AGREEMENT FOR PROVISION OF
HOSPITAL SERVICES
FOR THE
MEDICAL SERVICES INITIATIVE PROGRAM
BETWEEN
COUNTY OF ORANGE
AND

SEPTEMBER 1, 2010 THROUGH FEBRUARY 29, 2012

THIS AGREEMENT (Agreement) is entered into this 24th day of August 2010 which date is enumerated for purposes of reference only, is by and between the County of Orange (COUNTY), and ----------(HOSPITAL). This Agreement shall be administered by the County of Orange Health Care Agency (ADMINISTRATOR).

W I T N E S S E T H:

WHEREAS, COUNTY desires to assure the availability of Hospital Services to all indigent persons for whom COUNTY is legally responsible pursuant to State of California (State) Law; and,

WHEREAS, COUNTY anticipates the continued receipt of Coverage Initiative Funding to expand eligibility requirements for a limited number of additional indigent persons and expand scope of service benefits beyond its legal responsibility pursuant to State law; and,

WHEREAS, COUNTY, as provided herein, desires to reimburse hospitals which are providers of indigent hospital care services; and,

WHEREAS, HOSPITAL, a general acute care facility, is licensed in accordance with the requirements of the California Health Facilities Licensure Act (Health and Safety Code, sections 1250 et seq.) and any regulations promulgated pursuant thereto, and is equipped, staffed, and prepared to provide Hospital Services; and,

WHEREAS, HOSPITAL, upon the terms and conditions set forth herein, is willing to provide Hospital Services to persons covered by this Agreement; and,

WHEREAS, COUNTY has entered into a separate agreement for reimbursement of physicians and other non-hospital providers for provision of indigent medical care services; and,

WHEREAS, the parties wish to provide for equitable reimbursement of those providing Hospital Services with a minimum of administrative costs; and,

WHEREAS, the parties desire to state the respective rights and responsibilities of the parties related to providing, claiming, and reimbursing Hospital Services.

WHEREAS, COUNTY desires to modify the period for which Hospital Services shall be provided; and

WHEREAS, COUNTY desires to modify the period for Administrative/Claiming Responsibilities; and

WHEREAS, COUNTY, based on the modified periods, desires to provide a corresponding modification in funding; and

WHEREAS, HOSPITAL is agreeable to these changes; and

WHEREAS, the parties agree to amend that certain Agreement for the provision of Hospital Services for the Medical Services Initiative Program dated August 24, 2010

NOW, THEREFORE, IT IS MUTUALLY AGREED AS FOLLOWS:

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REFERENCED CONTRACT PROVISIONS

Master Agreement Term:

Hospital Services: ~~September~~ November 1, 2010 through ~~August~~ June 3~~1~~0, 2011

Administrative/Claiming Responsibilities: ~~September~~ November 1, 2010 through ~~February~~ December ~~29~~31, 201~~2~~1

"Period One" means the period September 1, 2010 through June 30, 2011

"Period Two" means the period July 1, 2011 through ~~February~~ December ~~29~~31, 201~~2~~1

HOSPITAL'S Term: Hospital Services: _____ through _____

Administrative/Claiming:_____ through _____

Aggregate Maximum Obligation:

	Period One	**Period Two**
Aggregate MSI Hospital Maximum Obligation:	$~~30,037,140~~24,429,712	$~~5,607,428~~0
Aggregate CI Hospital Maximum Obligation:	$ 4,481,032	$ ~~896,206~~0
Aggregate CHIP Maximum Obligation:	$ 0	$ 0
Total Hospital Maximum Obligation (Hospital Funding)	**$~~34,518,172~~28,910,744**	**$~~6,503,634~~0**

CFDA Number 93.778 Section 1115(a) Medi-Cal Hospital/Uninsured Care Demonstration/Coverage Initiative

Notices to COUNTY and HOSPITAL:

COUNTY:	County of Orange Health Care Agency MSI Program Manager 405 W. 5th Street, 6th Floor Santa Ana, CA 92701	County of Orange Health Care Agency Manager of Operations 405 W. 5th Street, Room 718 Santa Ana, CA 92701
HOSPITAL:	Hospital Name Attn: Hospital Chief Executive Officer	

Address
City, State Zip Code

HOSPITAL'S Insurance Coverage:

Workers' Compensation	Statutory
Employer's Liability	$1,000,000
Professional Liability	$3,000,000
Comprehensive General Liability	$5,000,000

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I. ALTERATION OF TERMS

This Agreement, together with Exhibits A through Exhibit E inclusive, attached hereto and incorporated herein by reference, fully expresses all understandings of COUNTY and HOSPITAL with respect to and the subject matter of this Agreement, and shall constitute the total Agreement between the parties for these purposes. No addition to, or alteration of, the terms of this Agreement, whether written or verbal, shall be valid unless made in writing and formally approved and executed by both parties.

II. COMPLIANCE

A. COMPLIANCE PROGRAM - ADMINISTRATOR has established a Compliance Program for the purpose of ensuring adherence to all rules and regulations related to federal and state health care programs.

1. ADMINISTRATOR shall ensure that HOSPITAL is made aware of the relevant policies and procedures relating to ADMINISTRATOR'S Compliance Program.

2. HOSPITAL has the option to adhere to ADMINISTRATOR'S Compliance Program or establish its own.

3. If HOSPITAL elects to adopt ADMINISTRATOR'S Compliance Program, then HOSPITAL shall ensure that its employees, subcontractors, interns, volunteers, and members of Board of Directors or duly authorized agents, if appropriate, ("Covered Individuals") relative to this Agreement are made aware of ADMINISTRATOR'S Compliance Program and related policies and procedures.

4. If HOSPITAL elects to have its own Compliance Program then it shall submit a copy of its Compliance Program and relevant policies and procedures to ADMINISTRATOR within thirty (30) calendar days of award of this Agreement.

5. ADMINISTRATOR'S Compliance Officer shall determine if HOSPITAL'S Compliance Program is accepted. HOSPITAL shall take necessary action to meet said standards or shall be asked to acknowledge and agree to the ADMINISTRATOR'S Compliance Program.

6. Upon approval of HOSPITAL'S Compliance Program by ADMINISTRATOR'S

Compliance Officer, HOSPITAL shall acknowledge existence of ADMINSTRATOR'S Compliance Program and shall ensure that its employees, subcontractors, interns, volunteers, and members of Board of Directors or duly authorized agents, if appropriate, ("Covered Individuals") relative to this Agreement are made aware of HOSPITAL'S Compliance Program and related policies and procedures.

7. Failure of HOSPITAL to submit its Compliance Program and relevant policies and procedures shall constitute a material breach of this Agreement. Failure to cure such breach within sixty (60) calendar days of such notice from ADMINISTRATOR shall constitute grounds for termination of this Agreement as to the non-complying party.

B. CODE OF CONDUCT - ADMINISTRATOR has developed a Code of Conduct for adherence by ADMINISTRATOR'S employees and contract providers.

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1. ADMINISTRATOR shall ensure that HOSPITAL is made aware of ADMINISTRATOR'S Code of Conduct.

2. HOSPITAL has the option to adhere to ADMINISTRATOR'S Code of Conduct or establish its own.

3. If HOSPITAL elects to have its own Code of Conduct, then it shall submit a copy of its Code of Conduct to ADMINISTRATOR within thirty (30) calendar days of award of this Agreement.

4. ADMINISTRATOR'S Compliance Officer shall determine if HOSPITAL'S Code of Conduct is accepted. HOSPITAL shall take necessary action to meet said standards or shall be asked to acknowledge and agree to the ADMINISTRATOR'S Code of Conduct.

5. Upon approval of HOSPITAL'S Code of Conduct by ADMINISTRATOR, HOSPITAL shall ensure that its employees, subcontractors, interns, volunteers, and members of Board of Directors or duly authorized agents, if appropriate, ("Covered Individuals") relative to this Agreement are made aware of HOSPITAL'S Code of Conduct.

6. If HOSPITAL elects to adhere to ADMINISTRATOR'S Code of Conduct then HOSPITAL shall submit to ADMINISTRATOR a signed acknowledgement and agreement that HOSPITAL shall comply with ADMINISTRATOR'S Code of Conduct.

7. Failure of HOSPITAL to timely submit the acknowledgement of ADMINISTRATOR'S Code of Conduct shall constitute a material breach of this Agreement, and failure to cure such breach within sixty (60) calendar days of such notice from ADMINISTRATOR shall constitute grounds for termination of this Agreement as to the non-complying party.

C. COVERED INDIVIDUALS - HOSPITAL shall screen all Covered Individuals employed or retained to provide services related to this Agreement to ensure that they are not designated as "Ineligible Persons," as defined hereunder. Screening shall be conducted against the General Services Administration's List of Parties Excluded from Federal Programs and the Health and Human Services/Office of Inspector General List of Excluded Individuals/Entities.

1. Ineligible Person shall be any individual or entity who:

a. is currently excluded, suspended, debarred or otherwise ineligible to participate in the federal health care programs; or

b. has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in the federal health care programs after a period of exclusion, suspension, debarment, or ineligibility.

2. HOSPITAL shall screen prospective Covered Individuals prior to hire or engagement. HOSPITAL shall not hire or engage any Ineligible Person to provide services relative to this Agreement.

3. HOSPITAL shall screen all current Covered Individuals and subcontractors annually to ensure that they have not become Ineligible Persons. HOSPITAL shall also request that its subcontractors use their best efforts to verify that they are eligible to participate in all federal and State of California health programs and have not been excluded or debarred from participation in any federal or state health care programs, and to further represent to HOSPITAL that they do not have any Ineligible Person in their employ or under contract.

4. Covered Individuals shall be required to disclose to HOSPITAL immediately any debarment, exclusion or other event that makes the Covered Individual an Ineligible Person. HOSPITAL shall notify ADMINISTRATOR immediately upon such disclosure.

5. HOSPITAL acknowledges that Ineligible Persons are precluded from providing federal and state funded health care services by contract with COUNTY in the event that they are currently sanctioned or excluded by a federal or state law enforcement regulatory or licensing agency. If HOSPITAL becomes aware that a Covered Individual has become an Ineligible Person, HOSPITAL shall remove such individual from responsibility for, or involvement with, COUNTY business operations related to this Agreement.

6. HOSPITAL shall notify ADMINISTRATOR immediately upon becoming aware if a Covered Individual or entity is currently excluded, suspended or debarred, or is identified as such after being sanction screened. Such individual or entity shall be immediately removed from participating in any activity associated with this AGREEMENT. ADMINISTRATOR will determine if any repayment is necessary as a result of services furnished by the ineligible person or individual.

D. REIMBURSEMENT STANDARDS

1. HOSPITAL shall take reasonable precaution to ensure that the coding of health care claims, billings and/or invoices for same are prepared and submitted in an accurate and timely manner and are consistent with federal, state and county laws and regulations.

2. HOSPITAL shall submit no false, fraudulent, inaccurate or fictitious claims for payment or reimbursement of any kind.

3. HOSPITAL shall bill only for those eligible services actually rendered which are also fully documented. When such services are coded, HOSPITAL shall use accurate billing codes to accurately describe the services provided and to ensure compliance with all billing and documentation

requirements.

4. HOSPITAL shall act promptly to investigate and correct any problems or errors in coding of claims and billing, if and when, any such problems or errors are identified.

E. COMPLIANCE TRAINING - ADMINISTRATOR shall make General Compliance Training and Provider Compliance Training, where appropriate, available to Covered Individuals.

1. HOSPITAL shall use its best efforts to encourage completion by Covered Individuals; provided, however, that at a minimum HOSPITAL shall assign at least one (1) designated representative to complete all Compliance Trainings when offered.

2. Such training will be made available to Covered Individuals within thirty (30) calendar days of employment or engagement.

3. Such training will be made available to each Covered Individual annually.

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4. Each Covered Individual attending training shall certify, in writing, attendance at compliance training. HOSPITAL shall retain the certifications. Upon written request by ADMINISTRATOR, HOSPITAL shall provide copies of the certifications.

III. CONFIDENTIALITY

A. Each party shall maintain the confidentiality of all records, including billings and any audio and/or video recordings, in accordance with all applicable federal and state codes and regulations, as they exist now or may hereafter be amended or changed.

B. Prior to providing any services pursuant to this Agreement, all members of the Board of Directors or its designee or duly authorized agent, employees, subcontractors, and volunteer staff or interns of HOSPITAL shall agree, in writing, with HOSPITAL to maintain the confidentiality of any and all information and records which may be obtained in the course of providing such services. The agreement shall specify that it is effective irrespective of all subsequent resignations or terminations of HOSPITAL'S Board members or its designee, employees, subcontractors, and volunteers or interns.

C. If HOSPITAL is a public institution, COUNTY understands and agrees that HOSPITAL is subject to the provisions of the California Public Records Act. In the event HOSPITAL receives a request to produce this Agreement, or identify any term, condition, or aspect of this Agreement, HOSPITAL shall contact COUNTY to advise of such request to release this information.

IV. DELEGATION, ASSIGNMENT, AND SUBCONTRACTS

A. HOSPITAL may not delegate the obligations hereunder, either in whole or in part, without prior written consent of COUNTY; provided, however, obligations undertaken by HOSPITAL pursuant to this Agreement may be carried out by means of subcontracts, provided such subcontracts are approved in advance, in writing by ADMINISTRATOR, meet the requirements of this Agreement as they relate to the service or activity under subcontract, and include any provisions that ADMINISTRATOR may require. No subcontract shall terminate or alter the responsibilities of HOSPITAL to COUNTY pursuant

to this Agreement. HOSPITAL may not assign the rights hereunder, either in whole or in part, without the prior written consent of COUNTY. This provision shall not be applicable to service agreements usually and customarily entered into by HOSPITAL to obtain or arrange for supplies, technical support, professional services, or medical services not necessarily provided directly by any hospital, including but not limited to dialysis. No such contract shall terminate or alter the responsibilities of HOSPITAL to COUNTY pursuant to this Agreement.

B. For HOSPITAL which are nonprofit corporations, any change from a nonprofit corporation to any other corporate structure of HOSPITAL, including a change in more than fifty percent (50%) of the composition of the Board of Directors within a two (2) month period of time, shall be deemed an assignment for purposes of this paragraph. Any attempted assignment or delegation in derogation of this paragraph shall be void. ADMINISTRATOR may disallow, from payments otherwise due HOSPITAL, amounts claimed for subcontracts not approved in accordance with this paragraph.

C. For HOSPITAL which are for-profit organizations, any change in the business structure, including but not limited to, the sale or transfer of more than ten percent (10%) of the assets or stocks of CONTRACTOR, change to another corporate structure, including a change to a sole proprietorship, or a change in fifty percent (50%) or more of HOSPITAL's directors at one time shall be deemed an assignment pursuant to this paragraph. Any attempted assignment or delegation in derogation of this paragraph shall be void.

V. EMPLOYEE ELIGIBILITY VERIFICATION

HOSPITAL shall fully comply with all federal and state statutes and regulations regarding the employment of aliens and others and to ensure that employees, performing work under this Agreement meet the citizenship or alien status requirement set forth in federal statutes and regulations. HOSPITAL shall obtain, from all employees, performing work hereunder, all verification and other documentation of employment eligibility status required by federal or state statutes and regulations including, but not limited to, the Immigration Reform and Control Act of 1986, 8 U.S.C. §1324 et seq., as they currently exist and as they may be hereafter amended. HOSPITAL shall retain all such documentation for all covered employees, for the period prescribed by the law.

VI. FACILITIES, PAYMENTS AND SERVICES

A. HOSPITAL agrees to provide the services, staffing, facilities, any equipment and supplies, and reports in accordance with Exhibits A through E inclusive to this Agreement. COUNTY shall compensate, and authorize, in accordance with this Agreement, said services. HOSPITAL shall operate continuously throughout the term of this Agreement with at least the minimum number and type of staff which meet applicable federal and state requirements, and which are necessary for the provision of the services hereunder.

B. HOSPITAL shall, at its own expense, provide and maintain the organizational and

administrative capabilities required to carry out its duties and responsibilities under this Agreement and in accordance with all applicable statutes and regulations pertaining to hospital service providers.

VII. INDEMNIFICATION AND INSURANCE

A. HOSPITAL agrees to indemnify, defend and hold COUNTY, its elected and appointed officials, officers, employees, agents and those special districts and agencies for which COUNTY'S Board of Supervisors acts as the governing Board ("COUNTY INDEMNITEES") harmless from any claims, demands, including defense costs, or liability of any kind or nature, including but not limited to personal injury or property damage, arising from or related to the services, products or other performance provided by HOSPITAL pursuant to this Agreement. If judgment is entered against HOSPITAL and COUNTY by a court of competent jurisdiction because of the concurrent active negligence of COUNTY or COUNTY INDEMNITEES, HOSPITAL and COUNTY agree that liability will be apportioned as determined by the court. Neither party shall request a jury apportionment.

B. COUNTY agrees to indemnify, defend and hold HOSPITAL, its officers, employees, agents, directors, members, shareholders and/or affiliates harmless from any claims, demands, including defense costs, or liability of any kind or nature, including but not limited to personal injury or property damage, arising from or related to the services, products or other performance provided by COUNTY pursuant to this Agreement. If judgment is entered against COUNTY and HOSPITAL by a court of competent jurisdiction because of the concurrent active negligence of HOSPITAL, COUNTY and HOSPITAL agree that liability will be apportioned as determined by the court. Neither party shall request a jury apportionment.

C. Each party agrees to provide the indemnifying party with written notification of any claim related to services provided by either party pursuant to this Agreement within thirty (30) calendar days of notice thereof, and in the event the indemnifying party is subsequently named party to the litigation, each party shall cooperate with the indemnifying party in its defense.

D. Without limiting HOSPITAL'S indemnification, HOSPITAL warrants that it is self-insured or shall maintain in force at all times during the term of this Agreement, the policy or policies of insurance covering its operations placed with reputable insurance companies in amounts as specified on Page 4 of this Agreement. Upon request by ADMINISTRATOR, HOSPITAL shall provide evidence of such insurance.

