AMENDMENT TO MOLINA HEALTHCARE OF WASHINGTON, INC. HOSPITAL SERVICES AGREEMENT

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

Whereas, Health Plan and Provider entered into a Hospital Services Agreement ("Agreement"), November 1, 2009 and

Whereas, Health Plan and Provider hereby agree to amend the Agreement in accordance with the terms and conditions of this Amendment.

Now therefore, in consideration of the rights and obligations contained herein, the parties to this Amendment, intending to be legally bound, do hereby agree as follows:

1. Attachment H (Credentialing Delegation) is added to the Agreement, attached hereto.

2. Effective Date. This Amendment shall become effective on February 1, 2017, and renew with and under the terms of the Agreement.

3. Use of Defined Terms. Terms utilized in this Amendment shall have the same meaning set forth in the definitions to the Agreement.

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

This Amendment is in addition to, and does not replace or supersede, the Agreement between Health Plan and Provider filed with Health Plan. All conditions and provisions of the Agreement, except as specifically modified herein, shall remain binding. If there is any ambiguity or inconsistency between the documents not specifically addressed in this Amendment, the original Agreement shall be operative and enforced.

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

Kadlec Regional Medical Center		Molina Healthcare of Washington, Inc.	
By:	DocuSigned by: Carladenise Edwards	By:	
	Carladenise Edwards		Andrew Nelson
Its:	GVP Contracting & Gov Pgms	Its:	Vice President
Date:	02/01/2017	Date:	02/03/2017

ATTACHMENT H
CREDENTIALING DELEGATION

I. Delegation: Provider is delegated for the credentialing activities described in II below. Delegation is contingent on Provider and its delegates in any tier meeting all applicable regulatory and accreditation requirements applicable to the lines of business contracted. These requirements include: National Committee for Quality Assurance (NCQA) Health Plan credentialing standards; Centers for Medicare and Medicaid Services (CMS) laws, regulations and CMS instructions; Washington State Health Care Authority (HCA) managed care laws, regulations, and contract requirements; Washington State Office of the Insurance Commissioner (OIC) laws and regulations; and Health Plan's requirements for credentialing delegation. Health Plan's requirements are stated in this attachment and in the most recent versions of Health Plan's delegation policies and procedures and annual program assessment documents, hereby incorporated by this reference. Health Plan retains the right, at its sole discretion, to amend, add, change, or modify its delegation policies and procedures and annual assessment program documents.

II. Delegate Responsibilities for Credentialing Activities: The following credentialing activities are specifically delegated:

A. For Provider Physicians and other practitioners credentialed by Provider:

1. The mailing, receipt, and processing of applications for credentialing and recredentialing via the Washington Practitioner Application (WPA), or another application that addresses at least the following elements:
   a. Disclosure of current practice contact information, including but not limited to, primary mailing address, phone and fax numbers; and secondary mailing, phone and fax numbers if appropriate
   b. Disclosure of current Washington State Licensure
   c. Disclosure of current Federal DEA registration, if applicable
   d. Disclosure of completed education and/or training in the appropriate specialty area
   e. Disclosure of current or intended ABMS board certification, if applicable
   f. Disclosure of work history for the most recent five year period, or since granting of an initial license, whichever is less
   g. Disclosure of any current or past malpractice claims history, including but not limited to pending, dismissed, or closed cases
   h. Disclosure of current or past license sanction history
   i. Disclosure of current or past Medicare/Medicaid sanction history
   j. Disclosure of an inability to perform the essential functions of the position, with or without accommodation
   k. Disclosure of any present illegal drug use
   l. Disclosure of any history of loss of license
   m. Disclosure of any history of felony conviction(s)
   n. Disclosure of any loss or limitation of privileges or disciplinary action(s)
   o. Disclosure of professional malpractice insurance coverage currently in effect

p. Disclosure of primary admitting plan, or 24 hour coverage plan, if applicable
q. A statement attesting to the correctness and completeness of the application and all attachments

