AMENDMENT NO. FOUR
TO THE
CONSULTING SERVICES AGREEMENT

This Amendment No. Four, dated October 1, 2021, (the "Amendment Effective Date") and amends the Consulting Services Agreement, dated April 1, 2019, (as amended, the "Agreement"), between County of Monterey, Natividad Medical Center ("Customer") and OptumInsight, Inc.

WHEREAS, Customer has elected to obtain Physician Advisory Services from Optum's affiliate Optum360 Solutions, LLC

WHEREAS the parties wish to utilize the Consulting Services Agreement already in place to govern the general terms for the physician advisory services.

WHEREAS, Optum360 Solutions, LLC, agrees to be bound by the terms and conditions of the Agreement applicable to OptumInsight, Inc. for the purposes of the services described in this Amendment No. Four.

NOW, THEREFORE, in consideration of the mutual covenants hereinafter set forth, the parties agree to amend the Agreement as follows:

1. **Existing Agreement.** Except as set forth in this Amendment No. Four, all terms and conditions of the Agreement remain in full force and effect. In the event of any conflict between the terms of this Amendment No. Four and the Agreement, this Amendment No. Four shall control.

2. **Physician Advisory Services** Optum will provide to Customer medical necessity review and other compliance related consulting services as set forth on Exhibit A to this Amendment No. Four.

2. **Term**. Section 9 of the Agreement is deleted in its entirety and replaced with the following:

> "9. Term. Either party may cancel and terminate this Agreement for good cause effective immediately upon written notice to the other party unless the reason for termination is capable of being cured and is reasonably cured within 30 days after receipt of notice. "Good cause" includes failure of either party to perform as provided under this Agreement. If Natividad terminated this Agreement for good cause, Natividad is obligated to compensate Optum for all fees incurred in connection with the performance of the Services through the date of termination. A final true-up invoice will be provided to Natividad for all fees incurred through the date of such termination and not previously paid for by Natividad and Natividad agrees to pay such amounts in accordance with the terms of this Agreement. Natividad's payments to Optum under this Agreement are funded by local, state and federal governments. If funds from local, state and federal sources are not obtained and continued at a level sufficient to allow for Natividad purchase of the indicated quantity of services, then Natividad may give a written notice of this fact to Optum and the obligations of the parties under this Agreement shall terminate immediately, or on such date thereafter, as the County may specify in its notice, unless in the meanwhile the parties enter into a written amendment modifying this Agreement.
>
> 9.1 The Services described in Exhibit A shall commence on the Amendment Effective Date and continue for three (3) years after the latest Go Live Date for any particular hospital (the "Initial Term"), unless earlier terminated pursuant to the Agreement. This Agreement is of no force or effect until signed by both Optum360 Solutions, LLC. and Natividad and with Natividad signing last and Optum360 Solutions, LLC. may not commence work before Natividad signs this Agreement."

[Signatures follow on next page]

IN WITNESS WHEREOF, the parties have accepted and agreed to this Amendment No. Four.

OPTUMINSIGHT, INC.		**NATIVIDAD MEDICAL CENTER**	
Signature:	Todd Gustin Todd Gustin (Dec 22, 2021 12:16 CST)	Signature:	
Print Name:	Todd Gustin	Print Name:	
Print Title:	President, Market Solutions	Print Title:	

Contract No.: 00556063.4

Reviewed and approved as to form.

Chief Deputy County Counsel

12/23/2021

EXHIBIT A

1. Services. Customer hereby engages Optum to provide the Case Advisor services defined below, as well as the medical necessity reviews and appeal support services described in Exhibit A, all of which are deemed to be "Services" under the Agreement. Optum shall provide the Services to the Customer owned hospital(s) (each of which is included in the definition of "Customer"). Optum's ability to perform the Services will be dependent upon Customer's ability to supply Optum the required information in a timely manner, including completion of all forms required to file an appeal.

Legal Name of Hospital	Hospital Provider ID	Is Provider ID Shared with any other hospital
Natividad Medical Center	050248	No

1.1 Case Advisor Services. Using its proprietary software, Optum shall screen cases referred from Customer to assist Customer in prioritizing certain types of cases for second level review ("Case Advisor"). Screening through Case Advisor will result in an outcome of either (i) "Meets Sorting Criteria" or (ii) "Does Not Meet Sorting Criteria." A "case" means one patient for one hospital visit or stay for purposes of determining the number of cases. A subsequent hospital visit or stay by the same patient shall be deemed a separate case. "Case Meets Sorting Criteria" means the case will be referred for second level review.