E. COUNTY warrants that it is self-insured or maintains policies of insurance placed with reputable insurance companies licensed to do business in the State of California which insures the perils of bodily injury, medical, professional liability, and property damage. Upon request by HOSPITAL, COUNTY shall provide evidence of such insurance.

VIII. INSPECTIONS AND AUDITS

A. ADMINISTRATOR, any authorized representative of COUNTY, any authorized representative of the State of California, the Secretary of the United States Department of Health and Human Services,

the Comptroller General of the United States, or any of their authorized representatives, shall have access to any books, documents, and records, including but not limited to, medical and patient records, of HOSPITAL that are directly pertinent to this Agreement, for the purpose of responding to a patient complaint or, conducting an audit, review, evaluation, or examination, or making transcripts during the periods of retention set forth in the Records Paragraph of Exhibit A to this Agreement. Such persons may at all reasonable times inspect or otherwise evaluate the services provided pursuant to this Agreement and the premises in which they are provided; provided, however, such inspections or evaluations shall not interfere with patient care.

1. These audits, reviews, evaluations, or examinations may include, but are not limited to, the following:

a. Level and quality of care, including the necessity and appropriateness of the services provided.

b. Financial records when determined necessary to protect public funds.

c. Internal procedures for assuring efficiency, economy, and quality of care.

d. Grievances relating to medical care, and their disposition, or other types of complaints or problems.

2. ADMINISTRATOR shall provide HOSPITAL with at least fifteen (15) days written prior notice of such inspection or evaluation; provided, however, that the California Department of Health Care Services, or duly authorized representative, which may include COUNTY, shall be required to provide at least seventy-two (72) hours notice for its onsite inspections and evaluations. Unannounced inspections, evaluations, or requests for information may be made in those situations where arrangement of an appointment beforehand is not possible or inappropriate due to the nature of the inspection or evaluation.

3. HOSPITAL agrees, until three (3) years after the termination of the contract between COUNTY and the California Department of Health Care Services for Coverage Initiative Funding, to permit the California Department of Health Care Services, or any duly authorized representative, to have access to, examine, or audit any pertinent books, documents, papers and records (collectively referred to as "records") related to this Agreement and to allow interviews of any employees who might reasonably have information related to such records.

a. If this Agreement if terminated prior to the termination of the contract between COUNTY and the California Department of Health Care Services, HOSPITAL shall ensure records are made available for a period of three (3) years from the date the last service was rendered under this Agreement.

b. If any litigation, claim, negotiation, audit or other action involving the records has been started before the expiration of the three (3) year period, the related records shall be retained until completion and resolution of all issues arising there from or until the end of the three (3) year period, whichever is later.

B. HOSPITAL shall actively participate and cooperate with any person specified in subparagraph A. above in any evaluation or monitoring of the services provided pursuant to this Agreement, and shall provide the above-mentioned persons adequate office space to conduct such evaluation. Such space must be capable of being locked and secured to protect the work of said persons during the period of their evaluation.

C. AUDIT RESPONSE

1. Following an audit report, in the event of non-compliance with applicable laws and regulations governing funds provided through this Agreement, COUNTY may terminate this Agreement or may direct HOSPITAL to immediately implement appropriate corrective action. A plan of correction shall be submitted to ADMINISTRATOR in writing within thirty (30) calendar days after receiving notice from ADMINISTRATOR.

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2. If the audit reveals that money is payable from one party to the other, that is, reimbursement by HOSPITAL to COUNTY, or payment of sums due from COUNTY to HOSPITAL, said funds shall be due and payable from one party to the other within sixty (60) calendar days of receipt of the audit results. If reimbursement is due from HOSPITAL to COUNTY, and such reimbursement is not received within said sixty (60) calendar days, COUNTY may, in addition to any other remedies, reduce any amount owed HOSPITAL by an amount not to exceed the reimbursement due COUNTY.

IX. LICENSES AND LAW

A. HOSPITAL, its officers, agents, employees, affiliates, and subcontractors shall, throughout the term of this Agreement, maintain all necessary licenses, permits, approvals, certificates, accreditations, waivers and exemptions necessary for the provision of services hereunder and required by the laws, regulations, or requirements of the United States, the State of California, COUNTY, and any other applicable governmental agencies. HOSPITAL shall notify ADMINISTRATOR immediately and in writing of its inability to obtain or maintain, irrespective of the pendency of any hearings or appeals, such permits, licenses, approvals, certificates, accreditations, waivers and exemptions. Said inability shall be cause for termination of this Agreement.

B. HOSPITAL shall comply with all applicable governmental laws, regulations, or requirements as they exist now or may be hereafter amended or changed.

1. HOSPITAL shall comply with the applicable terms and conditions of the contract between COUNTY and the California Department of Health Care Services ("Department") relating to the provision of services reimbursed with Coverage Initiative Funding. COUNTY shall provide HOSPITAL with a copy of any new or amended contract with Department as soon as it is available. HOSPITAL shall notify ADMINISTRATOR within thirty (30) calendar days of any inability of HOSPITAL to comply with the terms and conditions of COUNTY'S contract with Department.

2. HOSPITAL shall comply with all requirements of Section 114 of the Clean Air Act, as

amended, and Section 308 of the Federal Water Pollution Control Act respectively relating to inspection, monitoring, entry, reports, and information, as well as other requirements specified in Section 114 of the Clean Air Act and Section 308 of the Federal Water Pollution Control Act, and all regulations and guidelines issued there under.

3. HOSPITAL shall not perform services required by this Agreement in a facility listed on the Environmental Protection Agency (EPA) List of Violating Facilities unless and until the EPA eliminates the name of such facility from such listing.

4. HOSPITAL shall use its best efforts to comply with clean air standards and clean water standards at the facility in which services required by this Agreement are being performed.

C. The parties acknowledge that each is a Covered Entity, as defined by the Health Insurance Portability and Accountability Act (HIPAA) and is responsible for complying with said regulations for purposes of safeguarding any Protected Health Information (PHI) generated by each party for its own purposes. Except as otherwise limited by said regulations or law, HOSPITAL shall provide to COUNTY, and COUNTY may use or disclose PHI to perform functions, activities, or services for, or on behalf of, HOSPITAL as specified in this Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by HOSPITAL or the Minimum Necessary policies and procedures of HOSPITAL as required and/or defined by HIPAA.

D. HOSPITAL warrants, to the best of its knowledge, that all hospital-based physicians providing services at HOSPITAL, under this Agreement, are and will continue to be as long as this Agreement remains in effect, the holders of currently valid licenses to practice medicine in the State of California and are members in "good standing" of the medical staff of HOSPITAL'S facility.

E. Enforcement of Child Support Obligations

1. HOSPITAL agrees to furnish to ADMINISTRATOR within thirty (30) days of award of the Agreement:

a. In the case of an individual contractor, his/her name, date of birth, Social Security number, and residence address:

b. In the case of a contractor doing business in a form other than as an individual, the name, date of birth, social security number, and residence address of each individual who owns an interest of ten percent (10%) or more in the contracting entity;

c. A certification that HOSPITAL has fully complied with all applicable federal and State reporting requirements regarding its employees;

d. A certification that HOSPITAL has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, and will continue to so comply.

2. Failure of HOSPITAL to timely submit the data and/or certifications required by subparagraphs 1.a., 1.b., 1.c., or 1.d. above, or to comply with all Federal and State employee reporting requirements for child support enforcement, or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment shall constitute a material breach of this Agreement, and

failure to cure such breach within sixty (60) calendar days of notice from COUNTY shall constitute grounds for termination of this Agreement as to the non-complying party.

3. It is expressly understood that this data will be transmitted to governmental agencies charged with the establishment and enforcement of child support orders, or as permitted by federal and/or state statute.

X. MAXIMUM OBLIGATION

The Aggregate Maximum Obligations of COUNTY for services provided in accordance with this Agreement for Hospital Services for the Medical Services Initiative Program is as specified on Page 4 of this Agreement. COUNTY may make available additional funding for Hospital Services for the Medical Services Initiative Program as specified in its Agreement with Advanced Medical Management, Inc., dated August 19, 2008, including any amendments hereto. This specific Agreement with HOSPITAL is only one of several agreements to which this Aggregate Maximum Obligation and any additional funding apply. It is understood by the parties that reimbursement to HOSPITAL will only be a fraction of this Aggregate Maximum Obligation and only a fraction of any additional funding as may be added by COUNTY.

XI. NONDISCRIMINATION

A. EMPLOYMENT

1. During the performance of this Agreement, HOSPITAL shall not unlawfully discriminate against any employee or applicant for employment because of his/her ethnic group identification, race, religion, ancestry, color, creed, sex, marital status, national origin, age (40 and over), sexual orientation, medical condition, or physical or mental disability. HOSPITAL shall warrant that the evaluation and treatment of employees and applicants for employment is free from discrimination in the areas of employment, promotion, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rate of pay or other forms of compensation; and selection for training, including apprenticeship. There shall be posted in conspicuous places, available to employees and applicants for employment, notices from ADMINISTRATOR and/or the United States Equal Employment Opportunity Commission setting forth the provisions of this Equal Opportunity clause.

2. All solicitations or advertisements for employees placed by or on behalf of HOSPITAL and its subcontractors shall state that all qualified applicants will receive consideration for employment without regard to their ethnic group identification, race, religion, ancestry, color, creed, sex, marital status, national origin, age (40 and over), sexual orientation, medical condition, or physical or mental disability. Such requirement shall be deemed fulfilled by use of the phrase “an equal opportunity employer.”

3. HOSPITAL shall give written notice of its obligations under this Equal Opportunity Clause to each labor union with which HOSPITAL has a collective bargaining agreement.

4. In the event of non-compliance with this paragraph or as otherwise provided by federal and state law, this Agreement may be terminated or suspended in whole or in part and CONTRACTOR may be declared ineligible for further contracts involving federal or state funds provided through COUNTY.

B. SERVICES, BENEFITS, AND FACILITIES - HOSPITAL shall not discriminate in the provision of services, the allocation of benefits, or in the accommodation in facilities on the basis of ethnic group identification, race, religion, ancestry, creed, color, sex, marital status, national origin, age (40 and over), sexual orientation, medical condition, or physical or mental disability pursuant to all applicable federal and state laws and regulations, as all may now exist or be hereafter amended or changed.

C. PERSONS WITH DISABILITIES - HOSPITAL agrees to comply with the provisions of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.A. 794 et seq., as implemented in 45 CFR 84.1 et seq.), and the Americans with Disabilities Act of 1990 (42 U.S.C.A. 12101, et seq.), pertaining to the prohibition of discrimination against qualified persons with disabilities in all programs or activities, as they exist now or may be hereafter amended together with succeeding legislation.

D. RETALIATION - Neither HOSPITAL, nor its employees or agents, shall intimidate, coerce, or take adverse action against any person for the purpose of interfering with rights secured by federal or state laws, or because such person has filed a complaint, certified, assisted or otherwise participated in an investigation, proceeding, hearing or any other activity undertaken to enforce rights secured by federal or state law.

XII. NOTICES

A. Unless otherwise specified in this Agreement, all notices, claims, correspondence, reports and/or statements authorized or required by this Agreement shall be effective:

1. When delivered personally; or

2. When written and deposited in the United States mail, first class postage prepaid and addressed as specified on Page 4 of this Agreement or as otherwise directed by ADMINISTRATOR;

3. When faxed, transmission confirmed; or

4. When sent by electronic mail; or

5. When delivered by U.S. Postal Service Express Mail, Federal Express, United Parcel Service or other expedited delivery service.

B. Termination Notices shall be addressed as specified on Page 4 of this Agreement or as otherwise directed by ADMINISTRATOR and shall be effective when faxed, transmission confirmed, or when delivered by U.S. Postal Service Express Mail, Federal Express, United Parcel Service, or other expedited delivery services.

C. CONTRACTOR shall notify ADMINISTRATOR, in writing, within twenty-four (24) hours of becoming aware of any occurrence of a serious nature, which may expose COUNTY to liability. Such occurrences shall include, but not be limited to, accidents, injuries, or acts of negligence, or loss or

damage to any COUNTY property in possession of CONTRACTOR.

D. Any party to this Agreement may change the address at which it wishes to receive notice by giving notice to the other party in the manner set forth above.

For purposes of this Agreement, any notice to be provided by COUNTY may be given by ADMINISTRATOR.

E. For purposes of this Agreement, HOSPITAL agrees that the Hospital Association of Southern California (HASC) shall act as a representative of all Contracting Hospitals for the purpose of distributing and/or coordinating any notices which shall be provided by ADMINISTRATOR and which shall be applicable to all Contracting Hospitals. In such instances, notification to HASC shall be deemed as notification to HOSPITAL.

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XIII. SEVERABILITY

If a court of competent jurisdiction declares any provision of this Agreement or application thereof to any person or circumstances to be invalid or if any provision of this Agreement contravenes any federal, state, or county statute, ordinance, or regulation, the remaining provisions of this Agreement or the application thereof shall remain valid, and the remaining provisions of this Agreement shall remain in full force and effect, and to that extent the provisions of the Agreement are severable.

XIV. STATUS OF PARTIES

A. Each party is, and shall at all times be deemed to be, an independent contractor and shall be wholly responsible for the manner in which it performs the services required of it by the terms of this Agreement. Each party is entirely responsible for compensating staff and consultants employed by that party. This Agreement shall not be construed as creating the relationship of employer or employee, or principal and agent, between COUNTY and HOSPITAL or any of either party's employees, agents, consultants or subcontractors. Each party assumes exclusively the responsibility for the acts of its employees, agents, consultants, or subcontractors as they relate to the services to be provided during the course and scope of their employment. Each party, its agents, employees, or subcontractors, shall not be entitled to any rights or privileges of the other party's employees and shall not be considered in any manner to be employees of the other party.

B. COUNTY shall neither have, nor exercise, any control or direction over the methods by which HOSPITAL shall perform its obligations under this Agreement. The standards of medical care and professional duties of HOSPITAL'S employees providing Hospital Services under this Agreement shall be determined, as applicable, by HOSPITAL'S Board of Directors and the standards of care in the community in which HOSPITAL is located and all applicable provisions of law and other rules and regulations of any and all governmental authorities relating to licensure and regulation of HOSPITAL.

XV. TERM

A. This specific Agreement with HOSPITAL is only one of several agreements to which the term of this Master Agreement applies. The term of this Master Agreement shall commence on September 1, 2010 and terminate on February 29, 2012; provided, however, that the specific term for HOSPITAL shall be as specified on Page 4 of this Agreement; and provided further that the parties shall continue to be obligated to comply with the requirements and perform the duties specified in this Agreement. Such duties include, but are not limited to, obligations with respect to claims processing, reimbursement, reporting, indemnification, audits, and accounting.

B. Any duties pursuant to this Agreement to deposit monies or make any payment shall not be due until ten (10) days after the commencement of this Agreement.

C. Any administrative duty or obligation to be performed pursuant to this Agreement on a weekend or holiday may be performed on the next regular business day.

XVI. TERMINATION

A. Except as otherwise specified below, neither party may terminate this Agreement.

B. Either party may terminate this Agreement upon fifteen (15) days prior written notice given the other for material breach of the Agreement; provided, however, the allegedly breaching party has been given prior written notice setting forth the facts underlying the claim that breach of this Agreement has occurred, and has failed to cure the alleged breach within thirty (30) days.

C. Neither party shall be liable nor deemed to be in default for any delay or failure in performance under this Agreement or other interruption of service or employment deemed resulting, directly or indirectly, from Acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquakes, floods, failure of transportation, machinery or suppliers, vandalism, strikes or other work interruptions by a party's officers, agents, employees, affiliates, or subcontractors, or any similar cause beyond the reasonable control of any party to this Agreement. However, all parties shall make good faith efforts to perform under this Agreement in the event of any such circumstance.

D. If a court of competent jurisdiction determines that Eligible Persons are fully covered by the State Medi-Cal Program, or any other State program, all obligations and rights related to such persons under this Agreement shall be suspended while such court order is effective, or HOSPITAL and COUNTY shall have the right to terminate this Agreement upon ten (10) days prior written notice given the other parties and without any cure period, notwithstanding any other prior or subsequent provisions of this Agreement. In the event of any suspension or termination pursuant to this Agreement, deposits of Funding and reimbursement to any party shall be adjusted to reflect the obligations and duties thereby reduced.

E. EMERGENCY ROOM CLOSURE/LOSS OF LICENSE

1. HOSPITAL shall give COUNTY thirty (30) days prior written notice and shall terminate this Agreement in the event that HOSPITAL loses its general acute care license, or no longer intends to operate at least a Basic Emergency Service, without any cure period, notwithstanding any other prior or

subsequent provisions of this Agreement. Such notice shall include the date that operation of its Emergency Service will cease. Interim payments to HOSPITAL may, if supported by actual service data obtained from Intermediary, cease upon notification of intent to cease its Emergency Services and shall cease upon discontinuance of its Emergency Services. HOSPITAL terminating for such reason shall be eligible for additional payments, and shall pay back any over payments, at the time of Final Settlement, if such payments are required pursuant to this Agreement.

2. In the event that HOSPITAL ceases to operate at least a Basic Emergency Service at any time during this Agreement, for reasons other than those specified in subparagraph XV.C above, and HOSPITAL fails to notify COUNTY of said action, COUNTY shall immediately terminate this Agreement and Interim payments to HOSPITAL shall also cease immediately; provided, however, that HOSPITAL shall be eligible for additional payments, and shall pay back any over payments, at the time of Final Settlement, if such payments are required pursuant to this Agreement.

F. CONTINGENT FUNDING

1. Any obligation of COUNTY under this Agreement shall be contingent upon the following:

a. The continued availability of Federal, State and County funds for reimbursement of COUNTY'S expenditures, and

b. Inclusion of sufficient funding for the services hereunder in the applicable budget approved by the Board of Supervisors.