2. Verification from approved primary sources of all file elements as required by NCQA, CMS when applicable, and Health Plan as follows and within the identified timeframes:
   a. License(s) in States in which the practitioner is providing care to Health Plan members, within 180 days of the current committee decision date.
   b. Current DEA Certificate registered to a practice location in each state in which the practitioner is providing care to Health Plan members, or DEA Coverage Plan when applicable, prior to committee decision date. Coverage Plans must be documented in each applicable file. When delegation includes CMS lines of business, verification of certificate or coverage plan must be within 180 days of the current committee decision date.
      i. If a physician or other practitioner does not have a DEA certificate and is practicing in a specialty that would otherwise require a DEA certificate (i.e. Family Medicine, Rheumatology, Internal Medicine, etc.) a description of why there is no certificate and a DEA coverage plan must be documented in the file prior to the committee decision, within the timeframes identified directly above.
   c. Highest level of education and training, or board certification. Verification of completion of fellowship training via the educational institution does not meet the intent of this requirement.
      i. If a physician is practicing in a fellowship specialty, verification of completion of the fellowship program, or fellowship specialty board certified, must be completed.
         - If a physician has not yet completed fellowship training at the time of committee decision, follow up verification of successful completion of the fellowship program, via the sources listed above, must be completed within 6 months of anticipated completion date.
   d. Work history for the most recent 5 year period or since granting of initial licensure, whichever is less, disclosed in Month/Year format. Gaps of 6 months or more may be clarified verbally with the physician or other practitioner; gaps of 12 months or more must be clarified with the practitioner in writing. Verification must be documented on an application checklist or in a Memo to File that includes the date of verification and signature or initials of verifier. When delegation includes CMS lines of business, verification of work history must be within 180 days of the committee decision date.
   e. Most recent 5 years of malpractice claims history, within 180 days of the current committee decision date.
   f. History of license sanctions from the previous 5 years in all states in which the practitioner is/was licensed, within 180 days of the current committee decision date.

g. History of Medicare and Medicaid sanctions from the previous 5 years within 180 days of the current committee decision date. When delegation includes CMS lines of business, verification of Medicare sanctions must come directly from the OIG and SAM webpage.
h. Admitting privileges or coverage plan, when applicable. Primary Source Verification of this element is not required.
i. Malpractice Insurance coverage within 180 days of the current committee decision date. A practitioner attestation of coverage is not acceptable.
j. When delegation includes Medicare lines of business, review of the Medicare Opt Out Report within 180 days of the credentialing and recredentialing committee decision dates.
k. When delegation includes Medicare lines of business, review of Quality Information for all practitioners as a part of the recredentialing process within 180 days of the recredentialing committee decision date.

3. Ongoing monitoring of sanctions as defined below:
   a. Monthly review of state licensing agency sanctions and Medicare and Medicaid sanctions within 30 days of release from the source
   b. When delegation includes Medicare lines of business, quarterly review of the Medicare Opt Out Report within 30 days of release from the source.

B. Credentialing committee review and decision-making to approve or deny Provider practitioners at both initial credentialing and recredentialing;
C. Recredentialing of Physicians and other Practitioners at least once every 36 months in a manner similar to those described in Section II A above
D. Handling credentialing/recredentialing decision appeals;
E. Oversight of any credentialing activities subdelegated to Credentials Verification Organizations or other provider organizations.

III. Excluded Healthcare Professional: Pursuant to section 1128 of the Social Security Act, Provider may not subcontract with an excluded healthcare professional/person. The Provider shall terminate subcontracts immediately when the Provider becomes aware of such excluded healthcare professional/person or when the Provider receives notice from Health Plan or HCA, whichever is earlier. Provider certifies that neither it nor its Provider contractor is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Provider is unable to certify to any of the statements in this certification, Provider shall attach a written explanation to this Agreement.

A. In the event an excluded individual is discovered during the Credentialing, Recredentialing, or Ongoing Monitoring process, Provider will:
   1. Report to Health Plan any excluded individual or entity within five (5) business days of discovery
   2. Report to Health Plan any actions taken by Provider to terminate the relationship with the excluded individual or entity
   3. Report civil or criminal convictions of any individual(s) with an ownership or controlling interest of 5% or more or who is a managing employee, within five (5) business days of discovery. If the individual owner is related to another owner, a managing employee, general manager, business manager, administrator, director,

or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency, board of directors, agents with the authority to act on behalf of the provider, officers or directors of a provider entity that is organized as a corporation, or someone with controlling interest, report the individual only if they are a spouse, parent, child or sibling.