1.1.1 Meets Sorting Criteria. In the event that Case Advisor results in an outcome that the Case Meets Sorting Criteria, Optum will perform the second-level medical necessity concurrent review Services set forth in Exhibit A. Cases that result in Meets Sorting Criteria and are subsequently billed according to Optum's recommendation will be eligible for Appeals Support Services as defined in Exhibit A.

1.1.2 Does Not Meet Sorting Criteria. In the event that Case Advisor results in an outcome that the case Does Not Meet Sorting Criteria, Optum will return the case without providing second-level medical necessity review Services. Optum will provide notification to Customer when a Case results in Does Not Meet Sorting Criteria. A case that Does Not Meet Sorting Criteria is not eligible for Appeal Support Services.

1.2 Case Advisor Go Live Date. "Case Advisor Go Live Date" shall mean the earlier of (i) the date on which a hospital refers its first case to Optum using Case Advisor; or (ii) the ninetieth (90th) day after the Effective Date of this Schedule.

1.3 Authorization of Representation. Customer hereby retains Optum to perform the Services, the scope of which may include, but shall not be limited to: (a) the preparation of medical necessity reviews and reimbursement appeals on behalf of Customer including the preparation of correspondence with respect to such reviews and appeals on behalf of Customer personnel specified by Customer, and (b) the receipt of third party payer correspondence relating to the reviews and appeals. In connection herewith, Customer agrees to support Optum in its representation of Customer, including execution of all documentation necessary for Optum to perform the Services; e.g., a letter of authorization, which Optum shall provide to third party payers. Customer agrees to hold Optum harmless from any claims related to a third party payer's refusal to acknowledge Optum as Customer's representative.

1.4 Case Advisor Reporting.

1.4.1 Bi-Annual Reporting. Optum will provide reports to Customer for Case Advisor every six months using the claims and remittance data provided to Optum by Customer. Optum will provide Customer with Case Advisor performance reviews and analysis. Optum will evaluate health plan observation rates, reimbursements, and denial activity, along with other payer activity, to determine the impact and value of Case Advisor. Optum will provide Customer with a compliance performance review. Optum will assist participating hospitals in the following three core areas: (i) first level screening – are all Medicare admissions screened and documented; (ii) second level status – are all failed first level screens being reviewed by a physician; and (iii) billing status – does the bill accurately reflect the decisions made at the first and second level review.

1.4.2 Key Metrics Benchmarking. As part of the reporting, Optum will perform statistical analysis of billing claims data, remittance advice, and screening criteria results data for commercial and government payers that has been aggregated across participating Optum customers in order to facilitate a comparison of experience among hospitals ("Key Metrics"). Optum will not disclose Customer's individual performance measures or Customer's identity (name, location, etc.) when Customer's information is aggregated as part of a Key Metric statistic.

1.4.3 Additional Reporting. Customer may request that Optum perform an analysis that is unique to Customer or outside Optum's standard Services. If a unique analysis is requested, the parties shall mutually agree by separate written instrument on the scope of such Services and the fees associated if applicable.

2. Implementation Services.

2.1 Initial Implementation. At the fees set forth below, Optum will work with Customer to confirm adequate and appropriate implementation of the Services. Initial implementation includes the collection and transfer of applicable information between Customer and Optum, initial case management, physician education, meeting with appropriate Customer staff, and introducing the program to Customer executives. Standard implementation includes an Optum Implementation Director on-site at Customer or hospital location for one to two days as well as remote coordination, data management and set-up, and one dedicated calendar day of medical and executive staff education by a Senior Optum Physician Advisor. Telephonic implementation is available.

2.2 Re-Implementation. Re-implementation Services are the same as the initial implementation Services described above and are provided as a refresher to Customer personnel at the request of Customer. An implementation fee, set forth below, shall be applied for each Customer hospital that requests re-implementation Services.

2.3 Vendor Registration and Registration Maintenance. If Customer requires Optum to register through Customer's vendor registration system (whether internal or external), Optum will charge Customer a registration fee and an annual maintenance fee. Customer, however, agrees that Optum shall not be required to provide Optum's financial or other confidential information or Optum employees' personal information through this registration process.