2. In the event such funding is subsequently reduced or terminated:

a. COUNTY may reduce MSI Base Funding and its obligations to make payments under this Agreement upon thirty (30) days written notice to HOSPITAL.

b. HOSPITAL may terminate this Agreement; provided, however, HOSPITAL shall give thirty (30) days prior written notice to COUNTY, which notice shall be given no later than thirty (30) days after notice by COUNTY of its intent to reduce MSI Base Funding, without any cure period, notwithstanding any other prior or subsequent provisions of this Agreement.

c. COUNTY may reduce Coverage Initiative Funding and its obligations to make payments for services funded through the Coverage Initiative under this Agreement upon thirty (30) days written notice to HOSPITAL. The parties agree that such reduction may necessitate that HOSPITAL substantially reduce or terminate its provisions of services funded through Coverage Initiative Funding. HOSPITAL shall give thirty (30) days prior written notice to COUNTY of any reduction or termination of Coverage Initiative services, which notice shall be given no later than thirty (30) days after notice by COUNTY of its intent to reduce Coverage Initiative Funding.

G. AMENDMENT

1. In the event of a formal amendment to this Agreement which increases the amount of funding to the Hospital Pool and which requires formal execution by both COUNTY and HOSPITAL (Amendment), HOSPITAL shall return a fully executed Amendment to ADMINISTRATOR or HASC within sixty (60) days of ADMINISTRATOR'S delivery to HASC of said Amendment to be executed

by Contracting Hospitals. Said Amendment shall be negotiated in good faith between the parties.

2. If HOSPITAL does not return a fully executed Amendment by the date specified, COUNTY or HOSPITAL may terminate this Agreement; provided, however, COUNTY shall first notify HASC and then give thirty (30) days prior written notice to HOSPITAL, which notice shall be given no later than fifteen (15) days after the fully executed Amendment was due to HASC or ADMINISTRATOR. At ADMINISTRATOR'S discretion, a cure period may be provided to HOSPITAL. If this Agreement is terminated, HOSPITAL'S Final Settlement calculations shall be based on the amount of funding that would have been available to HOSPITAL prior to the Amendment.

H. After receiving or providing a Notice of Termination, HOSPITAL shall do the following:

1. Comply with termination instructions provided by ADMINISTRATOR in a manner which is consistent with recognized standards of quality of care and prudent business practice for hospitals in the communities in which HOSPITAL is located.

2. Until the date of termination, continue to provide the same level of service required by this Agreement.

3. Until the date of termination, continue to be reimbursed by COUNTY for provision of services specified herein.

4. If patients are to be transferred to another facility for services, furnish ADMINISTRATOR, upon request, all patient information and records deemed necessary by ADMINISTRATOR to effect an orderly transfer.

5. Assist ADMINISTRATOR in effecting the transfer of patients in a manner consistent with their best interests.

I. The rights and remedies of COUNTY and HOSPITAL provided in this Termination Paragraph shall not be exclusive, and are in addition to any other rights and remedies provided by law or under this Agreement.

XVII. THIRD PARTY BENEFICIARY

No party hereto intends that this Agreement shall create rights hereunder in third parties including, but not limited to, any subcontractors or any patients provided services hereunder.

XVIII. WAIVER OF DEFAULT OR BREACH

Waiver by either party of any default by the other party shall not be considered a waiver of any other or subsequent default. Waiver by either party of any breach by the other party of any provision of this Agreement shall not be considered a waiver of any other or subsequent breach. Waiver by the other party of any default or any breach by the other party shall not be considered a modification of the terms of this Agreement.

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IN WITNESS WHEREOF, the parties have executed this Agreement, in the County of Orange, State of California.

COUNTY OF ORANGE

BY: _____
DIRECTOR HEALTH CARE AGENCY

DATED: _____

HOSPITAL

DATE: _____ DATE: _____

PRINTED NAME: _____ PRINTED NAME: _____

BY: _____ BY: _____

TITLE: _____ TITLE: _____

If Contractor is a corporation, two (2) signatures are required: one (1) signature by the Chairman of the Board, the President or any Vice President; and one (1) signature by the Secretary, any Assistant Secretary, the Chief Financial Officer or any Assistant Treasurer. If the Agreement is signed by one (1) authorized individual only, a copy of the corporate resolution or by-laws whereby the board of directors has empowered said authorized individual to act on its behalf by his or her signature alone is required.

APPROVED AS TO FORM
OFFICE OF THE COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

BY: _____ DATED: _____
DEPUTY

EXHIBIT A
AGREEMENT FOR PROVISION OF
HOSPITAL SERVICES
FOR THE
MEDICAL SERVICES INITIATIVE PROGRAM
SEPTEMBER 1, 2010 THROUGH FEBRUARY 29, 2012

I. DEFINITIONS

The parties agree to the following terms and definitions, and to those terms and definitions that, for convenience, are set forth elsewhere in this Agreement.

A. "Administrative Days" means those days of acute inpatient care provided to an inpatient who is appropriate for, and awaiting, placement at a lower level of care.

B. "All Providers" or "Providers" means Contracting Hospitals, Contracting Clinics, Receiving Hospitals, and Other Providers.

C. "Allowable Charges" means, for Physicians, Clinics (including Contracting Clinics), a maximum of 130% of the national Medicare RBRVS for charges that are determined by the Intermediary to be attributable to reimbursable services to Eligible persons in accordance with all Agreements for the MSI Program.

D. "Allowable Costs" means a maximum of one hundred percent (100%) of HOSPITAL'S actual costs according to the most recent Hospital Annual Financial Data report issued by the Office of Statewide Health Planning and Development, as calculated using a cost-to-charge ratio, for charges that are determined by INTERMEDIARY to be attributable to reimbursable services to Eligible Persons in accordance with this Agreement.

E. "CI Claimable Services" means Hospital Services provided to all persons meeting CI Eligibility as specified in Paragraph II.B of Exhibit C to this Agreement and COUNTY'S contract with Department. CI Claimable Services may also include Hospital Services provided on or after September 1, 2008 to MSI Eligible Persons who also meet all CI Eligibility requirements set forth in Paragraph II.B of Exhibit C to this Agreement and COUNTY'S contract with Department.

F. "Clinic" means any provider registered with the MSI Program that is not also considered to be a Contracting Clinic or a physician.

G. "Consultation" means the rendering by a specialty physician of an opinion or advice, or prescribing treatment by telephone, when determined to be medically necessary by the on-duty emergency department physician and specialty physician, as appropriate. Such Consultation includes review of the patient's medical record, and the examination and treatment of the patient in person, when appropriate, by a specialty physician who is qualified to give an opinion or render treatment necessary to stabilize the patient.

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H. "Continuously" means without interruption, twenty-four (24) hours per day throughout the term of this Agreement.

I. "Contract Rate" means: one hundred percent (100%) of Points, as provided for in the Final Settlement Paragraph X of Exhibit D to this Agreement, for services provided by HOSPITAL or such other reimbursement system as may be agreed upon pursuant to Paragraph IV. of Exhibit D to this Agreement.

J. "Contracting Clinic" means a clinic that has executed an Agreement for the Provision of Clinic Services for the Medical Services Initiative Program with COUNTY.

K. "Contracting Hospital" means a hospital that has executed an Agreement for the Provision of Hospital Services for the Medical Services Initiative Program with COUNTY that is the same as this Agreement.

L. "Coverage Initiative" or "CI" means funding provided through COUNTY'S contract with Department for expanded health care coverage including increasing the number of MSI Eligibles who are provided Hospital Services and providing preventative services and early intervention. As of the execution of this Agreement, COUNTY anticipates an extended or new contract with Department to continue the funding effective September 1, 2010.

M. "Coverage Initiative Agreement" or "CI Agreement" means the agreement with the California Department of Health Care Services for participation in the California Healthcare Coverage Initiative program as amended. . As of the execution of this Agreement, COUNTY anticipates an extended or new contract with Department to continue the funding effective September 1, 2010.

N. "Department" means the California Department of Health Care Services.

O. "Emergency Service" means a Basic Emergency Medical Service, or a Comprehensive Emergency Medical Service, as provided for in Title 22, Sections 70411 et seq.

P. "Emergency Services and/or Care" means lawfully provided medical screening, examination, and evaluation by a physician, or other physician-supervised personnel in a hospital to determine if an emergency medical condition exists, and includes treatment necessary to relieve the condition; provided, however, such treatment shall be within the capabilities required of HOSPITAL as a condition of its emergency medical services permit, on file with the Office of Statewide Health Planning and Development.

Q. "Final Settlement" means the final reimbursement to HOSPITAL and Other Providers, as specified in Paragraph X of Exhibit D to this Agreement.

R. "Funds" means any payments, transfers, or deposits made by COUNTY, and any refunds, repayments, adjustments, earned interest or other payments made by, or recovered from, HOSPITAL or Other Provider, patient, third-party, or other entity as the result of any duty arising from this Agreement.

S. "General Relief" means the cash assistance program approved by COUNTY'S Board of Supervisors for needy persons who do not qualify for other cash assistance programs.

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T. "Hospital Funding" means the amount of MSI Base Funding identified by COUNTY for reimbursement of Hospital Services.

U. "Hospital Service(s)" means inpatient and outpatient hospital services, including, but not limited to, laboratory, pharmacy and ancillaries, necessary to protect life, prevent significant disability, or prevent serious deterioration of health. As a result of CI Funding, Hospital Services may also include preventative services and early intervention. Guidelines for Reimbursable Medical Services are set forth in Exhibit B to this Agreement."

V. "Intermediary" means the organization, under a separate agreement dated August, 19th, 2009, with COUNTY, contracted to act as a fiscal intermediary for an eighteen (18) month period for the purpose of reimbursing All Providers in accordance with this Agreement and other specified Agreements for the MSI Program.

W. "Maintenance of Effort" or "MOE" means the minimum amount of non-federal MSI funding required during each Program Year, in accordance with COUNTY'S contract with Department, to maintain the same level of MSI Funding that was actually expended for the MSI Program during FY 2006-07.

X. "MSI" means Medical Services Initiative Program.

Y. "MSI Base Funding" means the amount of funds identified by COUNTY for reimbursement of all MSI Program Services, including those specified in this Agreement.

Z. "MSI Eligible," or "Eligible Person" means, in accordance with Exhibit C to this Agreement, an adult legal resident between and including the ages of twenty-one (21) and sixty-four (64) years who lacks sufficient financial resources to pay for Hospital Services, who does not meet federal linkage requirements for Medi-Cal eligibility, and who completes the MSI Eligibility process and meets the eligibility standards set forth in Title 22 of the California Code of Regulations (Title 22) and as established by COUNTY and described in this Agreement. For persons presenting at HOSPITAL, MSI Eligibility shall be verified electronically or by telephone.

AA. "MSI Patient" means a person who is either MSI Eligible or MSI Pending.

AB. "MSI Pending" means an adult legal resident between and including the ages of twenty-one (21) and sixty-four (64) years who lacks sufficient financial resources to pay for Hospital Services, who does not meet federal linkage requirements for Medi-Cal eligibility, and who has completed an MSI Eligibility application which has been submitted for approval.

AC. "MSI Program" means all Hospital Services, physician services, administrative services, and other non-hospital services for which reimbursement is authorized by this Agreement and all other agreements for the MSI Program.

AD. "On-Call Physician" means a physician available for medical consultation to Emergency Services staff by telephone and, when jointly determined to be medically necessary by the On-Call and the on-duty Emergency Service physicians, to personally examine and treat the patient.

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AE. "Other Provider" means a physician, osteopath, podiatrist, dentist, Clinics, ambulance operator, home health services provider, pharmacy or supplier of durable medical equipment.

AF. "Program Year" means the period commencing ~~September~~ November 1, 2010and ending ~~August~~ June 3~~1~~0, 2010.

AG. "Qualified Clinic(s)" means a fully licensed community clinic or federally qualified health center, that has been licensed by the State of California or the Federal Government, has provided services to MSI eligible patients for twelve consecutive months, and has received eligibility identification training by the Hospital Association of Southern California (HASC), Orange County office or by any other means approved, in writing, by ADMINISTRATOR.

AH. "Quarter" means a three (3)-month period beginning September 1, December 1, March 1, or June 1 e.g., Fourth Quarter means the period covering June, July, and August .

AI. "Receiving Hospital" means a hospital that has entered into a separate agreement with ADMINISTRATOR for the purpose of accepting MSI Patients transferred or diverted from Referring Hospital in accordance with Paragraph II.E. of this Exhibit A to the Agreement. Said MSI Patients shall not be considered Transfer Patients.

AJ. "Referring Hospital" means a Contracting Hospital authorized by ADMINISTRATOR to request transfers or diversions of MSI Patients to a Receiving Hospital.

AK. "Recovery Accounts" means separate hospital and physician accounts for monies recovered by Intermediary from HOSPITAL, Other Providers, or third-party payors.

AL. "Registered Provider" means any California licensed physician or clinic that had completed the MSI registration application and provides services to MSI Patients in the County of Orange.

AM. "Skilled Nursing Facility (SNF)" means a health facility or distinct part of a hospital which provides, under a separate agreement with COUNTY, continuous skilled nursing and supportive care to MSI Eligibles in lieu of acute hospitalization.

AN. "Special Permit Medical Service" means a burn center service, cardiovascular surgery service, radiation therapy service, trauma center service, renal transplant center service, acute psychiatric service, or a service provided by a hospital with a special rehabilitation unit licensed in accordance with appropriate laws and, if applicable, with Section 70351 et seq. of Title 22. Special Permit Medical Service shall also include such types or kinds of transfers as may be approved in writing by ADMINISTRATOR.

AO. "Special Permit Transfer" means a MSI Patient, who needs a Special Permit Medical Service that is not available from a Hospital, which another Hospital elects to accept for treatment.

AP. "Specialized Receiving Hospital" means a hospital that has identified specific services it can provide, is willing to accept additional MSI Eligibles requiring these specific services from other Contracting Hospitals, and has entered into a separate agreement with ADMINISTRATOR for the purpose of accepting said MSI Eligibles in accordance with Paragraph II.F of this Exhibit A to the Agreement. Said MSI Eligibles shall not be considered Transfer Patients.

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AQ "Temporary Eligibility" or "TE" means the granting of MSI benefits by ADMINISTRATOR for thirty (30) calendar days. TE shall be granted only under the circumstances defined in the MSI Provider Manual, as it exists now or may be amended.

AR. "Third Party-Covered Claim" means a claim for reimbursement of Hospital Services, which services are covered, at least in part, by a non-COUNTY third-party payor.

AS. "Transfer Patient" means a person accepted by HOSPITAL, or transferred by a hospital to another hospital or health facility without prior approval of ADMINISTRATOR.

AT. "Utilization Management Department" or "UMD" means appropriately licensed COUNTY staff and/or COUNTY contracted staff responsible for the coordination of services as well as the concurrent and retrospective utilization review of the medical appropriateness, level of care, and utilization of all services provided to MSI Patients by All Providers.

II. HOSPITAL OBLIGATIONS

A. HOSPITAL shall continuously provide or make available Hospital Services to all indigent persons covered by this Agreement presenting for treatment. Such Hospital Services shall include, but not be limited to inpatient, outpatient, ancillary, laboratory, and pharmaceutical services provided by HOSPITAL or its subcontractor, but only in accordance with applicable law. HOSPITAL shall not allow or cause available Hospital Services to be reduced below the licensure level and associated scope available at commencement of this Agreement, unless, due to circumstances beyond its control, HOSPITAL lacks appropriate facilities and/or personnel qualified to provide Hospital Services. Such a reduction shall be a material breach of this Agreement.

1. By all appropriate means available, HOSPITAL shall assure that it meets licensing requirements, including physician staffing and physician support of its Emergency Service, to provide Hospital Services to Eligible Persons under this Agreement.

2. HOSPITAL shall continuously maintain and provide Emergency Services.

3. HOSPITAL shall comply with the Emergency Medical Treatment and Active Labor Act, (specifically 42 CFR 413.65), herein referred to as EMTALA, as it exists now or may hereafter be amended. Said regulations require that HOSPITAL provide Emergency Services to all indigent persons covered by this Agreement who present anywhere on HOSPITAL'S campus and request Emergency Services, or who would appear to a reasonably prudent person to be in need of medical attention. "Campus" means the physical area immediately adjacent to HOSPITAL'S main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within two-hundred-fifty (250) yards of the main buildings, and any other areas, determined on an individual case basis, by the Centers for Medicare and Medicaid Services regional office, to be part of HOSPITAL'S campus.

4. HOSPITAL shall provide Hospital Services in the same manner to MSI Patients as it provides to all other patients and shall not discriminate against MSI Patients in any manner, including:

admission practices, placement in special wings or rooms, or provision of special or separate meals.

a. ADMINISTRATOR shall notify HOSPITAL and investigate allegations of discrimination in the provision of services on the basis of the patient's status as an MSI Patient, including but not limited to denial of care based on the MSI Patient's place of residence. ADMINISTRATOR may request that the Medical Review Committee (MRC) assist with the investigation of service denials for discrimination.

b. In the event that HOSPITAL is determined by ADMINISTRATOR to have discriminated in the provision of Hospital Services on the basis of the patient's status as an MSI Patient, ADMINISTRATOR shall advise the Intermediary to levy appropriate financial penalties for each occurrence against HOSPITAL, which may include, but not be limited to, the following:

1) Removal of Points related to the episode of care from HOSPITAL'S total Point calculation.

2) A percentage reduction, up to one (1) percent, from HOSPITAL'S total Point calculation.

5. HOSPITAL shall provide interpreters, as needed by persons seeking Hospital Services, in accordance with applicable law.

6. HOSPITAL must notify, via telephone, fax transmission, or other reporting mechanisms as established by ADMINISTRATOR, COUNTY'S Utilization Management Department (UMD) within twenty-four (24) hours of verifying an MSI Patient admission, which for MSI Pendings shall mean that an MSI Eligibility Application has been completed and submitted.

a. If the admission and/or verification occurs on a weekend or holiday, HOSPITAL may notify the UMD on the next business day.

b. HOSPITAL must send MSI Patient information to the UMD for concurrent review within twenty-four (24) hours upon request of the UMD or send MSI Patient discharge information within ten (10) days to the UMD. HOSPITAL'S failure to meet either of these requirements may result in denial of patient days.

c. HOSPITAL shall assist the UMD in the evaluation of MSI Patients for recommendation regarding the appropriate level of care and need for the MSI Patient's hospitalization. HOSPITAL may
request through the UMD that an MSI Eligible be transferred to a Specialized Receiving Hospital; provided, however, that any such transfer shall be in accordance with subparagraph c. below.

d. At UMD'S discretion, an MSI Eligible may be transferred to a Specialized Receiving Hospital if said MSI Eligible meets the medical criteria negotiated between ADMINISTRATOR and the Specialized Receiving Hospital pursuant to subparagraph F. below. If such a determination is made, and the MSI Eligible is determined by HOSPITAL to be medically stable for transfer, then the UMD shall, within thirty (30) minutes of consulting with HOSPITAL, advise HOSPITAL if a transfer can be arranged.