4. Report for cause termination of any individual(s) with an ownership or controlling interest of 5% or more or who is a managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency, board of directors, agents with the authority to act on behalf of the provider, officers or directors of a provider entity that is organized as a corporation, or someone with controlling interest, report the individual only if they are a spouse, parent, child or sibling within five (5) business days of discovery.

B. Provider shall maintain a list of any individual(s) with an ownership or controlling interest of 5% or more or who is a managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency, board of directors, agents with the authority to act on behalf of the provider, officers or directors of a provider entity that is organized as a corporation, or someone with controlling interest related to another person with ownership or control interest as a spouse, parent , child, or sibling. List must be provided to Health Plan within five (5) business days of request.

IV. Subdelegation: Health Plan retains the right to approve arrangements for any credentialing activities subdelegated by Provider or any of its delegates. Provider shall obtain Health Plan's approval prior to subdelegation in any tier of any credentialing activities initiated during the term of this Agreement, and shall report any change in approved subdelegation arrangements to Health Plan at least thirty (30) days in advance of such change. Subdelegates shall be subject to all applicable federal and state regulations and requirements as stated in section I above.

V. Delegate Reporting Requirements: In addition to reporting requirements described in other sections of this Agreement, Provider shall provide Health Plan with the following information necessary for the oversight of delegated credentialing:

A. Immediate Notice: Within one working day of taking adverse action against a Provider Physician or other practitioner credentialed by Provider, including termination, suspension, or other disciplinary action, Provider shall provide written notice to Health Plan of such adverse action. Such notice shall include the specific reason(s) for the adverse action.

B. Provider shall use its best efforts to provide Health Plan with at least 90 days prior written notice of new Provider Physicians or other practitioners joining Provider, and at least 120 days prior written notice of Provider Physicians or other practitioners terminating participation with Provider. This requirement is in addition to Health Plan's monthly reporting requirements for credentialing delegates, which are summarized in C below.

C. Provider shall provide Health Plan with the monthly credentialing activity information as required in Health Plan policy, which is incorporated by reference, including, but not limited to:
   1. Detailed credentialing information regarding practitioners initial credentialed and recredentialed;
   2. Updates to important business information for practitioners;
   3. Changes to credentialing policy;
   4. When applicable, a summary of any other activities carried out to improve performance

D. Provider shall notify Health Plan of any significant changes to the Credentialing Program 60 days prior to change. Significant changes include, but are not limited to, a change in provider types credentialed and/or not credentialed, a change in recredentialing cycle length, or a change in provider rights during the Credentialing or Recredentialing process.

E. Provider shall send all notices and reports for credentialing delegation to Health Plan's Delegation Manager.

VI. Health Plan Responsibilities:

A. Health Plan has delegated all credentialing and recredentialing responsibilities except facility credentialing and site visits based on a pre-delegation assessment of Provider's credentialing program, which found the credentialing program to be in substantial compliance with all application regulatory and accreditation requirements and required corrective action for all aspects that were not found to be fully compliant.

B. Health Plan's oversight responsibilities are described in sections VI-VII and XI of this attachment. In addition, Health Plan will:
   1. review monthly any other required reports as described in section V on an ongoing basis;
   2. monitor federal and state exclusions, sanctions and license limitations for the entire Health Plan network, including practitioners for whom credentialing is delegated;
   3. conduct required site visits and medical record keeping practice review according to Health Plan policy.

C. Health Plan will provide Provider with monthly reports of member complaints received on Health Plan's Member Services toll-free line and adverse event information for Provider members.

D. Review of Member Complaints and Adverse Events, and implementing appropriate interventions, when applicable.

E. Review monthly report information and follow-up with Provider as necessary.

F. Requiring a corrective action plan for any compliance issues identified and tracking it to completion.

VII. Right to Approve and Terminate: Health Plan retains the right to review and approve, deny, suspend or terminate practitioners for participation under the terms of this Agreement if Health Plan credentialing requirements are not met. Health Plan agrees to notify Provider in writing within one working day of taking an adverse action against any Provider physician or other practitioner and to evaluate its decision promptly if new

information is provided by Provider.