2.4 Customer Thresholds. Customer is solely responsible for setting Case stratification Thresholds during the implementation process. Thresholds set by Customer during implementation of the Services and/or Hosted Solution may be used by Customer to determine which cases may require either (i) further clinical review either internally by Customer or referred to Optum for Case Review Services; or (ii) cases that do not require additional review but instead require further validation and processing by the Customer. All information submitted to payers based on the Thresholds and any workflows, suggested actions, or referrals based on the Thresholds, are the sole responsibility of the Customer. "**Threshold**" means Customer determined and designated parameters to assist in identifying cases that have a lower or higher likelihood of either inpatient or outpatient status.

3. Customer Responsibilities.

3.1 Customer Notification. Customer agrees to notify Optum within fifteen (15) days after receipt of notification of an investigation by a government agency or contractor, where the subject of the investigation includes cases reviewed or appealed by Optum on behalf of Customer.

3.2 Electronic Case Retrieval. Customer must allow electronic retrieval of cases by Optum for case review. If Customer requests that Optum staff provide their personal information, Customer agrees that it will maintain the confidentiality of such personal information, and will use the same degree of care to protect such personal information as it would with the personal information of its own employees. In no event shall Optum personnel be required to provide full Social Security numbers or submit to an additional background check. Furthermore, Customer shall abide with all applicable federal and state laws with regard to the protection, use and disclosure of such personal information, as well as any applicable requirements in the event of a breach of such personal information. Customer shall promptly provide to all affected users written notice of any actual or suspected breach of their personal information and reasonable mitigation efforts.

Optum shall have no liability or obligation, whether in tort, contract or otherwise to Customer, or any individual or entity, for any reason whatsoever arising in connection with Customer's use of electronic case submission, including, but not limited to: (a) any interruption or failure of the submission for any reason; (b) any failure of Customer to provide access to Customer's systems, the records, or other information in a timely manner; (c) any error, addition or omission in any record or file contained in the transmission of data; (d) any failures, transmission problems, data corruption, data storage issues, technology issues or other issues relating to the submission or transmission of data; or (e) any acts or omissions by Customer.

3.3 Submission of Cases. At a minimum, Customer agrees to send Optum observation cases where the attending order is outpatient for the selected payer(s). Customer may also choose to send additional cases that fail first level review.

3.3.1 Claims Data Transfer. Customer agrees to use commercially reasonable efforts to send Optum its claims and remittance data within ten (10) business days of the Effective Date. Customer shall also either (i) initiate an automatic feed for transmitting remittance data on a regular basis (daily or weekly) or (ii) send Optum claims and remittance data every six months. Customer understands and agrees that its failure to send claims and remittance data will hinder Optum's ability to track outcomes and Case Advisor performance.

3.3.2 Clinical Data Transfer. Customer agrees to use commercially reasonable efforts to assist Optum in establishing an ongoing HL7-based, or other agreed upon format, clinical data feed to transmit the necessary clinical data to Optum for use in performing the Services within six months of the Case Advisor Go-Live Date. In the event such feed is not established within six months, due to the fault of Customer, upon Optum's notice to Customer, Optum may increase the fees as set forth below

4. Fees and Payment Terms.

4.1 Monthly Subscription Fee. Customer shall pay to Optum a monthly subscription fee for Case Advisor, which includes second level reviews of Meets Sorting Criteria Cases. The subscription fee allows Optum to process up to the number of Meets Sorting Criteria Cases set forth in 4.2 below. In the event the Case Advisor Go-Live Date is the middle of a month, the first and last month's fees shall be prorated. For each month after the first month, Optum shall invoice Customer on the first day of each month.

Case Advisor Per Case	Annual Fees	Quarterly Fees	Included Optum SLR Cases Quarterly	Case Rate	Overage Case Rate
Year 1	$77,280	$19,320	84	$230	$215
Year 2	$77,280	$19,320	84	$230	$215
Year 3	$77,280	$19,320	84	$230	$ 215

4.2 Monthly Reconciliation. On each anniversary of the Case Advisor Go Live Date, Optum shall perform a calculation of all cases for the preceding month. In the event that Customer's actual number of close and return cases exceeds the included number set forth above, Optum may adjust the thresholds, at the individual facility level, used to determine which cases meet the sorting criteria so that no more than 30% of all cases submitted, by any individual facility, are closed and returned without further action by Optum. "

	All Years
Monthly included number of on close and return cases (cases that do not meet sorting criteria calculated on a per facility basis	30% of all cases that Meet Sorting Criteria for each facility

4.3 Fees for Lack of Clinical Data Feed. If the clinical data feed has not been established in accordance with 3.3.2, the monthly subscription fees set forth in above shall be increased by five percent (5%). Optum will provide written notification to Customer no less than thirty (30) days prior to the increase in the subscription fees.