1) Transfer shall occur following a physician to physician consultation and agreement to accept transfer between HOSPITAL and the Specialized Receiving Hospital.

2) If a transfer cannot be arranged, in accordance with applicable law, the parties agree such person may be admitted to HOSPITAL if medically appropriate.

3) If transfer can be arranged, in accordance with applicable law, the UMD shall make necessary arrangements as soon as possible.

7. HOSPITAL shall not make Inappropriate Patient Referrals to another Contracting Hospital. "Inappropriate Patient Referral" means a patient referral by one Contracting Hospital to another Contracting Hospital, in a manner not specifically identified or provided for in this Agreement, when the referring Contracting Hospital had, or should have had, the personnel, facilities, equipment, and expertise to treat the patient within the scope of the said Contracting Hospital's licensure; excepting, however, unforeseen and/or unpreventable circumstances as documented in the patient's medical record.

a. ADMINISTRATOR shall notify all involved parties and investigate allegations of inappropriate patient referrals in accordance with procedures contained in the current MSI Provider Manual. ADMINISTRATOR may request that the Medical Review Committee (MRC) assist with the investigation of any Inappropriate Patient Referrals.

b. In the event that HOSPITAL is determined by ADMINISTRATOR to have made an Inappropriate Patient Referral, ADMINISTRATOR shall advise the Intermediary to levy appropriate financial penalties for each occurrence against HOSPITAL, which may include, but not be limited to, one or both of the following:

1) Removal of Points related to the episode of care from HOSPITAL'S total Point calculation.

2) A percentage reduction, up to one (1) percent, from HOSPITAL'S total Point calculation.

B. As a condition of reimbursement for Hospital Services provided by HOSPITAL to all persons covered by this Agreement, HOSPITAL shall comply with all requirements set forth herein, including, but not limited to, Exhibit D of this Agreement. ADMINISTRATOR may withhold or delay any payment due HOSPITAL for failure to comply with the terms of this Agreement.

1. Reimbursement provided through this Agreement shall be payment of last resort. HOSPITAL shall bill and attempt collection of third-party, primary, or other insurance covered claims to the full extent of such coverage and, upon submission of any claim, shall submit to the Intermediary, proper documentation demonstrating compliance with this requirement.

2. Acceptance by HOSPITAL of reimbursement made by Intermediary for services provided in accordance with this Agreement shall be deemed satisfaction in full, with respect to the services for which payment was made, except for claims covered by any third-party, primary, or other insurance or a third-party settlement, include those received by or on behalf of an MSI Patient. HOSPITAL shall attempt to bill and collect to the full extent of coverage those claims covered by all known third-party,

primary, or other insurance or third-party payors. If HOSPITAL becomes aware of any third-party, primary, or other insurance or a third-party settlement, including those received by or on behalf of an MSI Patient after reimbursement is made by Intermediary, nothing herein shall prevent HOSPITAL from pursuing reimbursement from these sources; provided, however, that HOSPITAL shall comply with Paragraph VI.G. of Exhibit D to this Agreement. Nothing in this paragraph shall prohibit HOSPITAL from applying any unreimbursed portion of HOSPITAL'S charges toward HOSPITAL'S charity and write-off policy.

3. HOSPITAL shall bill and/or notice MSI Patients of the MSI Patients' responsibility to provide a $25 co-payment to HOSPITAL covering any or all Hospital Services received in HOSPITAL'S emergency department. Inability of HOSPITAL to collect said co-payment shall not be a barrier to care for MSI Patients presenting for Hospital Services. Revenue resulting from such co-payments shall be in addition to payments otherwise provided in accordance with this Agreement. ADMINISTRATOR may ~~modify~~ delete co-payment ~~amounts upon thirty (30) days'~~requirement upon written notice to HOSPITAL.

C. HOSPITAL shall assist COUNTY and Intermediary in the conduct of any appeal hearings conducted by COUNTY or Intermediary in accordance with this Agreement.

D. SPECIAL PERMIT TRANSFER

1. If HOSPITAL has an MSI Eligible, who is medically stable as defined under EMTALA, that requires Special Permit Medical Services which HOSPITAL is unable to provide under its current licensure, HOSPITAL shall contact the UMD to request the transfer of said MSI Eligible to, at the discretion of ADMINISTRATOR, a Contracting Hospital or other facility capable of providing said services.

a. If transfer can be arranged, in accordance with applicable law, the UMD shall make necessary arrangements as soon as possible.

b. HOSPITAL shall cooperate with and assist the UMD and Contracting Hospital or other facility accepting the MSI Eligible.

2. COUNTY may negotiate, as reimbursement for accepting a medically stable, as defined under EMTALA, Special Permit Transfer, Points or per diem reimbursement appropriate for securing care, as mutually agreed upon, in writing, between the Contracting Hospital or other facility and ADMINISTRATOR.

E. RECEIVING HOSPITAL SERVICES

1. If HOSPITAL is not a Referring Hospital:

a. HOSPITAL may notify ADMINISTRATOR, in writing, of its desire to become a Receiving Hospital. ADMINISTRATOR shall have sole discretion regarding HOSPITAL'S designation as a Receiving Hospital.

1) HOSPITAL and ADMINISTRATOR shall mutually agree, in writing, on any diagnoses and procedures that HOSPITAL desires to limit or exclude in its capacity as a Receiving

Hospital.

2) Upon designation as a Receiving Hospital, HOSPITAL agrees to accept, as reimbursement, Points or per diem reimbursement, as mutually agreed upon in writing, between HOSPITAL and ADMINISTRATOR. Subsequent admissions of these MSI patients directly into HOSPITAL shall be considered as being admitted into a Contracting Hospital and the Points shall be calculated as such. The disproportionate share factor shall not be applied to Receiving Hospital Points or per diem reimbursement unless otherwise approved, in writing, by ADMINISTRATOR.

3) Either party may terminate the Receiving Hospital agreement, without cause, upon thirty (30) days written notice to the other party; provided, however, that HOSPITAL shall be obligated to continue to accept MSI Patients in accordance with the Receiving Hospital agreement until the effective date of termination.

4) ADMINISTRATOR shall send, to the Referring Hospital(s), a copy of the final Receiving Hospital agreement with HOSPITAL.

5) It shall be HOSPITAL'S responsibility to negotiate in good faith with the Referring Hospital(s) for reimbursement pursuant to subparagraph E.2.c.2 below for MSI Pendings who do not subsequently become MSI Eligible or do not qualify for third party, primary or other insurance or any other third-party coverage.

b. If Receiving Hospital services are requested by either the UMD or the Referring Hospital, HOSPITAL must advise the Referring Hospital and the UMD immediately of its ability to accept the MSI Patient. Transfer shall occur following a physician to physician consultation and agreement to accept transfer between the Referring Hospital and HOSPITAL.

1) If transfer can be arranged, HOSPITAL shall cooperate with and assist the Referring Hospital and the UMD to make necessary arrangements as soon as possible.

2) HOSPITAL shall coordinate with the UMD for those MSI Patients that are determined to be MSI Eligible regarding diversions, admissions, discharges, and transitions to lower levels of care. The UMD shall make recommendations regarding denials of inpatient days at HOSPITAL should HOSPITAL admit a patient that could have been more appropriately transferred or diverted to a lower level of care; provided, however, that such services were available at the time of admission.

2. ADMINISTRATOR may negotiate with non-Contracting Hospitals to provide Receiving Hospital Services.

3. If HOSPITAL is a Referring Hospital:

a. HOSPITAL may notify ADMINISTRATOR, in writing, of its desire to become a Referring Hospital. ADMINISTRATOR shall have sole discretion regarding HOSPITAL'S designation as a Receiving Hospital.

b. HOSPITAL and ADMINISTRATOR shall identify and mutually agree to, in writing, a list of diagnoses deemed appropriate and desirable to transfer to HOSPITAL. Throughout the term of

this Agreement, said parties may mutually agree to modify said transfer criteria.

c. HOSPITAL must notify the UMD within thirty (30) minutes of stability of any MSI Patient presenting in the emergency department for whom admission is not emergent so as to protect life, prevent serious disability or prevent serious deterioration of health. At such time, HOSPITAL shall also advise the UMD:

1) If the MSI Patient meets transfer criteria, the UMD shall make a determination, within thirty (30) minutes of consulting with HOSPITAL, and advise HOSPITAL if a transfer can be arranged.

a) If a transfer cannot be arranged, in accordance with applicable law, the parties agree such person may be admitted if medically appropriate.

b) If transfer can be arranged, in accordance with applicable law, the UMD shall make necessary arrangements as soon as possible.

2) If the MSI Patient does not meet transfer criteria, the parties shall agree such person may be admitted to HOSPITAL if medically appropriate.

3) If the MSI Patient was previously admitted to HOSPITAL within the past eighteen (18) months and presenting with same diagnosis as the previous admission, upon determination of HOSPITAL, such person may be admitted if medically appropriate.

d. For MSI Patients meeting transfer criteria, HOSPITAL shall coordinate with the UMD to conduct a telephone assessment of the MSI Patient regarding the appropriate level of care and need for the MSI Patient's hospitalization at HOSPITAL or diversion to a Receiving Hospital.

1) If HOSPITAL transfers an MSI Pending that does not subsequently become MSI Eligible, and does not have or qualify for third party, primary, or other insurance or any other third-party coverage, HOSPITAL agrees to reimburse Receiving Hospital at a rate negotiated in good faith between HOSPITAL and Receiving Hospital. HOSPITAL agrees to pay said billings.

2) Nothing in this subparagraph shall prevent HOSPITAL from pursuing payment directly from non-MSI Eligibles for reimbursement of costs paid to HOSPITAL.

F. SPECIALIZED RECEIVING HOSPITAL SERVICES

1. Any Contracting Hospital may notify ADMINISTRATOR, in writing, of its desire to become a Specialized Receiving Hospital. ADMINISTRATOR shall have sole discretion regarding HOSPITAL'S designation as a Receiving Hospital.

a. HOSPITAL and ADMINISTRATOR shall identify and mutually agree to, in writing, a list of diagnoses deemed appropriate and desirable for HOSPITAL to receive as transfers from other Contracting Hospitals. Throughout the term of this Agreement, said parties may mutually agree to modify said transfer criteria.

b. Upon designation as a Specialized Receiving Hospital, HOSPITAL agrees to accept, as reimbursement, Points or per diem reimbursement, as mutually agreed upon in writing, between HOSPITAL and ADMINISTRATOR. Subsequent admissions of these MSI patients directly into

HOSPITAL shall be considered as being admitted into a Contracting Hospital and the Points shall be calculated as such. The disproportionate share factor shall not be applied to Specialized Receiving //
Hospital Points or per diem reimbursement; unless otherwise approved, in writing, by ADMINISTRATOR.

c. Either party may terminate the Specialized Receiving Hospital agreement, without cause, upon thirty (30) days written notice to the other party; provided, however, that HOSPITAL shall be obligated to continue to accept MSI Patients in accordance with the Specialized Receiving Hospital agreement until the day of termination.

d. ADMINISTRATOR shall notify all other Contracting Hospitals regarding the Specialized Receiving Hospital services available.

2. For MSI Eligibles who are medically stable and can be transferred to a Specialized Receiving Hospital, HOSPITAL shall coordinate with the UMD to conduct a telephone assessment of the MSI Eligible regarding the appropriate level of care and need for the MSI Eligible's hospitalization at HOSPITAL as a Specialized Receiving Hospital.

a. HOSPITAL must advise the UMD immediately, upon request, of its ability to accept the MSI Eligible. Transfer shall occur following a physician to physician consultation and agreement to accept transfer between the Contracting Hospital and HOSPITAL.

1) If transfer can be arranged, HOSPITAL shall cooperate with and assist the transferring Contracting Hospital and the UMD to make necessary arrangements as soon as possible.

2) HOSPITAL shall coordinate with the UMD for those MSI Eligibles regarding diversions, admissions, discharges, and transitions to lower levels of care. The UMD shall make recommendations regarding denials of inpatient days at HOSPITAL should HOSPITAL admit a patient that could have been more appropriately transferred or diverted to a lower level of care; provided, however, that such services were available at the time of admission.

b. If HOSPITAL admits an MSI Eligible meeting transfer criteria without first consulting with the UMD, the entire length of stay associated with such admission may be denied.

3. ADMINISTRATOR may negotiate with non-Contracting Hospitals to provide Specialized Receiving Hospital Services.

G. Long Beach Memorial Medical Center (Medical Center) as a designated Orange County trauma hospital, and its affiliated physicians, shall be obligated to only those terms of this Agreement that apply to Hospital Services provided by its trauma center. Medical Center, and its affiliated physicians, may submit claims for only those Eligible Persons who are brought by Orange County paramedics for trauma services or other services specifically negotiated by ADMINISTRATOR in accordance with subparagraph IV.D.2.of this Exhibit A to this Agreement.

H. HASC shall provide administrative support services that directly support the purposes of this Agreement. Such services shall include, but not be limited to, provider eligibility screening

training/education, and activities that facilitate communication between patients, hospitals, and the parties to this Agreement.

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1. HASC shall train HOSPITAL and Qualified Clinic personnel in taking eligibility applications.

2. Upon thirty (30) days prior written notice, ADMINISTRATOR may require HASC to submit, not more than once per month, reports of activities and efforts that directly support the purposes of this Agreement and an accounting of the manner in which Funds received through this Agreement have been expended by HASC.

I. HOSPITAL shall make its best efforts to provide services pursuant to this Agreement in a manner that is culturally and linguistically appropriate for the population(s) served. HOSPITAL shall be in compliance with the current The Joint Commission Requirements Related to the Provision of Culturally and Linguistically Appropriate Health Care. If HOSPITAL is not accredited by The Joint Commission, HOSPITAL shall maintain documentation of such efforts which may include, but not be limited to: records of participation in COUNTY-sponsored or other applicable training; recruitment and hiring policies and procedures; copies of literature in multiple languages and formats, as appropriate; and descriptions of measures taken to enhance accessibility for, and sensitivity to, persons who are physically challenged.

J. HOSPITAL shall not conduct any proselytizing activities, regardless of funding sources, with respect to any person who has been referred to CONTRACTOR by COUNTY under the terms of this Agreement. Further, HOSPITAL agrees that the funds provided hereunder shall not be used to promote, directly or indirectly, any religion, religious creed or cult, denomination or sectarian institution, or religious belief.

III. FUNDING AND PAYMENTS

A. MSI Trust Fund

1. From the MSI Base Funding, COUNTY shall establish an interest-bearing trust fund (MSI Trust Fund) into which it shall transfer the following amounts of Hospital Funding to the "Hospital Trust Fund Account", not to exceed $~~35,644,568~~24,429,712 for the Program Year.

~~a. $3,003,714 per month for Period One~~

~~b. $2,803,714 per month for Period Two~~

2. In addition to the above Hospital Funding an estimated $~~448,104~~560,129 per month, not to exceed $~~5,377,238~~4,481,032 for the Program Year, of CI Funding, which amount shall not be greater than the actual allocation received by COUNTY from Department.

a. Said amount shall not be available until CI Funding is received by COUNTY.

b. The parties understand that at the execution of this Agreement, COUNTY has not executed a new or amended contract with Department for continued CI Funding commencing

~~September~~ November 1, 2010. HOSPITAL is agreeable to execute this Agreement in good faith that said contract between COUNTY and Department will be executed during the term of this Agreement.

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1) COUNTY, in recognition of HOSPITAL'S good faith execution of this Agreement, shall not willfully and intentionally expand the enrollment of persons into the MSI Program unless and until COUNTY has a written commitment from Department that additional CI Funding will be made available so as to allow for expanded enrollment, unless otherwise mutually agreed to in writing between HOSPITAL and ADMINISTRATOR. COUNTY and HOSPITAL shall mutually agree to make good faith efforts to negotiate and amend this Agreement regarding the use and allocation of the additional funding in consideration of the impact of expanded enrollment on the level of Contracting Hospital reimbursement.

a) ADMINISTRATOR shall provide HASC, on a monthly basis, the number of unduplicated MSI enrollees for the prior month.

b) If the number of unduplicated MSI enrollees exceeds the unduplicated number of enrollees for July, 2010 (Enrollment Level), ADMINISTRATOR and HOSPITAL shall meet to discuss measures which may be implemented by COUNTY to reduce or limit the number of MSI enrollees and ADMINISTRATOR shall make a good faith effort to implement said measures in a manner consistent with COUNTY'S obligations under W & I 17000. If additional CI Funding is received so as to allow for expanded enrollment into the MSI Program, the parties will mutually agree in writing to amend the Enrollment Level.

2) If additional funding is made available through COUNTY'S new or amended contract with Department for services provided on or after ~~September~~ November 1, 2010, COUNTY and HOSPITAL shall mutually agree to make good faith efforts to negotiate and amend this agreement regarding the use and allocation of the additional funding with the intent of improving Contracting Hospitals' reimbursement levels.

c. At ADMINISTRATOR'S sole discretion, CI Funding provided through this and any other agreements for the MSI Program may be modified to ensure full expenditure of all CI Funding allocated to COUNTY for each Program Year.

3. During Preliminary Final Settlement as specified in Paragraph X of Exhibit D to this Agreement, additional funding may be added to Hospital Funding to ensure full expenditure of CI Funding allocated to COUNTY each Program Year and ability of COUNTY to meet its MOE requirement.

4. Except as otherwise specified, Monthly Trust Fund Deposits shall commence by ~~September~~ November 10, 2010, and continue thereafter by the tenth (10th) day of each month through and including ~~August~~ June 10, 2011.