VIII. Annual Program Assessment: Subsequent to predelegation assessment, and following reasonable advance notice, Health Plan shall conduct annual assessments of Provider's credentialing program. Health Plan shall base such assessment on NCQA, CMS, HCA, and OIC standards for credentialing and will include review of credentialing and recredentialing files. Provider shall provide access to all records necessary to assess Provider's credentialing program. CMS requirements for Medicare will only be reviewed for Providers with agreements that include Medicare lines of business.

IX. Corrective Action: Health Plan shall request corrective action for any deficiencies identified during the annual assessment, through required reporting, or through regulatory oversight by federal or state authorities listed in section I above. Provider shall respond in writing within thirty (30) days of receipt of a request for a corrective action from Health Plan, and shall complete corrective action in a manner and timeframe acceptable to Health Plan. Health Plan and Provider agree to allow reasonable time periods to cure deficiencies. Should CMS, HCA, OIC, or Health Plan, determine that Provider is not performing satisfactorily after having been given a reasonable timeframe to cure deficiencies, Health Plan will rescind credentialing delegation upon thirty-days (30) advance written notice to Provider. Health Plan agrees not to rescind credentialing delegation without having first requested corrective action from Provider unless ordered to do so by CMS, HCA, or OIC.

X. Federal and State Reviewers: Upon request and with reasonable advance notice, Provider shall provide access to credentialing files and records for duly authorized representatives of the federal and state government

XI. NCQA Reviewers: Provider agrees to provide access to credentialing files and records for NCQA reviewers as necessary to facilitate Health Plan's NCQA accreditation process. Health Plan agrees to provide Provider with notice of a file request within one working day of receiving the request from NCQA.

XII. Delegation Termination: In the event this Agreement or credentialing delegation ends, Provider and Health Plan will develop a mutually agreeable transfer of Provider's credentialing file information necessary for Health Plan to adopt Provider's credentialing cycle.

XIII. Confidentiality: Provider and Health Plan shall only use member and practitioner information shared under this Agreement for credentialing and credentialing delegation oversight purposes. Provider and Health Plan agree to hold all provider and member information shared under the terms of this Agreement confidential, except as required by law. Protected health information (PHI) shall mean information defined as such in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

A. Provider may use and disclose PHI as follows:
    1. To the member (or member's representative) who is the subject of the PHI;
    2. To carry out treatment, payment and healthcare operations necessary to fulfill Provider's obligations under this Agreement;

3. Pursuant to and in compliance with a valid written authorization;
4. To regulatory agencies, public health agencies, law enforcement, and judicial and administrative hearing officials, or as otherwise required by law.

B. Safeguards to prohibit the inappropriate use or disclosure of protected health information are described as follows.
   1. Provider shall not request, use or release more than the minimum amount of PHI necessary to accomplish the purpose of the use or disclosure.
   2. Provider shall establish safeguards to prevent unauthorized use or disclosure of PHI.
   3. Provider shall immediately report to Health Plan any unauthorized uses or disclosures of which it becomes aware, and shall take all reasonable steps to mitigate any harmful effects of such breach.
   4. Provider shall ensure that all of its subcontractors and agents are bound by the same restrictions and obligations contained herein whenever PHI is made accessible to such subcontractors or agents.

C. Provider stipulates that:
   1. Any subdelegates have safeguards to protect information from inappropriate use or disclosure;
   2. Provider and any subdelegates will provide members with access to their protected health information as required by law;
   3. Provider will inform Health Plan in writing if any inappropriate uses or disclosures of information occur;
   4. Provider will continue to protect information shared under the terms of this Agreement after delegation ends as required by law.

XIV. Protection from Discovery: Assessment documents, corrective action, reports, and correspondence pertaining to credentialing delegation are protected from discovery under RCW 43.70.510 as part of Health Plan's confidential quality improvement program.