4.4 Implementation Fees. Customer shall pay Optum $7,500 per hospital for implementation Services.

4.5 Re-implementation Fees. Should Customer request re-implementation Services, Customer shall pay Optum $7,500 per hospital for such Services.

5. Additional Terms.

5.1 Access to Records. In accordance with Medicare requirements under section 952 of the Omnibus Reconciliation Act of 1980 (P.O. 96-499) and such regulations related thereto as may be promulgated by the Secretary of the U.S. Department of Health and Human Services (the "Secretary"), Optum shall, while this Schedule is in effect and until the expiration of four years after furnishing any Services hereunder, make available, upon written request to the Secretary or the Comptroller General of the United States, or any of their duly authorized representatives, a copy of the Agreement and this Schedule and such books, documents and records of Optum that are necessary to certify the nature and extent of the costs incurred by Customer with respect to the Services furnished by Optum hereunder. Optum shall notify Customer promptly of any such request for records. If either party carries out any of its duties hereunder through a subcontract having a value or cost of Ten Thousand Dollars ($10,000.00) or more over a twelve (12) month period, such subcontract shall contain a clause that includes the same obligations as this Section.

5.2 Optum Representation and Warranty. Optum represents and warrants that the Optum physicians providing Services under this Schedule are not "sanctioned individuals" as defined in the Social Security Act, 42 U.S.C. section 1320a-7, regarding individuals penalized for Medicare/Medicaid fraud or abuse, and have no action pending.

5.3 Liability for Missing Information. Customer shall be responsible for the timely and accurate submission of all required forms necessary for appeals and the accuracy of any Customer Data delivered to Optum.

ATTACHMENT 1
SERVICES DEFINITIONS

Following are the definitions applicable to the Services:

I. Services Relevant to Commercial Payers.

A. Commercial Admission Review – Concurrent. Optum will review all commercial admissions for all payers for cases that fail to meet initial case management admission screening criteria (such as InterQual® or MCG®). Optum Physicians work with case management and the attending physicians, when appropriate, to perform a medical necessity review concurrently at time of admission or retrospectively (up to forty-eight (48) hours post discharge) based on medical judgment and clinical evidence (consistent with local and/or national standards of care). Optum will issue a recommendation regarding the appropriate admission status and provide individualized case documentation. It is Customer's responsibility to identify the applicable commercial payer contracts for which a concurrent admission review is appropriate. This review does not apply apply to admissions that have already been discussed with a payer medical director. Periodically, Optum may perform analytics services for ongoing program monitoring. Optum may provide Customer with commercial performance review and /or key metric analysis.

B. Other Commercial Admission Review – Concurrent. Optum will review other commercial admissions for cases that do not meet initial case management admission screening criteria (such as InterQual® or MCG®). Optum physicians work with case management and the attending physicians, when appropriate, to perform medical necessity review concurrently at time of admission or retrospectively based on clinical evidence. Optum will provide a medical necessity recommendation regarding admission status, as well as individualized case documentation. It is Customer's responsibility to identify the applicable commercial payer contracts for which a concurrent admission review is appropriate. This review does not apply to admissions that have already been discussed with a payer medical director.

II. Services Relevant to Medicare.

A. Medicare Admission Review and Compliance - Concurrent. Optum will review Medicare admissions for cases that do not meet initial case management admission screening criteria (such as InterQual® or MCG®). Optum will provide a medical necessity recommendation regarding admission and provide individualized case documentation. This process will be carried out in accordance with the requirements for utilization review as set forth by the Medicare Conditions of Participation (42 C.F.R. § 482.30). Specifically, the attending/treating physician shall make the final determination regarding admission in conjunction with Customer's Utilization Review Committee. This review does not apply to admissions that have already been denied or downgraded. Appeal Support (defined below) applies to these case reviews.