5. Monies in the MSI Trust Fund shall be treated in the same fashion as all other monies held by COUNTY in trust funds, and COUNTY may commingle said monies with other monies for purposes

of investment. Except for pharmacy dollars as specified in COUNTY'S Agreement with Intermediary, interest earned on MSI Trust Fund monies shall be apportioned, at Final Settlement, 70% to the Hospital Trust Fund Account and the remaining 30% to the "Physicians Trust Fund Account," established in accordance with the COUNTY'S Agreement with the Intermediary; provided, however, no interest shall be credited to MSI Funds before they are deposited in the MSI Trust Fund, nor before this Agreement becomes effective as specified in the Term Paragraph of this Agreement.

B. MSI Hospital Funding Disbursements to HOSPITAL - Commencing ~~September~~ November 15, 2010, and thereafter on the fifteenth (15th) day of each month through and including ~~August~~ June 15, 2011, COUNTY shall pay the Intermediary an amount equal to eighty percent (80%) of the monthly Hospital Funding available pursuant to subparagraph A.1. above. Such Funds shall be deposited immediately by the Intermediary into its Hospital Account maintained for all payments to HOSPITAL in accordance with Exhibit D to this Agreement. Payment by the Intermediary to HOSPITAL shall be contingent upon COUNTY'S receipt or confirmation of receipt by HASC of a fully executed Agreement from HOSPITAL.

C. Sub-Acute Services – COUNTY shall pay the Intermediary, from the MSI Trust Fund Account, the amount necessary to cover reimbursement for Sub-Acute Services in accordance with implementation and payment procedures agreed to in accordance with subparagraph IV.B. of this Exhibit A to the Agreement.

D. Skilled Nursing Facilities (SNFs) – COUNTY shall pay the Intermediary, from the MSI Trust Fund Account, the amount necessary to cover reimbursement to SNFs accepting MSI Eligibles referred by COUNTY'S Utilization Management Department. Such amount shall be deducted as follows: 100% of institutional costs from the Hospital Trust Fund Account and 100% of professional costs from the Physicians Trust Fund Account. HOSPITAL and ADMINISTRATOR may agree to expand SNF services to include MSI Pendings upon mutual agreement, in writing, as to implementation and payment procedures.

E. Ambulance, Home Health, and Durable Medical Equipment Providers - COUNTY shall pay the Intermediary, from the MSI Trust Fund, the amount necessary to cover reimbursements to ambulance operators, home health providers, and durable medical equipment providers.

1. Unless otherwise directed by ADMINISTRATOR, said amounts shall be deducted 70% from the Hospital Trust Fund Account, and 30% from the Physicians Trust Fund Account.

2. In order to appropriately reduce emergency department usage by MSI Patients, COUNTY has established an Outpatient Trust Fund Account for the purpose of providing reimbursement to non-hospital based outpatient providers, approved in writing by ADMINISTRATOR, including, but not limited to, laboratories, imaging, surgery centers and urgent care centers which may include professional services, as negotiated by ADMINISTRATOR.

a. In the event that the total of all payments to non-hospital outpatient providers is less than the amount of Outpatient Funding available, at ADMINISTRATOR'S sole discretion, the balance

of MSI Funds shall either carry forward and be included in as Outpatient Funding in a subsequent agreement, moved to another Funding category to ensure expenditure of CI Funding and/or MOE, or shall be retained by COUNTY.

b. In the event that the total of all claims for Outpatient Funding exceeds the amount of Outpatient Funding available for the Program Year, any additional payments for non-hospital based outpatient services shall be made proportionately from available Hospital Funding and Physician Funding, in accordance with all claims submitted for Outpatient Funding.

F. Special Permit Transfer, Receiving Hospital and Specialized Receiving Hospital Services – COUNTY shall pay Intermediary, from the MSI Trust fund, the amount necessary to cover reimbursement for Special Permit Transfer, Receiving Hospital, and Specialized Receiving Hospital Services as allowed in Paragraph II.D, E, and F. which costs shall be paid one hundred percent (100%) from the Hospital Trust Fund Account.

G. Penalty Assessments - At the sole discretion of ADMINISTRATOR, a penalty (Penalty Assessment) may be assessed against Intermediary if the it fails to process and reimburse claims in accordance with the standards set forth in its agreement with COUNTY for such services, and as evidenced by a monthly Processing Timeliness Report. HASC may, within thirty (30) days after receiving a Processing Timeliness Report that indicates deficient performance, request ADMINISTRATOR to withhold the Penalty Assessment. Penalty Assessments, if any, shall be deposited seventy percent (70%) to the Hospital Trust Fund Account and thirty percent (30%) to the Physicians Trust Fund Account.

H. Final Settlement - COUNTY shall pay the balance of the MSI Trust Fund, including all Hospital Trust Fund Account, CHIP-MSI Trust Fund Account, and Physicians Trust Fund Account Funds, to the Intermediary. The Intermediary shall use these Funds to make Final Settlement of claims as provided herein, including Exhibit D.

IV. COUNTY OBLIGATIONS

A. COUNTY shall provide oversight of the MSI Program, including appropriate program administration, coordination, planning, evaluation, financial and contract monitoring, public information and referral, standards assurance, and review and analysis of data gathered and reported.

B. COUNTY shall establish either directly and/or through subcontract(s), a Utilization Management Department (UMD) which shall:

1. Coordinate and make arrangements for the medical needs and care of MSI Eligibles. The UMD shall not be responsible for the coordination of social services needs of such patients.

2. Perform concurrent and retrospective utilization review of the medical appropriateness, level of care, and utilization of all services provided to MSI Patients by All Providers. The parties understand that the UMD shall use the latest available version of the Milliman Continuum of Care Criteria as its guideline for such utilization review. COUNTY acknowledges that HOSPITAL may use

Interqual criteria for similar purposes within its own operations and with this understanding:

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a. Prior to recommendation of denial of any inpatient day provided by HOSPITAL that does not meet Milliman criteria, the UMD shall notify HOSPITAL of a pending denial recommendation within two (2) business days of such determination.

b. HOSPITAL shall have the opportunity to provide written justification, within two (2) business days after receiving written notice of recommended denial, to the UMD which justification may include the application of Interqual criteria and/or other supporting information, as HOSPITAL deems necessary.

c. If the UMD subsequently recommends denial of the inpatient day, HOSPITAL shall have the right to appeal the decision to the Medical Review Committee as specified in Paragraph V. of this Exhibit A to the Agreement.

3. Communicate with HOSPITAL regarding diversions, admissions, and discharge planning.

4. Assist in coordinating the transitions of MSI Patients to appropriate outpatient care, lower levels of care or needed services through COUNTY contracted providers for skilled nursing facilities, durable medical equipment and pharmacy services and through community-based providers for home health care.

5. Conduct patient, HOSPITAL, and Other Provider education which shall include, but not be limited to:

a. Availability of MSI Program services at locations other than UCI Medical Center.

b. MSI Program services available at Community Clinics

c. Services for which pre-authorization is recommended through the UMD.

C. Upon mutual written agreement, COUNTY may enter into separate agreements for Sub-Acute Services for MSI Eligibles or MSI Patients. Execution of such agreements shall be contingent upon mutual written agreement regarding the definition of sub-acute services, implementation, and payment procedures.

D. ADMINISTRATOR may negotiate additional Points for patient-specific specialized outpatient services provided by certain Contracting Hospitals as specified by the MSI Program Medical Director, and authorized in writing by ADMINISTRATOR, at a number of Points negotiated by ADMINISTRATOR.

1. Specialized outpatient services shall be limited to those types of services that require the transfer of care for an MSI Eligible from one Contracting Hospital to another Contracting Hospital so that the required specialized outpatient service may be provided. Said services and the required transfer of care shall be verified by the MSI Program Medical Director.

2. When needed services are not available through any Contracting Hospital, ADMINISTRATOR may negotiate rates appropriate for securing care for the provision of such services

with non-Contracting Hospitals, including but not limited to, Long Beach Memorial Medical Center.

3. ADMINISTRATOR shall provide copies of negotiated agreements to the Intermediary and HASC.

E. COUNTY assures HOSPITAL that it will make every reasonable best effort to facilitate the transfer of MSI Patients, who require acute psychiatric care which is not a reimbursable service under this Agreement, from HOSPITAL to a hospital or health care facility that is operated by or has contracted with COUNTY to provide such acute psychiatric treatment.

V. COMMITTEES/GROUPS

A. Medical Review Committee (MRC) shall be formed by the parties, and shall perform the duties specified in this Agreement through ~~February~~ December ~~29~~31, 201~~2~~1.

B. The MRC shall consist of the following members:

1. One physician appointed by ADMINISTRATOR, who shall be chairperson of the committee.

2. One physician appointed by the Orange County Medical Association (OCMA), and approved by ADMINISTRATOR.

3. One physician representative of a Contracting Hospital appointed by HASC, and approved by ADMINISTRATOR.

C. The MRC shall adopt and follow rules as it deems necessary to carry out its responsibilities.

D. HOSPITAL, Other Providers, and patients may request MRC review of only claims that were denied based upon scope of services.

E. The MRC shall decide upon appeals no later than thirty (30) days after receipt of the appeal by the MRC.

F. The MRC shall have final authority to determine whether any medical service for which a claim is submitted is a reimbursable Medical Service under this Agreement.

G. The MRC shall approve and make modifications, deletions, and additions to, the list of services for which All Providers will be recommended to seek pre-authorization from COUNTY'S Utilization Management Department.

H. The MRC shall review all claims for home health, home IV infusion, and podiatrist services provided to Eligible Persons, and determine whether they are Reimbursable Medical Services, as set forth in Exhibit B to this Agreement, unless otherwise approved by COUNTY'S Utilization Management Department.

I. The MRC shall complete its review and determination of home health, home IV infusion, and podiatrist claims no later than thirty (30) days after their receipt by the Intermediary.

J. The MRC shall review all diversions, transfers and lengths of stay of Skilled Nursing Facilities and determine whether services were appropriately provided in lieu of acute inpatient hospitalization.

K. Decisions of the MRC shall be binding and final.

L. At ADMINISTRATOR'S request, MRC may be asked to investigate allegations of Inappropriate Patient Referrals.

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VI. RECORDS

A. HOSPITAL shall maintain records that are adequate to substantiate the services for which claims are submitted for reimbursement under this Agreement and the charges thereto. Such records shall include, but not be limited to, individual patient charts and utilization review records.

1. HOSPITAL shall keep and maintain records of each service rendered to each MSI Patient, the MSI Patient to whom the service was rendered, the date the service was rendered, and such additional information as COUNTY or Department may require.

2. HOSPITAL shall maintain books, records, documents, and other evidence, accounting procedures, and practices sufficient to reflect properly all direct and indirect cost of whatever nature claimed to have been incurred in the performance of this Agreement and in accordance with Medicare principles of reimbursement and generally accepted accounting principles.

3. HOSPITAL shall ensure the maintenance of medical records required by Sections 70747 through and including 70751 of the California Code of Regulations, as they exist now or may hereafter be amended, and other records related to a MSI Patient's eligibility for services, the service rendered, the medical necessity of the service, and the quality of the care provided. Records shall be maintained in accordance with Section 51476 of Title 22 of the California Code of Regulations, as it exists now or may hereafter be amended.

B. Records Retention

1. All financial records connected with the performance of this Agreement shall be retained by the parties, at a location in the County of Orange, for a period of seven (7) years after termination of this Agreement.

2. All patient records connected with the performance of this Agreement shall be retained by the parties, at a location in the County of Orange, for a period of seven (7) years after termination of this Agreement.

3. Records which relate to litigation or settlement of claims arising out of the performance of this Agreement, or costs and expenses of this Agreement as to which exception has been taken by COUNTY or State or Federal governments, shall be retained by HOSPITAL until disposition of such appeals, litigation, claims or exceptions is completed.

C. Report Distribution

1. Upon HOSPITAL'S request, COUNTY shall provide or cause the Intermediary to provide, a complete copy of any data and reports prepared by the Intermediary in accordance with the Agreement between COUNTY and the Intermediary for services relating to the MSI Program.

2. As directed by COUNTY, HOSPITAL shall compensate either the Intermediary or COUNTY for the cost of any record and data duplication under this subparagraph.

3. HOSPITAL shall not be entitled to any patient identifying information under this subparagraph. Said patient identifying information shall mean for purposes of this Agreement the name and address of an Eligible Person. Nothing in this subparagraph shall affect the ability of HOSPITAL to examine records it submits.

EXHIBIT B
HOSPITAL SERVICES
FOR THE
MEDICAL SERVICES INITIATIVE PROGRAM
SEPTEMBER 1, 2010 THROUGH FEBRUARY 29, 2012

GUIDELINES FOR REIMBURSABLE HOSPITAL SERVICES

I. REIMBURSABLE HOSPITAL SERVICES – STANDARD MSI PROGRAM

A. Hospital Services shall be reimbursable through this Agreement if such services are medically necessary to protect life, prevent significant disability, or prevent serious deterioration of health. Reimbursable and non-reimbursable services include those covered in the MSI Provider Manual, as approved by the Medical Review Committee.

1. The scope of Hospital Services may include, but are not limited to, the following:

a. Acute hospital inpatient services, including room and board, diagnostic and therapeutic ancillary services, laboratory, therapy services, anesthesia services, pharmacy services, Administrative Days, and other acute hospital inpatient services necessary to the care of the patient.

b. Outpatient services, including, hospital based surgical center services, emergency department services, diagnostic and therapeutic services, and physical and occupational therapy services.

c. Outpatient hemodialysis.

d. Blood and blood derivatives.

e. Prosthetic and medical supplies.

f. Nursing Care Day Level 1 and Nursing Care Day Level 2 services as defined in the MSI Provider Manual. The MRC or COUNTY'S Utilization Management Department (UMD) shall review every fourteen (14) day length of stay for appropriateness and medical necessity.

2. HOSPITAL has no obligation to provide the following services, but the parties understand that such services shall be reimbursable services funded 70% from the Hospital Trust Fund Account and 30% from the Physicians Trust Fund Account or as otherwise specified in this Agreement:

a. Home Health Services

b. Durable Medical Equipment

c. Emergency Medical Transportation

d. Skilled Nursing Facility (SNF) services arranged by COUNTY'S UMD in lieu of acute inpatient hospitalization for which the length of stay shall not exceed fourteen (14) days unless approved by the MRC or COUNTY UMD and subsequently approved by the MRC.

1) The MRC or COUNTY'S UMD shall review, every fourteen (14) days, any length of stay authorized beyond the initial fourteen (14) day length of stay, for appropriateness and medical

necessity.

2) A single length of stay may exceed thirty (30) days in those instances in which the MSI Patient has a Medi-Cal application pending. In such instances, the MRC may approve, and ADMINISTRATOR may authorize, the Intermediary to continue to reimburse the SNF until such time the Medi-Cal application is approved. Upon approval of the Medi-Cal application, the SNF shall be required to pay the Intermediary all MSI services subsequently reimbursed by Medi-Cal or shall assign recovery of Medi-Cal reimbursement to the Intermediary's Third Party Recovery Group.

II. REIMBURSABLE HOSPITAL SERVICES – EXPANDED CI SERVICES

General Primary Care provided in HOSPITAL'S emergency department including, but not limited to, treatment of colds, flu, sore throats, and back aches are reimbursable through this Agreement as a result of CI Funding. Intermediary, acting on behalf of COUNTY, may add to this list of CI Reimbursable Services with MRC approval. This list is not exhaustive and may be reviewed on a case by case basis by Intermediary on behalf of COUNTY. Should CI Funding be terminated, the services specified below shall be considered Non-Reimbursable Services.

III. NON-REIMBURSABLE SERVICES

The following services are not reimbursable through this Agreement and are not required to be provided by HOSPITAL to any MSI Patient. Intermediary, acting on behalf of COUNTY, may add to this list of Non-Reimbursable Services with MRC approval. This list is not exhaustive and may be reviewed on a case by case basis by Intermediary on behalf of COUNTY.

A. All diagnostic, therapeutic and rehabilitative procedures and services which are considered experimental or of unproved medical efficacy under the State Medi-Cal program.

B. Organ transplants.

C. Pregnancy related services, including complications of pregnancy.

D. Extended or long-term care facility services.

E. Adult day care health services.

F. Routine dental prophylactic and radiological studies, orthodontia, and fixed prostheses.

G. Routine eye examinations; eyeglasses for refraction and eye appliances, hearing aids and radial keratotomy.

H. Acupuncture, chiropractic, optometry, podiatry.

I. Diagnostic and therapeutic services for male and female infertility, voluntary sterilization and birth control.

J. Routine injections of antigen to ameliorate allergic conditions.

K. All medications available over the counter and medications not on the program formulary.

L. All cosmetic procedures.

M. Ultrasound, massage and therapeutic thermal packs.

N. Personal convenience items for inpatient stay.

O. Inpatient and outpatient mental health services.

P. Non-emergency medical transportation.

Q. Any services not reimbursable by the State Medi-Cal Program.

R. COUNTY shall not reimburse HOSPITAL for services provided to Transfer Patients not approved by ADMINISTRATOR; provided, however, COUNTY shall reimburse HOSPITAL for Hospital Services provided to Special Permit Transfers. This Agreement shall not obligate HOSPITAL to accept a transfer from, nor to provide compensation to, any other health care facility, subject to requirements of applicable law.

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EXHIBIT C
HOSPITAL SERVICES
FOR THE
MEDICAL SERVICES INITIATIVE PROGRAM
SEPTEMBER 1, 2010 THROUGH FEBRUARY 29, 2012

ELIGIBILITY

I. REIMBURSEMENT

Reimbursement provided through this Agreement is only intended to cover those indigent patients who would not be eligible for medical benefits from the State Medi-Cal Program, or whose medically necessary services would not be covered by other non-COUNTY third-party payors.

