or identified as specific to a product other than the Health Benefit Exchange Product in the Agreement.

12. The following Sections are not applicable to the Molina Health Benefit Exchange Product and are replaced, for purposes of the Molina Health Benefit Exchange Product only, by Attachment H-Molina Health Benefit Exchange Requirements, attached hereto:

    Section 2.10, **Claims Payment**, subsection a, **Submitting Claims**
    Section 2.10, **Claims Payment**, subsection d, **Copayments and Deductibles**
    Section 2.10, **Claims Payment**, subsection e, **Coordination of Benefits**
    Section 2.10, **Claims Payment**, subsection f, **Offset**
    Section 2.10, **Claims Payment**, subsection h, **Member Billing**

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

14. Health Plan and Provider recognize that this Amendment and/or the Agreement may require further amendments in the event that any federal, state or local agency, administration, board or other governing body requires changes to this Amendment or Agreement as a condition of approval. Health Plan will be entitled to revise this Amendment and/or the Agreement immediately without Provider's consent, if an additional amendment is being effected by Health Plan to comply with any federal, state or local agency, administration, board or other governing body request and/or regulatory requirement regarding the Health Benefit Exchange. Health Plan will provide Provider notice of any such revisions to this Amendment or the Agreement.

15. Effective Date. This Amendment will become effective on January 1, 2014, and renew with and under the terms of the Agreement.

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

17. No Other Modifications. Except as provided herein, and regardless of any citations or references to the UMCC or UMCM, the terms and conditions of the Agreement will remain the same, in full force and effect.

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

Parkland Health and Hospital System		**Molina Healthcare of Texas, Inc.**	
By:	LIZ MCMULLEN	By:	Anne P Rote
	VICE PRESIDENT FINANCE		Anne P Rote
Its:		Its:	COO
Date:	4-4-14	Date:	4-4-2014

ATTACHMENT D-1 – Compensation Schedule for Molina Texas Medicaid, CHIP products and Medicare Advantage plans

Compensation Schedule

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

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

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

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

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

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

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

Network Access Assurance Payment:

In the event that HHSC allocates Network Access Assurance Payment or other similar payments to the Health Plan that have historically been paid or that are derived from amounts intended for payment to Provider for either hospital or professional services, the Health Plan will assure one hundred percent (100%) of those funds are paid to the Provider within thirty (30) days of the Health Plan receiving such funds.

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

ATTACHMENT D-2-COMPENSATION SCHEDULE FOR MOLINA HEALTH BENEFIT EXCHANGE PRODUCT

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

Molina Health Benefit Exchange Product:

Inpatient Services: Covered Services shall be paid at One Hundred and Twenty Percent (120%) of Hospital's Standard Dollar Amount in accordance with the State of Texas Medicaid DRG reimbursement methodology in effect on the date of service. Inpatient Service reimbursement will follow the terms and conditions that currently exist in Providers Hospital Service Agreement.

Outpatient Services: Covered Services shall be paid at One Hundred and Twenty Percent (120%) of the payable rate as defined below for the applicable service in accordance with the State of Texas Medicaid reimbursement methodology in effect on the date of service.

- Radiology services shall be paid at 120% of the then current Texas Medicaid Radiology Fee Schedule
- Labatory servies shall be paid 120% of the then current Texas Medicaid Interim Cost-to-Charge ratio less the Texas Medicaid high volume provider discount
- ASC/HASC services shall be paid at 120% of the then current Texas Medicaid ASC Grouper rate following the then current Texas Medicaid methodology
- Professional services shall be reimbursed at 120% of the then current Texas Medicaid Fee Schedule for professional services
- All other services shall be reimbursed at 120% of the then current Texas Medicaid Interim Cost-to-Charge ratio not reduced by any outpatient reduction factor

If there is no payment rate in the Medicare Fee-For-Service Program as of the date(s) of service, payment shall be at 120% of the ICCR as of the date(s) of service.