B. Medicare Admission Review and Compliance – Post Discharge. Optum will review Medicare post discharge (where a final non-conditional discharge order exists on the chart) cases and will provide a medical necessity recommendation regarding the admission. Customer shall provide all required documentation prior to Optum's rendering of a recommendation. Notwithstanding the foregoing, the attending/treating physician, in conjunction with Customer's Utilization Review Committee, shall make the final determination regarding admission and billing status. This review does not apply to admissions that have already been denied or downgraded. Appeal Support applies to these case reviews.

C. Medicare Continued Stay Review and Compliance - Concurrent. Optum will review Medicare continued hospital stays for inpatient cases that do not meet case management screening criteria (such as InterQual® or MCG®). Optum will provide a medical necessity recommendation regarding the continued stay days at issue and provide individualized case documentation. This process will be carried out in accordance with the requirements for utilization review as set forth by the Medicare Conditions of Participation (42 C.F.R. § 482.30). The attending/treating physician shall make the final determination regarding the continued stay in conjunction with Customer's Utilization Review Committee. This review does not apply to admissions or any continued stay days that have already been denied or downgraded.

D. Medicare Readmission Review and Compliance - Concurrent. When a readmission review is requested by Customer, Optum physicians will work with case management and the attending and consulting physicians, to review the medical necessity of an admission in which a patient has been recently discharged from the hospital and readmitted to the same hospital. In addition, Optum will review the case to recommend if the second admission is potentially related to the first

admission at the same hospital. Optum will provide a medical necessity recommendation regarding the readmission at issue and provide individualized case documentation. The attending/treating physician shall make the final determination regarding admission in conjunction with Customer's Utilization Review Committee. Appeal Support applies to these case reviews.

E. Medicare Other Procedural Setting Review and Compliance - Concurrent. Optum physician advisors work with case management, and the attending and consulting physicians to review surgical cases postoperatively, providing medical necessity recommendations for appropriate admission status (inpatient or outpatient). This process will be carried out in accordance with the requirements for utilization review as set forth by the Medicare Conditions of Participation (42 C.F.R. § 482.30). The attending/treating physician shall make the final determination regarding admission in conjunction with Customer's Utilization Review Committee. The review does not apply to admissions that have already been denied or downgraded.

III. Services Relevant to Medicaid.

A. Medicaid Admission Review and Compliance - Concurrent. Optum will review Medicaid admissions for cases that do not meet initial case management admission screening criteria (such as InterQual® or MCG®). Optum will provide a medical necessity recommendation regarding admission and provide individualized case documentation. The attending/treating physician shall make the final determination regarding admission in conjunction with Customer's Utilization Review Committee regarding admission. This review does not apply to admissions that have already been denied or downgraded. Appeal Support applies to these case reviews.

B. Medicaid Continued Stay Review and Compliance - Concurrent. Optum will review Medicaid continued hospital stays for inpatient cases that do not meet case management screening criteria (such as InterQual® or MCG®). The attending/treating physician shall make the final determination regarding the continued stay in conjunction with Customer's Utilization Review Committee. Optum will provide a medical necessity recommendation regarding the continued stay days at issue and provide individualized case documentation. This review does not apply to admissions or any continued stay days that have already been denied or downgraded.

C. Medicaid Readmission Review and Compliance - Concurrent. When a readmission review is requested by Customer, Optum physicians will work with case management and the attending and consulting physicians, to review the medical necessity of an admission in which a patient has been recently discharged from the hospital and readmitted to the same hospital. In addition, Optum will review the case to recommend if the second admission is potentially related to the first admission at the same hospital. Optum will provide a medical necessity recommendation regarding the readmission at issue and provide individualized case documentation. (Note: for certain states, readmission timelines are strictly defined according to Medicaid billing rules and not medical necessity requirements, and thus would not provide an opportunity for Optum to review and/or intervene). The attending/treating physician shall make the final determination regarding admission in conjunction with Customer's Utilization Review Committee. Appeal Support applies to these case reviews.

D. Medicaid Other Procedural Setting Review and Compliance - Concurrent. Optum physicians work with case management, the admission department, and the attending and consulting physicians to review surgical cases postoperatively, providing medical necessity recommendations for admission (inpatient or outpatient). This process will be carried out in accordance with a generally accepted utilization review protocol. The attending/treating physician shall make the final determination regarding admission in conjunction with Customer's Utilization Review Committee. This review does not apply to admissions that have already been denied or downgraded.