II. ELIGIBLE PERSONS

A. 'Eligible Person' or 'MSI Eligible' means a person who meets all of the following criteria:

1. Is an adult legal resident between and including the ages of twenty-one (21) and sixty-four (64) years.

a. Applicants shall meet United States citizenship requirements in accordance with Section 6036 of the Deficit Reduction Act of 2005, entitled 'Improved Enforcement of Documentation Requirements.'

b. ADMINISTRATOR may waive the provision for residency to be equal to or greater than five (5) years if subparagraph A.7 below applies;

2. Is a legal resident of Orange County;

3. Is not otherwise eligible for medical benefits under a Medi-Cal program, unless eligible as medically indigent, long term care, TB outpatient or as special treatment program - supplement;

4. Has income at or below two hundred percent (200%) of the Federal Poverty Level as updated April of each year, and who lacks sufficient financial resources to pay for Medical Services;

5. Is otherwise eligible based on the application and eligibility determination process as set forth in this Exhibit C and in those sections of the California Code of Regulations, Title 22, applicable to Indigent Adults.

6. Unless otherwise waived by ADMINISTRATOR, must not have had insurance in the three (3) months prior to enrollment except as may otherwise be allowed in the contract between COUNTY and Department;

7. Has an urgent, emergent, or eligible chronic medical condition;

B. CI Eligibility - As a result of CI Funding, COUNTY shall allow a limited number of persons to qualify as an MSI Eligible by meeting all the following criteria:

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1. Is an adult legal resident between and including the ages of twenty-one (21) and sixty-four (64) years.

a. Applicants shall meet United States citizenship requirements in accordance with Section 6036 of the Deficit Reduction Act of 2005, entitled 'Improved Enforcement of Documentation Requirements.'

b. Applicants must have been a resident in the United States for a minimum of five (5) years.

2. Is a legal resident of Orange County;

3. Is not otherwise eligible for medical benefits under a Medi-Cal program, unless eligible as medically indigent, long term care, TB outpatient or as special treatment program - supplement;

4. Has income at or below two hundred percent (200%) of the Federal Poverty Level as updated April of each year, and who lacks sufficient financial resources to pay for Medical Services;

5. Is otherwise eligible based on the application and eligibility determination process as set forth in those sections of the California Code of Regulations, Title 22, applicable to Indigent Adults.

6. Must not have had insurance in the three (3) months prior to enrollment except as may otherwise be allowed in the contract between COUNTY and Department.

C. Medi-Cal Eligibility

1. Persons who appear to be eligible for Medi-Cal and who refuse or fail to cooperate in completing the Medi-Cal eligibility determination process shall be ineligible for benefits from MSI.

2. Persons who are eligible for Medi-Cal who refuse or fail to pay a premium, if applicable and said requirement is implemented by the State of California, to maintain eligibility shall be ineligible for benefits from MSI.

3. MSI Patients found to have been terminated from Medi-Cal for non-payment of premiums, if applicable and said requirement is implemented by the State, will be immediately terminated from MSI and COUNTY shall make reasonable efforts to inform HOSPITAL of such patients.

D. A person approved for General Relief shall be an "Eligible Person" or "MSI Eligible."

III. INITIAL SCREENINGS

A. As part of its usual registration or financial screening process, HOSPITAL submitting claims for payment of Hospital Services through this Agreement shall use its reasonable best efforts to screen whether a patient:

1. Lacks financial resources to pay for services, and

2. Is currently Medi-Cal or MSI Eligible.

B. If the patient is unable to provide the information necessary to make the above determination, HOSPITAL shall use its reasonable best efforts to obtain this information from any other person with knowledge of the patient.

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IV. FINAL SCREENING OF PATIENTS REFERRED TO CONTRACTING HOSPITAL

A. Staff designated by HOSPITAL shall review the status of patients referred to them for screening, to conclude whether or not a patient is already eligible for Medi-Cal or is an MSI Eligible, lacks sufficient financial resources to pay for services, and is a legal resident. As appropriate, HOSPITAL shall:

1. Complete an MSI Program screening form, and refer patients who appear to be Medi-Cal eligible to Orange County Social Services Agency (SSA) Eligibility Technicians.

2. Complete an MSI application for patients who appear to be MSI Eligible. Said applications shall be submitted, in a manner specified by ADMINSTRATOR, to the "Application Processor," which at the execution of this Agreement shall be Net Chemistry, but may be changed upon thirty (30) days written notice by ADMINISTRATOR.

B. MSI applications shall include:

1. The patient's attestation and signature that under penalty of perjury all information contained in the MSI application is true and correct.

2. Verification of social security number whenever possible.

3. Documentation of legal resident alien status for patients who are not citizens.

4. The patient's attestation and signature on the application forms that requirements for spend down of excess resources must be completed by the last day of the month as a condition of eligibility.

5. Any additional information that may be reasonably required in determining eligibility, including a statement of medical need if deemed necessary.

C. HOSPITAL shall maintain sufficient staff to expeditiously obtain and screen information, and complete MSI applications as required by this Exhibit C to the Agreement.

D. HOSPITAL shall provide adequate messenger service to ensure timely delivery of applications, referrals and eligibility information to and from COUNTY.

V. ELIGIBILITY PROCESSING

A. HOSPITAL shall deliver MSI applications and refer MSI Pending(s) to the Application Processor in a timely manner.

B. HOSPITAL shall refer patients who are potentially Medi-Cal eligible to SSA in a timely manner.

C. As a condition of eligibility processing by the Application Processor, MSI applications, and any other required documentation, shall be received by the Application Processor no later than the end of the third month following the month during which services were provided. Applications received after this deadline shall be denied.

D. The Application Processor shall be solely responsible for determining whether a person meets the eligibility criteria as set forth in this Agreement.

E. Patients determined to be Eligible Persons by the Application Processor shall be eligible for a twelve-month period, or as may be modified by the ADMINISTRATOR and updated in the MSI Provider Manual; commencing the first day of the month in which MSI Program Services were first rendered,

F. HOSPITAL shall use its best efforts to inform physicians, osteopaths, podiatrists, and dentists on its medical staff that an applicant for MSI eligibility is or is not eligible.

G. Dual Payments - If HOSPITAL subsequently receives any Medi-Cal reimbursement for a patient, all MSI payments received under this Agreement shall be repaid either to the Intermediary within thirty (30) days after receipt of Medi-Cal payment or to the Third Party Recovery Group in accordance with subparagraph VI.G.4 of Exhibit D to this Agreement.

H. COUNTY shall contract with the Intermediary to:

1. Collect all MSI eligibility data by direct on-line input provided by the Application Processor.

2. Print and distribute, daily, the "Notice of Action" forms as to the disposition of claims to both patient and provider.

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EXHIBIT D
HOSPITAL SERVICES
FOR THE
MEDICAL SERVICES INITIATIVE PROGRAM
SEPTEMBER 1, 2010 THROUGH FEBRUARY 29, 2012

CLAIMS AND DISBURSEMENTS

I. SATISFACTION OF COUNTY OBLIGATION

In consideration of payments made by COUNTY through its Intermediary for Hospital Services to indigents pursuant to this Agreement, COUNTY'S obligation to HOSPITAL and indigent persons for whom it may have any legal obligation to provide Hospital Services, shall be satisfied.

II. HOSPITAL ACCOUNT

COUNTY shall require the Intermediary to maintain an account, herein referred to as the Hospital Account, for the purpose of depositing and disbursing Funds to HOSPITAL, as specified in Exhibit A to this Agreement. The Intermediary shall thereafter make the Periodic Interim Payments (PIP payments) as specified in Exhibit E to this Agreement.

III. REVIEW OF CLAIMS

COUNTY shall require Intermediary to:

A. Review all claims to determine whether the services for which reimbursement is sought are Hospital Services, reimbursable pursuant to Exhibit B to this Agreement, and whether such services were rendered to an Eligible Person.

B. Review claims, and provide a medical utilization review, in accordance with its Operations Manual, as approved by the MRC.

C. Deny all claims that do not meet the conditions and requirements of this Agreement for claim submission, processing, and reimbursement, including, but not limited to obligations pursuant to pursuing Third Party, Primary or Other Insurance Claims as specified in this Exhibit D to this Agreement.

D. Be responsible for monies paid, in any form, for non-reimbursable services, for services to persons who are not Eligible Persons, or for payment to any provider or other entity not entitled under this Agreement to such payment. The Intermediary shall reimburse the appropriate Hospital and/or Physicians Accounts for any such payments.

E. Process claims submitted by Long Beach Memorial Medical Center (Medical Center), and affiliated physicians, for only those Eligible Persons brought by Orange County Paramedics to Medical

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Center for trauma services or specialty services specifically negotiated by ADMINISTRATOR in accordance with subparagraph IV.D.2. of Exhibit A to the Agreement.

IV. CONDITIONS OF REIMBURSEMENT

A. As a condition of reimbursement through this Agreement, all claims for reimbursement of Hospital Services provided to Eligible Persons shall be:

1. Claims for Hospital Services provided during the term of this Agreement, except for:

a. Claims for Hospital Services covered by a court order.

b. Claims for Hospital Services if eligibility for a person is established by SSA after the claims submission deadline for the applicable contract period.

2. Submitted electronically and completed in accordance with this Agreement. ADMINISTRATOR may authorize limited exceptions for periodic submission of paper claims upon request of HOSPITAL and/or Intermediary on behalf of HOSPITAL.

3. HOSPITALS that submit paper claims without permission from ADMINISTRATOR will be required to pay the difference in the cost to process a paper claim versus an electronic claim. Intermediary, at the direction of ADMINISTRATOR, will deduct these costs from HOSPITAL PIP Payments or any Final Settlement Payment due HOSPITAL.

4. Initially received by the Intermediary no later than ninety (90) days following the date of service or the date of the Notice of Action that establishes MSI eligibility, whichever is later; provided, however, that claims shall be received no later than ~~November~~ September 30, 2011.

B. The Intermediary shall initially approve or deny all claims no later than ~~December~~ October 31, 2011.

C. Upon approval, by either the Intermediary or the MRC, the Intermediary shall reimburse all claims as soon as possible, and in no event later than thirty (30) days following the end of the month in which the claim was approved.

D. Except as otherwise specified in this ~~p~~Paragraph IV., any unapproved claims for Medical Services provided during the period ~~September~~ November 1, 2010 through ~~August~~ June 3~~1~~0, 2011 shall be null and void after ~~January~~ November 3~~1~~0, 201~~2~~1.

E. ADMINISTRATOR, at its sole discretion, may direct Intermediary to pay certain claims received outside the timeframes specified in this paragraph. When directed, Intermediary shall pay claims from an available funding source designated by COUNTY.

F. Unless otherwise directed by ADMINISTRATOR, all claims shall be submitted to:

Advanced Medical Management, Inc.
P.O. Box 30428
Long Beach, CA 90853-0428

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V. CLAIM DENIAL/APPEAL

A. HOSPITAL and its respective patients shall be notified, in writing, of the reason for any denial of a claim(s).

B. Notice shall be deemed effective:

1. Three (3) days from the date written notice is deposited in the United States mail, first class postage prepaid; or

2. When faxed, transmission confirmed; or

3. When accepted by U.S. Postal Service Express Mail, Federal Express, United Parcel Service, or other expedited delivery service.

C. HOSPITAL may resubmit denied claims to the Intermediary; provided, however, HOSPITAL shall complete any necessary corrective action, and resubmit the claim no later than thirty (30) days after notification of the rejection.

D. HOSPITAL or its respective patients may appeal to the MRC only those claims denied by the Intermediary for which the service claimed was determined to be outside the scope of reimbursable services. Such appeal shall be made, in writing, to the MRC, no later than thirty (30) days after notification of denial. The MRC shall decide upon the appeal no later than thirty (30) days after appeal.

E. If a denied claim is not resubmitted and/or appealed in writing to the MRC, within thirty (30) days after notification of denial, the Intermediary's determination shall be final, and HOSPITAL or its patient shall have no right to review of the claim.

VI. THIRD PARTY, PRIMARY OR OTHER INSURANCE CLAIMS

A. Reimbursement provided through this Agreement shall be payment of last resort. Prior to submitting any claim to the Intermediary for reimbursement of Hospital Services provided to an Eligible Person, HOSPITAL shall:

1. Use its reasonable best efforts to determine whether the claim is a third party, primary or other insurance covered claim.

2. Bill and use its reasonable best efforts to collect third party, primary or other insurance covered claims to the full extent of such coverage.

B. HOSPITAL shall determine that a claim is not covered, in whole or in part, under any other State or Federal medical care program or under any other contractual or legal entitlement including, but not limited to, coverage defined in W&I Section 10020.

C. With submission of a claim, HOSPITAL shall give proof of denial to the Intermediary, if a third party, primary or other insurance denies coverage of the claim.

D. HOSPITAL shall report to the Intermediary any payments received from a third party, primary or other insurance covered claims.

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E. This Agreement shall not reimburse deductibles and co-payments required by an Eligible Person's third party, primary or other insurance coverage, except as allowed in accordance with Paragraph II.B.3. of Exhibit A of this Agreement.

F. HOSPITAL shall provide the Intermediary such records and other documentation as the Intermediary may reasonably require to maintain centralized data collection and referral services in support of third-party revenue recovery activities.

G. Provider Refunds Of Claims Covered By Other Payments

1. Medi-Cal Reimbursement and Third-Party Settlement

a. If HOSPITAL, through its own efforts, identifies and receives Medi-Cal reimbursement or third-party settlement for services reimbursed through this Agreement, during the term of this Agreement, HOSPITAL shall notify Intermediary of such reimbursement and provide the corresponding claim information to Intermediary, as directed by Intermediary. Intermediary shall retract the appropriate corresponding Points from HOSPITAL prior to Final Settlement. If Medi-Cal reimbursement or third-party settlement is identified and received by HOSPITAL due to efforts of Intermediary's Third-Party Recovery Group (Recovery Group) as specified in subparagraph G.4. below, HOSPITAL shall, within thirty (30) days of receipt unless disputed in accordance with subparagraph c. below, reimburse the Recovery Group an amount equal to the MSI payment or the Medi-Cal or third-party settlement payment, whichever is less. Third-party settlement payments may be paid directly to COUNTY or to the Intermediary's Third-Party Recovery Group specified in subparagraph G.4 below, as directed by ADMINISTRATOR..

b. If HOSPITAL, through its own efforts, identifies and receives Medi-Cal reimbursement or third-party settlement for services reimbursed through any prior Agreement for MSI Hospital Services, HOSPITAL shall, within thirty (30) days of receipt, reimburse the Intermediary an amount equal to the MSI payment or the Medi-Cal or third-party settlement payment, whichever is less. Third-party settlement payments may be paid directly to COUNTY or Intermediary. If Medi-Cal reimbursement or third-party settlement is identified and received by HOSPITAL due to efforts of the Recovery Group as specified in subparagraph G.4. below, HOSPITAL shall, within thirty (30) days of receipt unless disputed in accordance with subparagraph c. below, reimburse an amount equal to the MSI payment or the Medi-Cal or third-party settlement payment, whichever is less. Third-party settlement payments may be paid directly to COUNTY, Intermediary, or to the Intermediary's Third-Party Recovery Group specified in subparagraph G.4 below, as directed by ADMINISTRATOR.

c. Should HOSPITAL wish to dispute the accuracy of the Recovery Group's identification of Medi-Cal reimbursement or third-party settlement, HOSPITAL shall give written notice, within thirty (30) days of receipt of information from the Recovery Group, to ADMINISTRATOR'S MSI Program Manager (MSI Manager) setting forth in specific terms the existence and nature of any dispute or concern related the information provided by the Recovery Group.

MSI Manager shall have fifteen (15) working days following such notice to obtain resolution of any issue(s) identified in this manner, provided, however, by mutual consent this period of time may be extended to thirty (30) days. If MSI Manager determines that the Recovery Group information is accurate, HOSPITAL shall, within thirty (30) days of receipt reimburse an amount equal to the MSI payment or the Medi-Cal or third-party settlement payment, whichever is less

2. Third Party, Primary and Other Insurance

a. Except as allowed in Paragraph II.B.2 and II.B.3 of Exhibit A of this Agreement, if HOSPITAL, through its own efforts, identifies and receives reimbursement from a third party, primary or other insurance claim for services reimbursed through this Agreement, during the term of this Agreement, HOSPITAL shall notify Intermediary of such reimbursement and provide the corresponding claim information to Intermediary, as directed by Intermediary. Intermediary shall retract the appropriate corresponding Points from HOSPITAL prior to Final Settlement. If third party, primary or other insurance claim reimbursement is received due to efforts of a Recovery Group as specified in subparagraph G.4. below, HOSPITAL shall, within thirty (30) days of receipt unless disputed in accordance with subparagraph c. below, reimburse the Recovery Group an amount equal to the MSI payment or the third party, primary or other insurance claim payment, whichever is less.

b. Except as allowed in Paragraph II.B.2 and II.B.3 of Exhibit A of this Agreement, if HOSPITAL, through its own efforts, identifies and receives reimbursement from a third party, primary or other insurance Claim for services reimbursed through any prior Agreement, HOSPITAL shall within thirty (30) days of receipt, reimburse the Intermediary an amount equal to the MSI payment or the third party, primary or other insurance payment, whichever is less. If third party, primary or other insurance claim reimbursement is received due to efforts of a Recovery Group as specified in subparagraph G.4. below, HOSPITAL shall, within thirty (30) days of receipt unless disputed in accordance with subparagraph c. below, reimburse Intermediary an amount equal to the MSI payment or the third party, primary or other insurance claim payment, whichever is less.

c. Should HOSPITAL wish to dispute the accuracy of the Recovery Group's identification of third party, primary or other insurance claim, HOSPITAL shall give written notice, within thirty (30) days of receipt of information from the Recovery Group, to ADMINISTRATOR'S MSI Program Manager (MSI Manager) setting forth in specific terms the existence and nature of any dispute or concern related the information provided by the Recovery Group. MSI Manager shall have fifteen (15) working days following such notice to obtain resolution of any issue(s) identified in this manner, provided, however, by mutual consent this period of time may be extended to thirty (30) days. If MSI Manager determines that the Recovery Group information is accurate, HOSPITAL shall, within thirty (30) days of receipt reimburse an amount equal to the MSI payment or the third party, primary or other insurance payment, whichever is less.

3. For purposes of computing the amount of reimbursement due from HOSPITAL, after Final Settlement, the services provided an Eligible Person shall be valued at the percentage of reimbursement

for the applicable contract period.

