AMENDMENT TO THE COMBINED PROVIDER SERVICES AGREEMENT

THIS AMENDMENT TO THE COMBINED PROVIDER SERVICES AGREEMENT ("Amendment") is made and entered by and between Molina Healthcare of Washington, Inc. ("Health Plan") and Public Hospital District #1 of King County dba Valley Medical Center ("Provider").

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

Whereas, Health Plan and Provider entered into a Combined Provider Services Agreement ("Agreement"), November 1, 2020, as amended.

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. Article Five – General Provisions, 5.11 Attachments, of the Agreement is amended and attached hereto.
2. Attachment 2 – Required Provisions (Health Care Service Plans), item 14.a is amended to add the following clause:

   iv. On any undenied and/or unpaid clean claims over sixty-one (61) days old, interest shall be assessed at the rate of one percent (1%) per month and shall be calculated monthly as simple interest prorated for any portion of a month and shall be payable to the amount of the unpaid claim without the necessity of the provider or facility submitting an additional claim.
3. Exhibit 1-D (Medicare Quality Bonus Program) is deleted from the Agreement and replaced with Exhibit 1-D (Compensation Schedule Molina Public Option), attached hereto.
4. Effective Date. This Amendment shall become effective on January 1, 2023, and renew with and under the terms of the Agreement.
5. Use of Defined Terms. Terms utilized in this Amendment shall have the same meaning set forth in the definitions to the Agreement.
6. 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.

Public Hospital District #1 of King County
dba Valley Medical Center

By: Jeannine Grunkell

Its: CEO

Date: 5/11/22

Molina Healthcare of Washington, Inc.

By: DocuSigned by: Andrew Nelson 6F45AD3EE44148E...

Andrew Nelson

Its: VP, Network Management

Date: 5/19/2022

Article Five – General Provisions

5.11 **Attachments.** Each of the Attachments and Exhibits (as selected) and identified below is hereby made a part of this Agreement:

☒Attachment 1 - Provider Identification Sheet
☒Attachment 2 - Required Provisions (Health Care Service Plans)
☒Attachment 3 - Required Provisions (Health Care Authority)
☒Attachment 4 - Medicare Program Requirements-Health Care Services
☐Attachment 5 - Indian Health Care Providers Medicaid/CHIP Provisions
☐Attachment 6 - Indian Health Care Providers–Qualified Health Plan
☒Exhibit 1-A - Compensation Schedule - Medicaid (Version 1)
☐Exhibit 1-A - Compensation Schedule - Medicaid (Version 2)
☒Exhibit 1-B - Compensation Schedule - Medicare (Version 1)
☐Exhibit 1-B - Compensation Schedule - Medicare (Version 2)
☒Exhibit 1-C - Compensation Schedule - Molina Marketplace (Version 1)
☐Exhibit 1-C - Compensation Schedule - Molina Marketplace (Version 2)
☒Exhibit 1-D - Compensation Schedule - Molina Public Option

EXHIBIT 1-D
Compensation Schedule – Molina Public Option

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan's programs participation, 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:

I. Hospital Services:

Inpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred sixty percent (160%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service. The Existing Medicare MSDRG reimbursement rate is defined as: the current Center for Medicare and Medicaid Services (CMS) Inpatient Prospective Payment System (IPPS) grouper, DRG weights and base rate (including wage index, operating, base capital, base Disproportionate Share Hospital (DSH) and capital indirect Medical Education (IME) adjustments) plus applicable outlier amounts using CMS outlier methodologies under Medicare as of the date of service.

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

Outpatient Services:

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

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

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at sixty-five percent (65%) of billed charges.

II. Professional Services:

Hospital & Clinic Based Specialty Services:

Covered Services shall be paid at one hundred sixty percent (160%) of the prevailing local and geographically adjusted Medicare Fee-For-Service Program fee schedule in effect, as of the date of service.

If there is no payment rate in the prevailing local and geographically adjusted Medicare Fee-For-Service Program fee schedule in effect on the date of service, payment shall be at two hundred percent (200%) of the Medicaid Fee-For-Service Program fee schedule in effect, as of the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at sixty-five percent (65%) of billed charges.