IV. Specialty Case Reviews (all payers, unless otherwise noted).

A. Specialty Procedure Reviews.

1. Cardiology Procedure Review - Concurrent Post Procedure Review. Optum will review elective Interventional Cardiac Procedures including Implantable Defibrillators (ICDs), Pacemakers, Angioplasties, Stents, Brachytherapy, Atherectomy, and Ablations. Determining the medical necessity of Interventional Cardiac Procedures involves complex clinical and regulatory evaluation by specially trained Optum physicians. During implementation, Optum will work with Customer to establish an initial screening process to be performed by Customer staff to recommend which cases should be reviewed by Optum physicians. After an elective Interventional Cardiac Procedure is performed, Optum will

review the case and provide a medical necessity recommendation regarding admission (inpatient or outpatient). The attending/treating physician shall make the final determination regarding admission in conjunction with Customer's Utilization Review Committee. Optum physicians will work closely with the attending physician, cardiologist, anesthesiologist, and other consulting physicians, when appropriate, to understand the medical necessity and ensure appropriate documentation for the level of medical care provided. Appeal Support applies to these case reviews.

2. Vascular Procedure Review - Concurrent Post Procedure Review. Optum will review elective Vascular Procedures, including Carotid procedures, Cerebrovascular procedures, Renovascular procedures, and Upper and Lower extremity vascular procedures. Determining the medical necessity of Vascular Procedures involves complex clinical and regulatory evaluation by specially trained Optum physicians. During implementation, Optum will work with Customer to establish an initial screening process to be performed by Customer staff to recommend which cases should be reviewed by Optum physicians. After an elective Vascular Procedure is performed, Optum will review the case and provide a medical necessity recommendation regarding admission (inpatient or outpatient). The attending/treating physician shall make the final determination regarding admission in conjunction with Customer's Utilization Review Committee. Optum physicians will work closely with the attending physician, anesthesiologist, and other consulting physicians to understand the medical necessity. Optum will provide written documentation of the Optum physician's recommendation. Appeal Support applies to these case reviews.

3. Long Term Acute Care ("LTAC") Reimbursement Denials Review and Appeal - Retrospective. These Services are conducted after Customer has received a formal letter of notification that a claim has been downgraded or denied for a former inpatient and the case in question has been determined by Customer and Optum to be appropriate for retrospective reimbursement review and appeal. The relevant chart(s) containing the patient record of an inpatient admission that has been retrospectively denied or downgraded by the payer will be sent by Customer to Optum. Optum's clinician team will conduct a retrospective reimbursement denials review, which will, when deemed appropriate, result in a formal appeal letter prepared by Optum on behalf of Customer to the applicable payer. Copies of all retrospective reimbursement denials review appeal letters will be provided to Customer.

B. Specialty Concurrent Reviews.

1. Medicare Inpatient Rehabilitation Post-Admission Review – Concurrent. Optum will review Medicare Inpatient Rehabilitation post-admission cases for patients who have completed a multidisciplinary evaluation and for whom an individualized plan of care has been created. Optum will review the Rehabilitation Documentation (defined below) to determine whether the Rehabilitation Documentation supports the admission and continued provision of intensive inpatient rehabilitation services under applicable laws and regulations, and will prepare and deliver a recommendation as to whether (a) the inpatient admission was reasonable and appropriate, and therefore medically necessary; (b) the continued provision of intensive inpatient rehabilitation services, as of the date of the plan of care, is reasonable and appropriate, and therefore medically necessary. Customer is responsible for the correct coding and billing of services and therefore excluded from this review is the timeliness of documentation, documentation of Services rendered, and administrative recordkeeping. Customer shall provide Optum with the following Rehabilitation Documentation from the medical record: (i) the order indicating admission to Inpatient Rehabilitation, (ii) the date and time of the bed occupancy, (iii) the pre-admission screen, (iv) the history and physical examination, (v) the post-admission physician evaluation, and (vi) the individualized overall plan of care (the "Rehabilitation Documentation"). Upon the request of Customer, Optum shall review daily physician progress notes (one week at a time), and weekly team conference notes. Optum's review process will be carried out in accordance with the Medicare Benefit Policy Manual, Chapter 1, Section 110 and the requirements for utilization review as set forth by the Medicare Conditions of Participation (42 CFR 482.30). Appeal Support applies to these Services.