4. ADMINISTRATOR may authorize the Intermediary to utilize a Third-Party Recovery Group (Recovery Group) for the purpose of actively pursuing reimbursement of claims paid for MSI Eligibles later determined to be eligible for Medi-Cal or third party, primary or other primary other insurance. HOSPITAL shall reasonably cooperate with the Recovery Group in recovering these costs. Except as otherwise directed by ADMINISTRATOR, monies recovered due to the efforts of the Recovery Group shall be reimbursed to the Recovery Group. The Recovery Group, after deduction of appropriate administrative fees, shall remit the balance to the Intermediary for deposit as follows: ten percent (10%) into the HCA Recovery Account and the remainder into the Hospital Recovery Account.

5. If any reimbursement due the Intermediary or Recovery Group is not paid by HOSPITAL in accordance with subparagraphs G.1, G.2., or G.4 above, the Intermediary shall reduce HOSPITAL'S Periodic Interim Payment by an amount not to exceed the amount to be reimbursed. If funds were identified for reimbursement by the Recovery Group, said funds reduced from the HOSPITAL'S Interim Payment shall be allocated as if the amount had been paid to the Recovery Group in accordance with subparagraph G.4. above.

VII. RECOVERY ACCOUNTS

A. COUNTY shall require the Intermediary to collect and deposit refunds and any third-party payments related to any Hospital Service rendered by HOSPITAL in a Hospital Recovery Account. Refunds and third-party payments resulting from the actions of the Recovery Group shall be allocated in accordance with Paragraph VI.G.4 of this Exhibit D to the Agreement.

1. Refunds and payments from ambulance operators, home health services providers, and providers of medical equipment shall be deposited 100% to the Outpatient Recovery Account; provided, however, refunds and payments from ambulance operators relating to the transfer of an MSI Patient from UCI Medical Center to a Receiving Hospital shall be deposited into the HCA Recovery Account, which shall be either returned to COUNTY at Final Settlement or used for reimbursement of subsequent such ambulance claims, as directed by ADMINISTRATOR.

2. Refunds and payments from Skilled Nursing Facilities, including but not limited to reimbursement following approval of Medi-Cal applications in accordance with subparagraph I.A.2.d.2 of Exhibit B to this Agreement, shall be deposited as follows: 100% of institutional refunds and payments to the Hospital Recovery Account and 100% of professional refunds and payments to the Physicians Recovery Account.

3. Refunds and payment from Sub-Acute Facilities shall be deposited 100% in accordance with Subparagraph IV.C. of Exhibit A to this Agreement.

4. Refunds and payments resulting from services furnished by an Ineligible Person as defined in the Compliance Paragraph of this Agreement shall be recovered from appropriate party and deposited to the Recovery Account corresponding with the pool from which reimbursement for said services was

made. If the initial reimbursement for services were not made from the Physician or Hospital Pool, the funds shall be deposited 70% to the Hospital Recovery Account and 30% to the Physician Recovery Account.

B. At Final Settlement, Funds in the Hospital Recovery Account shall be deposited in the Hospital Account and paid in the same manner as are other Funds in this Account. Any funds in the HCA Recovery Account shall be either returned to COUNTY upon Final Settlement or used for reimbursement of other MSI Program costs through the Intermediary as directed by ADMINISTRATOR.

VIII. PERIODIC INTERIM PAYMENTS TO CONTRACTING HOSPITALS

A. COUNTY shall require the Intermediary to pay HOSPITAL, monthly in arrears, the "PIP payment" stipulated in Exhibit E to this Agreement, which payment and Exhibit may be revised by ADMINISTRATOR if Hospital Funding is modified as provided herein, if CI Funding to COUNTY has not been received from Department, or if data received from the Intermediary supports a revised PIP payment to HOSPITAL. If PIP payments are to be revised, ADMINISTRATOR shall provide the data received from the Intermediary to HASC and HOSPITAL and shall notify HASC and HOSPITAL of COUNTY'S intent prior to revising the PIP Payment; provided, however, that the total of all PIP payments shall not exceed one-twelfth (1/12) of eighty percent (80%) of total Hospital Funding per month.

1. PIP payments shall be disbursed from the Hospital Account commencing October 1, 2010, and thereafter, on or about the first (1st) day of each month through September 1, 2011; provided, however, that HOSPITAL has returned a fully executed Agreement to ADMINISTRATOR or HASC.

2. If HOSPITAL does not return a fully executed Agreement to ADMINISTRATOR or HASC within sixty (60) days of ADMINISTRATOR'S delivery to HASC of this Agreement to be executed by Contracting Hospitals, Points for services provided for the period September 1, 2010 through the date a fully executed Agreement is actually received by HASC shall not be allocated to HOSPITAL and HOSPITAL'S PIP payment shall be effective and commence the first (1^{st}) day of the month following the receipt of the fully executed Agreement and shall not be retroactive to September 1, 2010.

B. The PIP payments stipulated in Exhibit E to this Agreement assume that all hospitals listed in such Exhibit are Contracting Hospitals.

1. At the sole discretion of, and in accordance with the calculations made by ADMINISTRATOR, PIP payments to HOSPITAL shall be adjusted to reflect additions or deletions from the list of Contracting Hospitals in Exhibit E to this Agreement or to reflect a Contracting Hospital's percent of participation in the MSI Program. PIP Payments will be adjusted in March 2011 for PIP payments distributed for March, April, and May 2011 and again in June 2011 for PIP payments distributed for June, July, and August 2011.

2. Upon receipt of a written recommendation by HASC and mutual agreement by

ADMINISTRATOR, PIP payments to HOSPITAL may be adjusted to reflect the acquisition of one or more Contracting Hospitals listed in Exhibit E to this Agreement by any other Contracting Hospital listed in Exhibit E to this Agreement.

C. PIP payments to HOSPITAL are interim payments only for services to be provided, and are subject to Final Settlement, in accordance with this Exhibit D to this Agreement. It is understood by the parties that PIP payments to HOSPITAL represent the best effort of the parties to estimate payments that are due to all hospitals participating in providing services herein. It is further understood by the parties that after the computations required by Final Settlement, it may be determined that certain hospitals have received excess payment(s). The Intermediary shall use its best efforts to obtain repayment of such excess payments, and shall thereafter reimburse such monies in accordance with this Agreement. HOSPITAL shall repay such excess payments to the Intermediary. If such reimbursement is not made within ten (10) days of request by Intermediary, ADMINISTRATOR may, in addition to any other remedies, reduce any amount owed HOSPITAL by an amount not to exceed the reimbursement due the Intermediary.

D. In consideration of PIP payments, HOSPITAL shall hold COUNTY and the Intermediary harmless against any claim resulting from excess interim payments to any other Contracting Hospital. This hold harmless provision shall not prevent HOSPITAL from directly pursuing any claim it may wish to assert against any other Contracting Hospital by reason of such overpayment.

IX. PAYMENTS TO PHARMACEUTICAL PROVIDERS

A. If HOSPITAL elects to be an outpatient pharmaceutical provider, HOSPITAL shall bill COUNTY'S Pharmacy Benefits Manager and shall be reimbursed at rates to be negotiated by COUNTY with said Pharmacy Benefits Manager.

B. Products available over the counter shall not be reimbursed, including those products for which the prescribed dosage can be achieved through an increased dosage of an over the counter medication.

C. Unless otherwise directed by ADMINISTRATOR, all pharmacy claims shall be submitted electronically to COUNTY'S Pharmacy Benefits Manager.

X. FINAL SETTLEMENT

A. The Intermediary shall complete final reimbursement to All Providers, as specified below (Final Settlement). Final Settlement shall be accomplished no later than February 28, 2012.

B. Prior to Final Settlement, but not later than January 15, 2012, the Intermediary shall complete an estimated preliminary reimbursement to All Providers to determine redistribution of funds in order to maximize CI Funding and meet COUNTY MOE requirements (Preliminary Final Settlement) as specified in this Subparagraph B. It is understood by the parties that all adjustments are for the sole purpose of maximizing CI Funding and shall not result in a reduction in the Aggregate MSI Maximum Obligation as specified on Page 4 of this Agreement; provided, however, that total Allowable Costs for

all Contracting Hospitals exceed the Aggregated MSI Maximum Obligation. It is further understood by the parties that definitions included in this Subparagraph B may be defined further in COUNTY'S Agreement with the Intermediary.

1. The total of all CI Funding allocated by Department to COUNTY for each Program Year is $16,871,577. CI Funding must be matched with an equal amount of MSI Funds, therefore the total of all CI Claimable Services which must be provided to allow COUNTY to receive CI Funding must be equal to or greater than $33,743,154 which may include any or all of the CI Claimable services provided through this Agreement, the COUNTY'S Agreement with Intermediary; the MSI Clinic Agreement, and COUNTY'S Agreement with its Pharmacy Benefits Manager.

a. If the total of COUNTY'S CI Claimable Services is less than $33,743,154, or the CI Funding allocated by Department is reduced, the resulting reduction in CI Funding shall be deducted as follows; provided, however, reallocations in accordance with Preliminary Final Settlement as detailed herein still apply:

1) 39% from Hospital Funding.
2) 45% from Physician Funding.
3) 16% from Clinic Funding.

b. If the total of COUNTY'S CI Claimable Services for the Period September 1, 2009 through August 31, 2010 is greater than $33,743,154 and Department allocates additional CI Funding to COUNTY, the CI Funding shall be allocated as follows; provided, however, reallocations in accordance with Preliminary Final Settlement as detailed herein still apply. If Department allocates additional CI Funding after February 28, 2011, COUNTY shall request Intermediary to complete a Supplemental Final Settlement Process,

1) 39% towards Hospital Funding
2) 45% towards Physician Funding
3) 16% towards Clinic Funding

2. The COUNTY has a required MOE for each Program Year which includes the MSI funds required to match CI Funding in accordance with Subparagraph B.1 above and which represents the actual COUNTY expenditures for the MSI Program provided through this Agreement, the COUNTY'S Agreement with Intermediary, the MSI Clinic Agreement, and COUNTY'S Agreement with its Pharmacy Benefits Manager.

a. There is no financial impact to COUNTY or any Provider if the MOE is exceeded.

b. If the MOE is not met for any Program Year, Department may reduce COUNTY'S CI Funding by an amount not less than the difference between the amount of funds expended for the Program Year and COUNTY'S MOE. Any reduction in CI Funding shall be allocated in accordance with subparagraph B.l.a. above; provided, however, reallocations in accordance with Preliminary Final Settlement as detailed herein still apply.

3. Step 1: Pharmacy claims paid through COUNTY'S Pharmacy Benefits Manager shall be

reconciled by ADMINISTRATOR no later than October 1, 2011.

a. ADMINISTRATOR shall obtain from its Pharmacy Benefits Manager, a report of all Pharmacy Claims separately detailing those pharmacy claims that are CI Claimable from those that are not CI Claimable. Administrative fees charged by the Pharmacy Benefits Manager may not be CI Claimable.

b. If the total of all Pharmacy claims, when added to the MSI Funding provided through this Agreement, the COUNTY'S Agreement with Intermediary, and the MSI Clinic Agreement, are less than the required MOE, ADMINISTRATOR shall allocate MSI Funds and CI Funds exactly as detailed by the Pharmacy Benefits Manager and shall make adjustments to the MSI Base Funding as appropriate. It is understood by the parties that all adjustments are for the sole purpose of maximizing CI Funding and shall not result in a reduction in allocation amounts to any Provider that would otherwise have been available; provided, however, that the total Allowable Costs for each Trust Fund Account exceed each allocation amount.

1) The adjustments to the MSI Base Funding and the difference between the actual Pharmacy claims and the amount needed to meet MOE shall be reported to by ADMINISTRATOR to the Intermediary.

2) COUNTY shall deposit this amount into the MSI Trust Fund and prior to Preliminary Final Settlement, the Intermediary shall invoice COUNTY for this amount, which amount COUNTY shall pay, and the Intermediary shall deposit into an interest-bearing account ('Holding Account') pending continued calculation of the Preliminary Final Settlement.

a) Step 1A: After deduction of Physician Claims not subject to Final Settlement, if Intermediary determines that the total of all Physician Claims, paid at seventy percent (70%) of RBRVS, national rate, is estimated to exceed the total amount of Physician Funding available, the Intermediary shall first allocate an amount up to one hundred percent (100%) of the Holding Account until a minimum of seventy percent (70%) of RBRVS, national rate is achieved.

b) Step 1B: If Intermediary determines that the total of all Clinic Claims, paid at eighty-five percent (85%) of RBRVS, national rate, is estimated to exceed the total amount of Clinic Funding available, the Intermediary shall allocate an amount up to one hundred percent (100%) of the remaining balance of the Holding Account until a minimum of eighty-five percent (85%) of RBRVS, national rate is achieved.

c. If the total of all Pharmacy claims, when added to the MSI Funding provided through this Agreement, the COUNTY'S Agreement with Intermediary, and the MSI Clinic Agreement, is greater than the required MOE, ADMINISTRATOR shall allocate MSI Funds and CI Funds exactly as detailed by the Pharmacy Benefits Manager and shall make adjustments to the MSI Base Funding as appropriate.

4. Step 2: ADMINISTRATOR shall report to the Intermediary the estimated MSI Trust Fund balances to be used in calculating the Preliminary Final Settlement which shall be completed in the

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following order: Dental Trust Fund, Clinic Trust Fund, Outpatient Trust Fund, Physician Trust Fund and Hospital Trust Fund.

a. All calculations are subject to adjustment to maximize CI Funding, meet MOE requirements, and ensure rates of payment for CI Claimable Services and non-CI Claimable services are consistent for each specific Provider Funding allocation, subject to Final Settlement. All calculations are understood to be estimates only, subject to additional minor adjustments during Final Settlement.

b. ADMINISTRATOR, with the Intermediary as necessary, will be available at the request of HASC to discuss the Preliminary Final Settlement calculations before the Intermediary proceeds with Final Settlement; provided, however that such meetings shall be held no later than January 31, 2011.

c. ADMINISTRATOR and the Intermediary shall agree on timelines to begin and complete each step of the Preliminary Final Settlement Process to meet the final completion deadline of January 1, 2011 in order to allow HASC opportunity for review and questions.

5. Step 3: Dental Claims are not subject to a Final Settlement adjustment and Dental Funding shall not be augmented by funds in the Holding Account, if any, except as may be allowed in subparagraph X.B.9.b.3 below.

a. If the total of all Dental Claims is estimated to exceed the available Dental Funding for the Program Year, funding for additional Dental Claims shall be secured from Clinic Funding in accordance with COUNTY'S Agreement with the Intermediary. The Intermediary shall report the total of all Dental Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds, pending further adjustments as appropriate.

1) ADMINISTRATOR and the Intermediary shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

2) The Intermediary shall report the balance of Clinic Funding remaining after funding for additional Dental Claims has been made and proceed to Step 4 of Preliminary Final Settlement.

b. If the total of all Dental Claims is estimated to be less than the available Dental Funding available for the Program Year the Intermediary shall report the total of all Dental Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds.

1) The Intermediary shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

2) The difference between the estimated Dental Claims to be paid and the available Dental Funding for the Program Year shall be added to the Clinic Funding and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds, pending further adjustments as appropriate.

6. Step 4: The Intermediary shall utilize the procedures specified in the MSI Clinic Agreement to determine and compute amounts due to Contracting Clinics through Final Settlement; provided, however, that the procedure set forth herein for Preliminary Final Settlement shall be included for the purpose of determining the ratio of MSI Funds, CI Funds, and amounts, if any, allowed for retention in the Clinic Trust Fund Account and/or to be transferred to or from the Holding Account.

a. Case Management Clinic Expenditures: Of the total allocated for Clinic Claims through for the Program Year, $250,000 shall be set aside for the Contracting Clinics Pay for Performance Program in accordance with the MSI Clinic Agreement.

b. Contracting Clinic Claims: The Intermediary shall estimate the total amount of funds available to reimburse Contracting Clinic Claims including the Clinic Fund allocation for Program Year 2010-11 and any Dental Funding that may have been reallocated to Clinic Funding.

1) If the total of all Contracting Clinic Claims, paid at one hundred percent (100%) of Contracting Clinics' allowable charges, is estimated to exceed the total amount of Clinic Funding available, the Intermediary shall allocate an amount up to, but not exceeding, ten percent (10%) of the funds available in the Holding Account, if any, to the Clinic Funding to achieve the highest possible reimbursement without exceeding Contracting Clinics' allowable charges.

a) The Intermediary shall report the total of all Contracting Clinic Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds, pending further adjustments as appropriate.

b) ADMINISTRATOR and the Intermediary shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

2) If the total of all Contracting Clinic Claims, paid at one hundred percent (100%) of Allowable Charges, is estimated to be less than the total amount of Clinic Funding available, the Intermediary shall report the total of all Contracting Clinic Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds, pending further adjustments as appropriate.

a) At ADMINISTRATOR'S sole discretion, ADMINISTRATOR may authorize not more than the actual amount remaining at Final Settlement for the Prior Agreement and Prior Clinic Agreement to be retained in the 'Clinic Trust Fund' provided such action is determined to be consistent with actual MOE reported for FY 2006-07.

b) Any remaining balance, after deduction of any amount allowed to be retained, shall be deposited into the Holding Account.

c) ADMINISTRATOR and the Intermediary shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

7. Step 5: Outpatient Claims are not subject to a Final Settlement adjustment and Outpatient Funding shall not be augmented by funds in the Holding Account, if any, except as may be allowed in subparagraph XI.B.9.b.3 below.

a. If the total of all Outpatient Claims is estimated to exceed the available Outpatient Funding, funding for additional Outpatient Claims shall be secured from either Hospital Funding or Physician Funding in accordance with subparagraph III.E.2.b of Exhibit A to this Agreement. The Intermediary shall report the total of all Outpatient Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds, pending further adjustments as appropriate.