Example formulae for ICCR:
120% of the ICCR is calculated by:
If the current ICCR rate is 30% then 120% of the ICCR rate is calculated by the following:
30% x 120% = 120% of the ICCR
30% x 1.2 = 36%

ATTACHMENT H- MOLINA HEALTH BENEFIT EXCHANGE REQUIREMENTS

This Attachment H sets forth the Molina Health Benefit Exchange Product requirements. The provisions of this Attachments shall apply to all Members enrolled in Molina's Health Benefit Exchange Product or other product governed by the Texas Insurance Code. All of the provisions listed in this Attachment are inapplicable to Members in Health Plan's Star or Star Program, Star+Plus or Star+Plus Program, Children's Health Insurance Program, Children's Health Insurance Program Perinatal Program, Medicare Advantage or Medicare Advantage Special Needs Plan. In the event that any of the provisions in the Agreement conflict with the provisions of this Attachment, the provisions of the Agreement shall control for all Members enrolled in Molina's Health Benefit Exchange Product. The Agreements and this Attachment shall be automatically modified to conform to subsequent regulatory requirements.

1. Claim Submission

Provider will submit all claims to Health Plan no later than the three hundred sixty five (365th) day after the date the Provider provides health care services for which the claim is made. Provider may: (1) mail a claim by United States mail, first class, or by overnight delivery service; (2) submit the claim electronically; (3) fax the claim; or (4) hand deliver the claim. . Provider shall promptly submit Clean Claims, for Covered Services rendered to Members, on either a standard CMS 1500 (or its successor) using the billing rules, codes, and modifiers set forth in the most current standard edition of the AMA CPT Code manual, or UB-04 (or its successor) claim form using Medicaid billing rules, codes and guidelines or ASC X 12N 837 electronic format in compliance with federal laws related to electronic claims. For all services, Provider shall use best efforts to file claims within ninety-five (95) days from the date of service. Health Plan shall have the right to deny Clean Claims received after three hundred sixty five (365) days from date of service or discharge, as applicable (UMCC Att. B-1, §8.1.18.5.)

2. Duplicate Claim Submission

A Provider may not submit a duplicate claim for payment before the thirty first (31st) day after the original claim was submitted.

3. Determination of Claim

Health Plan is required to make a determination of whether a claim is payable not later than the thirtieth (30th) day after the date the Health Plan receives a Clean Claim from a Provider that is electronically submitted.

If Health Plan determines the entire claim is payable, Health Plan shall pay the total amount of the claim not later than the thirtieth (30th) day after the date the Health Plan receives a Clean Claim from a Provider that is electronically submitted.

If Health Plan determines a portion of the claim is payable, Health Plan shall pay the portion of the claim that is not in dispute not later than the thirtieth (30th) day after the date the Health Plan receives a Clean Claim from a Provider that is electronically submitted and notify the Provider in writing why the remaining portion will not be paid.

If Health Plan determines the entire claim is not payable, Health Plan shall deny the total amount of the claim not later than the thirtieth (30th) day after the date the Health Plan receives a Clean Claim from a Provider that is electronically submitted and notify the Provider in writing why the claim will not be paid.

4. Additional Information to Make Determination of Claim

If Health Plan needs additional information from a Provider to determine payment on a Clean Claim, Health Plan must request the additional information not later than the thirtieth calendar day after the date the Health Plan receives the Clean Claim. Health Plan shall determine whether the claim is payable on or before the later of the 15th day after the date the Health Plan receives the requested attachment or the latest date for determining whether the claim is payable as a Clean Claim. Health Plan may not make more than one request in connection with a claim. The Provider may (1) mail the additional information by United States mail, first class, or by overnight delivery service; (2) submit the additional information electronically; (3) fax the additional information; or (4) hand deliver the additional information.

5. Penalties for Late Payment of Claims

If Health Plan fails to make a payment on a Clean Claim within the required time frames, Health Plan shall pay the following penalties:

a. **Payment is made on or after the 1st say and before the 46th after the Health Plan is required to make a determination and make payment of claim:** Health Plan shall pay the Provider making the claim the contracted rate owed on the claim plus a penalty in the amount of the lesser of: (1) 50 percent of the difference between the billed charges, as submitted on the claim, and the contracted rate or (2) $100,000.

b. **Payment is made on or after the 46th day and before the 91st days after the Health Plan is required to make a determination and make payment of claim:** Health Plan shall pay the Provider making the claim the contracted rate owed on the claim plus a penalty in the amount of the lesser of: (1) 100 percent of the difference between the billed charges, as submitted on the claim, and the contracted rate or (2) $200,000.

c. **Payment is made on or after the 91st day after the Health Plan is required to make a determination and make payment of claim:** Health Plan shall pay a penalty in the amount of the lesser of: (1) 100 percent of the difference between the billed charges, as submitted on the claim, and the contracted rate or (2) $200,000, plus 18 percent annual interest on that amount. Interest accrues beginning on the date the Health Plan was required to pay the claim and ending on the date the claim and the penalty are paid in full.