V. Denials Review and Appeals (Medical Necessity and Coding).

A. Government Denials.

1. Redetermination & Reconsideration Levels (For Medicaid: Peer-to-Peer Review or Formal Written Appeals Level) – Medical Necessity Denial. Optum will work with Customer's case management staff and attending and consulting physicians to review and appeal cases in which Medicare and Medicaid agents (e.g., Quality Improvement Organizations ("QIOs"), Fiscal Intermediaries ("FIs"), Medicare Administrative Contractors ("MACs"), Medicaid Integrity Contractors ("MICs") and Recovery Audit Contractors ("RACs")) have issued denials of payment. Optum will

pursue the appeal on behalf of Customer, provided however, that Optum shall have no obligation to appeal any case where Optum made a medical necessity recommendation with respect to such case that was not followed by Customer. These Services are limited to those appeals up to but excluding appeals at the ALJ level, and do not include litigation support or expert witness services. All required forms, including, but not limited to an Appointment of Representation form shall be completed by Customer to enable Optum to file appeals on Customer's behalf.

2. Redetermination & Reconsideration Levels (For Medicaid: Peer-to-Peer Review or Formal Written Appeals Level) – Coding Denial. Optum will work with Customer's case management staff and attending and consulting physicians to review and appeal cases in which Medicare and Medicaid agents (e.g., QIOs, FIs, MACs, MICs and RACs) have issued denials of payment for coding reasons. These Services are limited to those appeals up to but excluding appeals at the ALJ level, and do not include litigation support or expert witness services. All required forms, including, but not limited to an Appointment of Representation form shall be completed by Customer to enable Optum to file appeals on Customer's behalf.

3. ALJ Level (For Medicaid: Hearing Level - different names apply to different states). Optum will review all cases denied at the Reconsideration Level to recommend if any particular case should be appealed to the Administrative Law Judge ("ALJ"). The Services include the submission of an appeal memorandum, when required by the ALJ, and include the attendance of an Optum hearing professional (clinical, coder, or regulatory analyst) for the purpose of presenting the case to the ALJ, when applicable. Customer is not required to appear at the ALJ hearing. Should Customer desire to have legal representation at the hearing, Customer must secure its own legal counsel. For Medicaid cases, an Optum physician will be available to provide expert testimony by phone if requested. Hearing expenses may apply.

4. Departmental Appeals Board Level (For Medicaid: Different names apply to different states). Optum will review all cases denied at the ALJ Level and review with Customer any case which Optum recommends should be brought to the Departmental Appeals Board ("DAB") level. These Services include the creation and submission of a written memorandum (supporting written argument) to the DAB and the attendance of an Optum physician and/or regulatory analyst at the DAB hearing, if applicable, for the purpose of presenting the case per the written memorandum (supporting written argument). Each case appealed at this level is considered a new/additional case. All required forms, including, but not limited to an Appointment of Representation form shall be completed by Customer to enable Optum to file appeals on Customer's behalf. This Service only includes appeal(s) at the DAB Level. Hearing expenses may apply.

B. Commercial Appeals.

1. Concurrent Reimbursement Medical Necessity Denials Review and Appeals. These Services are conducted when payer claim status for inpatient services or admission has been downgraded or denied and the patient is an inpatient at the time or has been recently discharged (concurrent reimbursement denial or downgrade). A denial or downgrade is defined as denied if payer-approved reimbursement is anything less than 100% of what would be the expected reimbursement if the admission was reimbursed entirely at an acute inpatient level of care or higher (i.e., ICU level of care). Optum will review concurrent reimbursement denials and downgrades with Customer's case management department and/or medical leadership and Optum will recommend which concurrent reimbursement denials/downgrades are appropriate for appeal. Where permissible by the payer, Optum will perform telephonic appeals with appropriate representatives of the relevant payer and communicate the results to the appropriate Customer personnel.

2. Retrospective Reimbursement Medical Necessity Denials Review and Appeals. These Services are conducted after Customer has received an explanation of benefits or received a formal letter notifying Customer that a claim has been downgraded or denied based on medical necessity for a former inpatient and the case in question has been mutually determined by Customer and Optum to be appropriate for retrospective reimbursement review and appeal. The relevant chart(s) containing the patient record of an inpatient admission that has been retrospectively denied or downgraded by the payer will be sent by Customer to Optum. Optum will conduct a retrospective reimbursement medical necessity denials review, which will, when deemed appropriate, result in a formal appeal letter prepared by Optum on behalf of Customer to the appropriate payer; provided however, that Optum shall have no obligation to appeal any case where Optum made a medical necessity recommendation with respect to such case that was not followed by Customer. All required forms shall be completed by Customer to enable Optum to file appeals on

Customer's behalf. Copies of all retrospective reimbursement denials review appeal letters will be provided to Customer.