1) ADMINISTRATOR and the Intermediary shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

2) The Intermediary shall report the balance of Hospital Funding and Physician Funding remaining after funding for additional Outpatient Claims has been made and proceed to Steps 6 and 7 of Preliminary Final Settlement.

b. If the total of all Outpatient Claims is estimated to be less than the available Outpatient Funding, the Intermediary shall report the total of all Outpatient Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds.

1) At ADMINISTRATOR'S sole discretion, ADMINISTRATOR may authorize not more than the actual amount remaining at Final Settlement for the Prior Agreement to be retained in the "Outpatient Trust Fund" provided such action is determined to be consistent with actual MOE reported for FY 2006-07.

2) Any remaining balance, after deduction of any amount allowed to be retained, shall be deposited into the Holding Account.

3) ADMINISTRATOR and the Intermediary shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

8. Step 6: Final Settlement for physicians shall be calculated in accordance with COUNTY'S Agreement with the Intermediary; provided, however, that the procedure set forth herein for Preliminary Final Settlement shall be included for the purpose of determining the ratio of MSI Funds, CI Funds, and amounts, if any, to be transferred to or from the Holding Account

a. After deduction of Physician Claims not subject to Final Settlement, if the total of all Physician Claims, paid at one hundred percent (100%) of Physicians' allowable charges, is estimated to exceed the total amount of Physician Funding available, the Intermediary shall allocate an amount up to, but not exceeding, thirty percent (30%) of the amount remaining in the Holding Account, if any, to the Physician Funding to achieve the highest possible reimbursement without exceeding Physicians' allowable charges.

1) The Intermediary shall report the total of all Physician Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds, pending further adjustments as appropriate.

2) ADMINISTRATOR and the Intermediary shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

3) If the total of all Physician Claims, paid at one hundred percent (100%) of Physicians' allowable charges, is estimated to be less than the total amount of Physician Funding available, INTERMEDIARY shall report the total of all Physician Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds, pending further adjustments as appropriate.

a) Any remaining balance after Physician Claims have been paid at one hundred percent (100%) of Physicians' allowable charges shall be deposited into the Holding Account.

b) ADMINISTRATOR and the Intermediary shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

9. Step 7: The Intermediary shall utilize the procedures specified in the in Subparagraph XI.C through XI. G below to determine and compute amounts due to HOSPITAL through Final Settlement; provided, however, that the procedure set forth herein for Preliminary Final Settlement shall be included for the purpose of determining the ratio of MSI Funds, CI Funds, and amounts, if any, to be transferred to or from the Holding Account. CHIP funding shall not be used to match CI Funds for CI Claimable Services and is not included in COUNTY'S MOE calculation.

a. After deduction of any Hospital Claims not subject to Final Settlement, if the total of all Hospitals Claims, paid at one hundred percent (100%) of Allowable Costs, is estimated to exceed the total amount of Hospital Funding available, the Intermediary shall allocate all remaining funding in the Holding Account, if any, to the Hospital Funding to achieve the highest possible reimbursement without exceeding Allowable Costs.

1) The Intermediary shall report the total of all Hospital Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds, pending further adjustments as appropriate.

2) ADMINISTRATOR and the Intermediary shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

b. If the total of all Hospital Claims, paid at one hundred percent (100%) of Allowable Costs, is estimated to be less than the total amount of Hospital Funding available, the Intermediary shall report the total of all Hospital Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds, pending further adjustments as appropriate.

1) Any remaining balance remaining after Hospital Claims have been paid at one hundred percent (100%) of Allowable Costs shall be deposited into the Holding Account.

2) ADMINISTRATOR and the Intermediary shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

3) If funds remaining in the Holding Account after completion of Step 7, the Intermediary and ADMINISTRATOR may make one or more of the following adjustments:

a) Reverse adjustments to the Clinic Funding as a result of Dental Claims

exceeding available Dental Funding.

b) Reverse adjustments to the Physician Funding as a result of certain Outpatient Claims exceeding available Outpatient Funding.

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c) Reverse adjustments to the Hospital Funding as a result of certain Outpatient Claims exceeding available Outpatient Funding.

d) Reduce and reallocate CHIP funding to one or more Contracting Hospitals in a manner to be determined by ADMINISTRATOR.

e) Increase the rate of Allowable Charges or Allowable Costs for any or all Providers, as determined by ADMINISTRATOR.

C. Immediately prior to Final Settlement, the Intermediary shall deposit any Hospital Recovery Account balance into its Hospital Account and any Physician Recovery Account balance into its Physician Account and shall advise ADMINISTRATOR of any funds in the HCA Recovery Account.

D. After Preliminary Final Settlement, and in preparation for Final Settlement, COUNTY shall report to the Intermediary the MSI Trust Fund Account balances to be distributed through Final Settlement. The Intermediary shall invoice COUNTY for this amount, which amount COUNTY shall pay, and the Intermediary shall deposit in the appropriate Hospital or Physician account. The Intermediary shall disburse such Funds, the balance of all other monies in the Hospital and any other accounts maintained for the purposes of this Agreement, and any earned interest, to All Providers. Disbursements to HOSPITAL shall be in the manner specified below:

E. Settlement to Contracting Hospitals - The Intermediary shall utilize the following procedures and Point Table values to determine and compute the amounts due to HOSPITAL through Final Settlement:

1. Final Settlement shall be based upon claims submitted and approved in accordance with this Agreement. All appeals of denied claims shall be heard and decided no later than January 15, 2011.

2. For informational and comparative purposes the value of a point shall equal that paid in the last completed Fiscal Year, as may have been amended or changed.

3. Trauma Points shall be applied to the entire length of stay, excluding administrative days, and Nursing Care Days – Level One and/or Level Two.

4. Conversion factors for High Tech Ancillary procedures shall be assigned by ADMINISTRATOR.

5. The following shall be used to compute the amount due to each Contracting Hospital at Final Settlement:

a. Step 1 - Retraction/void points shall be deducted from Gross Allowable Points to yield total Preliminary Net Points for all Contracting Hospitals.

b. Step 2 - Points shall be deducted from preliminary Net Points for Contracting Hospitals electing to be Receiving Hospitals or Specialized Receiving Hospitals in accordance with Points

negotiated for said services in accordance with Exhibit A to this Agreement, or for those Contracting Hospitals for which Points have been negotiated for Special Permit Transfers in accordance with Exhibit A to this Agreement. This shall yield the total Net Points for all Contracting Hospitals.

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c. Step 3 - Total September 1, 2010 through August 31, 2011 Hospital Account Funds available for distribution are apportioned to HOSPITAL based upon the ratio of HOSPITAL'S Net Points to the total of Net Points for all Contracting Hospitals.

d. Step 4 - Determine HOSPITAL'S "percentage of business" based upon the net amount of funds for each Contracting Hospital.

e. Step 5 - Multiply HOSPITAL'S "percentage of business" by the applicable disproportionate provider factor (DP Factor) below:

Percentage of Business			DP Factor
.000	-	3.75	.83258
3.760	-	5.00	.88431
5.010	-	10.00	.93603
10.010	-	15.00	.99293
15.010	-	20.00	1.04983
20.010	-	25.00	1.10673
25.010	-	30.00	1.16363
greater than		30.00	1.22053

f. Step 6- "Normalize" HOSPITAL'S percentage of business, and make necessary calculations, including addition of Special Permit Transfer Points, Receiving Hospital Points, or Specialized Receiving Hospital Points, if applicable, to balance the total of all Contracting Hospitals' percentage of business to 100%.

g. Step 7 - Calculate Final Settlement to all Contracting Hospitals based on:

1) The percentage of business, adjusted as specified above.

2) The total amount available for distribution to all Contracting Hospitals during the term of this Agreement.

3) Previous PIP payments and any other adjustments, such as Special Permit Transfer, Receiving Hospital, or Specialized Receiving Hospital Points.

h. The Point Table for services provided during the term of this Agreement shall be as follows. Upon mutual written agreement, Contracting Hospitals and ADMINISTRATOR may adjust the categories and corresponding Point values.

POINT TABLE

E.R. Outpatient Categories	Points
Minor w/o Ancillary – Room Only	1.00
Minor w/o Ancillary – Room w/Professional Component	2.00

Minor w/ Ancillary – Room Only 3.25
Minor w/ Ancillary – MD & Room..... 4.00
Minor w/ Ancillary – MD, Room & Professional Component 4.75
MD & Room Only – Physical Therapy..... 5.50
Ancillary Only – Level 1..... 2.50
Ancillary Only – Level 2..... 1.75
Major Ancillary 7.00
Major w/o Ancillary – Room Only 3.75
Major w/o Ancillary – MD & Room..... 7.50
Major w/ Ancillary – Room Only 10.75
Major w/ Ancillary – MD & Room Only..... 10.75
Surgical Procedure – Ancillary Only 1.75
Surgical Procedure w/o Ancillary – Room Only..... 3.75
Surgical Procedure w/o Ancillary – MD & Room 7.50
Surgical Procedure w/ Ancillary – Room Only..... 5.50
Surgical Procedure w/ Ancillary – MD & Room 9.25

Inpatient Points	Contracting Hospital
Acute Days	15
Critical Days (including Burn Days)	40
Acute & Telemetry (step-down)	20
Nursing Care Day – Level Two	8
Nursing Care Day – Level One	6.5
Admin Days	6

Trauma Points

Died in E.R.	32
Died in O.R.	149
Admitted	38

High Tech Ancillary – The Point value of High Tech Ancillary services shall be as specified in the MSI Provider Manual as may be reviewed and periodically adjusted by ADMINISTRATOR in consultation with HOSPITAL.

6. The Intermediary shall include in the Final Settlement computations, additional Points for patient-specific specialized outpatient services provided by certain Contracting Hospitals as negotiated in accordance with Paragraph IV.D of Exhibit A to this Agreement.

7. The results of the above computations shall be communicated to all Contracting Hospitals

on or before February 15, 2012. Such notice shall include notification to any hospital that has received an overpayment through PIP payments, and a demand for immediate repayment, which repayment shall be received by the Intermediary no more than ten (10) days after such hospital's receipt of said notice. Final distribution of all amounts due to HOSPITAL shall be made on or before February 28, 2011. If, by reason of any Contracting Hospital's failure to make timely repayment of any obligation calculated in accordance with the provisions of this subparagraph, the Intermediary is unable to make full payment to HOSPITAL of the amount otherwise due HOSPITAL under this Agreement, the Intermediary shall accompany the final distribution to HOSPITAL with a notice indicating the amount of the underpayment and the names of those Contracting Hospitals that have failed to make required repayments.

8. PIP Payment Withhold - In the event HOSPITAL failed to repay the amount calculated in accordance with Exhibit D to the FY 2009-10 Agreement between the parties, COUNTY shall direct the Intermediary to withhold HOSPITAL'S PIP payment(s) until such time as repayment is made. Such withhold shall continue until the full amount owed by HOSPITAL is recovered; provided, however, such withhold shall not continue beyond the time when final PIP payment is due in accordance with this Agreement. The Intermediary shall make one final distribution of withheld Funds to Contracting Hospitals that are owed money on or before September 1, 2011. If the Intermediary is unable to make full payment of such monies to HOSPITAL, the Intermediary shall include with the final distribution of withheld Funds to HOSPITAL, a notice indicating the amount of the underpayment and the names of those hospitals that have failed to make required repayments.

F. Settlement Limitation – Total interim payments shall be adjusted for other insurance, voided claims, settlements and refunds. No Contracting Hospital shall be reimbursed more than Allowable Costs.

G. All Funds in accounts maintained by the Intermediary relating to the term of this Agreement, which funds are remaining after one hundred percent (100%) of Allowable Costs have been reimbursed through Final Settlement, and all other payments required by this Agreement have been made, shall be returned to COUNTY by the Intermediary.

H. Supplemental Final Settlement for PY 2009-10 – If the total of COUNTY'S CI Claimable Services for PY 2009-10 is greater than $33,743,154 and Department allocates additional CI Funding to COUNTY after February 28, 2011 for PY 2009-10, COUNTY shall request Intermediary to complete a Supplemental Final Settlement process. Supplemental Final Settlement shall be calculated in the following order:

1. Step 1: Contracting Clinics

a. If the total of all Contracting Clinic Claims, paid at one hundred percent (100%) of Contracting Clinics' allowable charges, exceed the total amount of Clinic Funding available after completion of Final Settlement for PY 2009-10, the Intermediary shall allocate an amount up to, but not exceeding, sixteen percent (16%) of the additional CI Funding to the Clinic Funding to achieve the

highest possible reimbursement without exceeding Contracting Clinics' allowable charges. Any balance of funds remaining shall be allocated thirty percent (30%) to the Physician Funding and seventy percent (70%) to the Hospital Funding.

b. If Final Settlement for PY 2009-10 resulted in all Contracting Clinic Claims being paid at one hundred percent (100%) of Contracting Clinics' allowable charges, there will be no Supplemental Final Settlement for Contracting Clinics and the additional CI Funding which would have been apportioned to Contracting Clinics shall instead be allocated thirty percent (30%) to the Physician Funding and seventy percent (70%) to the Hospital Funding.

2. Step 2: Physicians

a. If the total of all Physician Claims, paid at one hundred percent (100%) of Physicians' allowable charges, exceed the total amount of Physician Funding available after completion of Final Settlement for PY 2009-10, the Intermediary shall first apply the Physician allocation of any Clinic Funding reallocated to Physician Funding in accordance with subparagraph H.1. above. Any balance of funds remaining shall be allocated one hundred percent (100%) to the Hospital Funding.

b. If the total of all Physician Claims, paid at one hundred percent (100%) of Physicians' allowable charges, still exceed the total amount of Physician Funding available after application of subparagraph 2.a. above, the Intermediary shall allocate an amount up to, but not exceeding, forty-five percent (45%) of the additional CI Funding received from Department to the Physician Funding to achieve the highest possible reimbursement without exceeding Physicians' allowable charges. Any balance of funds remaining shall be allocated one hundred percent (100%) to the Hospital Funding.

c. If Final Settlement for PY 2009-10 resulted in all Physician Claims being paid at one hundred percent (100%) of Physicians' allowable charges, there will be no Supplemental Final Settlement for Physicians and any additional CI Funding which would have been apportioned to Physicians shall instead be allocated one hundred percent (100%) to the Hospital Funding.

3. Step 3: Contracting Hospitals

a. If the total of all Contracting Hospital Claims, paid at one hundred percent (100%) of Allowable Costs, exceed the total amount of Hospital Funding available after completion of Final Settlement for PY 2009-10, the Intermediary shall first apply the Hospital allocation of any Clinic Funding reallocated to Hospital Funding in accordance with subparagraph H.1. above. Any balance of funds remaining shall be returned to COUNTY by the Intermediary.

b. If the total of all Contracting Hospital Claims, paid at one hundred percent (100%) of Allowable Costs, still exceed the total amount of Hospital Funding available after application of subparagraph 3.a. above, the Intermediary shall then apply the Hospital allocation of any Physician Funding reallocated to Hospital Funding in accordance with subparagraph H.2. above. Any balance of funds remaining shall be returned to COUNTY by the Intermediary.

c. If the total of all Contracting Hospital Claims, paid at one hundred percent (100%) of Allowable Costs, still exceed the total amount of Physician Funding available after application of

subparagraphs 3.a. and 3.b. above, the Intermediary shall allocate the balance of the additional CI Funding received from Department to the Hospital Funding to achieve the highest possible reimbursement without exceeding Allowable Costs. Any balance of funds remaining shall be returned to COUNTY by the Intermediary.

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d. If Final Settlement for PY 2009-10 resulted in all Contracting Hospital Claims being paid at one hundred percent (100%) of Allowable Costs, there will be no Supplemental FinalSettlement for Hospitals and any additional CI Funding which would have been apportioned to Hospital shall instead be returned to COUNTY by Intermediary.

e. Any CI Funding returned to COUNTY by Intermediary shall be returned to Department.

XI. SATISFACTION OF CLAIMS

A. Acceptance by HOSPITAL of payments made by the Intermediary in accordance with this Agreement shall be deemed satisfaction in full of any obligation to HOSPITAL with respect to those claims for Hospital Services for which payment has been made by the MSI Program, notwithstanding HOSPITAL'S right to appeal any denied claim, as provided for in Paragraph V. of this Exhibit D to this Agreement.

B. HOSPITAL shall not seek additional reimbursement from an MSI Eligible patient with respect to those claims for Hospital Services for which payment has been made by the MSI Program except as may be otherwise authorized in accordance with Paragraphs II.B.2 and II.B.3 of Exhibit A to this Agreement.

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EXHIBIT E
HOSPITAL SERVICES
FOR THE
MEDICAL SERVICES INITIATIVE PROGRAM
SEPTEMBER 1, 2010 THROUGH FEBRUARY 29, 2012

HOSPITAL PERIODIC INTERIM PAYMENTS (PIP)

COUNTY shall direct the Intermediary to pay HOSPITAL the PIP payment stipulated below for services provided during the period September 1, 2010 through August 31, 2011, which payment may be revised pursuant to Paragraph VIII. of Exhibit D to this Agreement.

HOSPITAL	PIP PAYMENTS
AHMC Anaheim Regional Medical Center, L.P.	$223,975
Chapman Medical Center, Inc., dba Chapman Medical Center	$13,947
Coastal Communities Hospital, Inc., dba Coastal Communities Hospital	$64,540
Fountain Valley Regional Hospital	$355,789
Hoag Memorial Hospital Presbyterian	$200,730
Kaiser Foundation Hospitals, Inc.	$10,442
Los Alamitos Medical Center	$29,262
Mission Hospital	$271,559
Orange Coast Memorial Medical Center	$87,238
Placentia Linda Community Hospital	$29,262
Prime Healthcare Anaheim	$76,299
Prime Healthcare Garden Grove	$41,841
Prime Healthcare Huntington Beach	$49,772
Prime Healthcare La Palma	$17,776
Regents of the University of California	$544,760
Saddleback Memorial Medical Center (SMMC)	$111,577
Saint Joseph Hospital - Orange	$187,330
Saint Jude Medical Center	$209,207
WMC-A, Inc., dba Western Medical Center Hospital -Anaheim	$27,894
WMC-SA, Inc., dba Western Medical Center Hospital - Santa Ana	$181,587
Total PIP Payments	$2,734,787

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