If Health Plan pays only a portion of the amount of a Clean Claim within the required time frames, Health Plan shall pay the following penalties:

a. **Payment is made on or after the 1st say and before the 46th after the Health Plan is required to make a determination and make payment of claim:** Health Plan shall pay the Provider making the claim the remainder of the contracted rate owed on the claim plus a penalty on the amount not timely paid in the amount of the lesser of: (1) 50 percent of the difference between the billed charges, as submitted on the claim, and the contracted rate or (2) $100,000. The underpaid amount is calculated on the ratio of the amount underpaid on the contracted rate to the contracted rate as applied to an amount equal to the billed charges as submitted on the claim minus the contracted rate.
b. **Payment is made on or after the 46th day and before the 91st days after the Health Plan is required to make a determination and make payment of claim:** Health Plan shall pay the Provider making the claim the remainder of the contracted rate owed on the claim plus a penalty on the amount not timely paid in the amount of the lesser of: (1) 100 percent of the difference between the billed charges, as submitted on the claim, and the contracted rate or (2) $200,000.
c. **Payment is made on or after the 91st day after the Health Plan is required to make a determination and make payment of claim:** Health Plan shall pay a penalty on the balance of the claim computed in the amount of the lesser of: (1) 100 percent of the underpaid amount or (2) $200,000, plus 18 percent annual interest on that amount. Interest accrues beginning on the date the Health Plan was required to pay the claim and ending on the date the claim and the penalty are paid in full.

For a penalty relating to a Clean Claim submitted by a Provider other than an institutional provider, the Health Plan shall pay the entire penalty, excluding a portion of the interest as described below, to the Provider. However, any interest paid for a Clean Claim that is payable and that the Health Plan does not pay on or after the 91st day after the date the Health Plan is required to make a determination or adjudication of the claim shall be paid to the Texas Health Insurance Risk Pool. For a penalty relating to a Clean Claim submitted by an institutional provider, the Health Plan shall pay 50 percent of the total penalty amount, including interest, to the institutional provider and the remaining 50 percent of that amount to the Texas Health Insurance Risk Pool. For purposes of assessing penalties, "Institutional provider" means a hospital or other medical or health-related service facility that provides care for the sick or injured or other care that may be covered in an evidence of coverage.

Notwithstanding the above, Health Plan is not liable for a penalty if 1) the failure to pay the claim is a result of a catastrophic event that substantially interferes with the normal business operations of the Health Plan or (2) if the claim was paid in accordance with the Texas Insurance Code, but for less than the contracted rate, and: the Provider notifies the Health Plan of the underpayment after the 270th day after the date the underpayment was received and the Health Plan pays the balance of the claim on or before the 30th day after the date the Health Plan received the notice.

6. Coordination of Benefits

Provider is required to use commercially reasonable effort to maintain updated information concerning other health benefit plan coverage for a Member and to provide the information to the Health Plan.

7. Offset

Health Plan may recover an overpayment to Provider if Health Plan provides written notice of the overpayment to the Provider that includes the basis and specific reasons for the request for recovery of funds not later than the 180th day after the date the Provider receives the payment, and the Provider does not make arrangements for repayment of the funds on or before the 45th day after the date the physician or provider receives the notice. The Provider may choose to appeal the request if the Provider disagrees with the request for recovery.

8. Member Hold Harmless

Provider hereby agrees that in no event, including, but not limited to non-payment by the Health Plan, Health Plan insolvency, or breach of this agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against subscriber, enrollee, or persons other than Health Plan acting on their behalf for services provided pursuant to this agreement. This provision shall not prohibit collection of supplemental charges or copayments made in accordance with the terms of the Agreement between Health Plan and Member. Provider further agrees that:

(i) this provision shall survive the termination of this agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Health Plan Member; and

(ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Member, or persons acting on their behalf. Any modification, addition, or deletion to the provisions of this clause shall be effective on a date no earlier than 15 days after the commissioner has received written notice of such proposed changes.

9. Deductibles and Copayments

Provider may bill a Member for any co-payment, deductible or co-insurance obligation applicable to Member's Health Plan product.