3. Retrospective Reimbursement Coding Denials Review and Appeals. These Services are conducted after Customer has received an explanation of benefits or received a formal letter notifying Customer that a claim has been downgraded or denied based on a coding issue for a former inpatient and the case in question has been mutually determined by Customer and Optum to be appropriate for retrospective reimbursement review and appeal. The relevant chart(s) containing the patient record of an inpatient admission that has been retrospectively denied or downgraded by the payer will be sent by Customer to Optum. Optum's certified coders will conduct a retrospective reimbursement coding denials review (with input from specially trained Optum physicians as needed), which will, when deemed appropriate, result in a formal appeal letter prepared by Optum on behalf of Customer to the appropriate payer. All required forms shall be completed by Customer to enable Optum to file appeals on Customer's behalf. Copies of all retrospective reimbursement denials review appeal letters will be provided to Customer.

4. Commercial and Managed Medicare External Hearings. Optum will review all cases denied at the initial payer levels of appeal with Customer to recommend if any particular case should be appealed to the External Hearing Entity ("EHE") (i.e., ALJ, Independent Review Organization ("IRO"), etc.). These Services may include the creation and submission of a written memorandum (supporting written argument) to the EHE and/or the attendance of a clinician representative on the EHE phone call for the purposes of presenting the case per the written memorandum. Customer is not required to appear at the EHE hearing. Additionally, Customer is not required to engage counsel for the cases referred to Optum that requires an appeal at this level, except as required by law. Each case appealed at this level is considered a new/additional case. All required forms shall be completed by Customer to enable Optum to file appeals on Customer's behalf. These Services only include appeals at the EHE Level. Hearing expenses and filing fees may apply and shall be the responsibility of Customer.

5. ALJ Level. For non-contracted Managed Medicare cases, Optum will appeal cases that are denied at the External Hearing Level with Customer and sent to the ALJ. These Services include the submission of an appeal memorandum, when required, and include the attendance of an Optum hearing professional (clinical, coder, or regulatory analyst) for the purpose of presenting the case to the ALJ, when applicable. Customer is not required to appear at the ALJ hearing. Should Customer desire to have legal representation at the hearing, Customer must secure its own legal counsel. Hearing expenses may apply.

6. Departmental Appeals Board Level. Optum will review all cases, denied at the ALJ/EHE level with Customer to recommend if any particular case should be taken to the DAB level. These Services include the creation and submission of a written memorandum (supporting written argument) to the DAB and the presence of an Optum physician and/or Optum regulatory analyst at the DAB hearing, if applicable, for the purposes of presenting the case per the written memorandum (supporting written argument). Each case appealed at this level is considered a new/additional case. All required forms shall be completed by Customer to enable Optum to file appeals on Customer's behalf. This Service only includes appeals at the DAB Level. Hearing expenses may apply.

C. Outcomes. For reporting purposes, Optum shall load the value of each case appealed based on case documentation provided by Customer. Where no claims value information is provided by Customer, Optum shall report "not available" on Customer reports. When permissible by Customer, Optum shall access the Customer's system to pull said data.

D. Litigation Support or Expert Witness Testimony. Optum can support Customer in litigation matters or provide expert witness testimony at hearings; however, unless such support relates to Services provided pursuant to Section V.A.3 above for Medicaid cases in order to comply with certain legal requirements regarding participation by a third party, this service is contracted and priced separately.

E. Document Retrieval Services. Optum will work with Customer to retrieve necessary and available documentation required for Optum to appeal Customer's cases. Optum will directly retrieve said appeal documentation, including not less than the entire patient medical record as one electronic file to be used for the appeal, from Customer's information system through remote-access log-in capabilities. This includes remote log-in to one information system for each hospital set forth in Section 1 of this Exhibit A. Customer agrees to provide Optum with access to the system, to notify Optum that documents need to be retrieved, and to support Optum operational requirements to ensure the success of the appeal process. Optum shall provide Customer with a weekly log of all open cases received by Optum either via Optum Exchange or report. The

"Optum Exchange" is a portal that provides an on-demand comprehensive view of Customer's compliance and appeals management program. Customer agrees to verify the log each week to ensure that Optum has received all cases sent/submitted by Customer and to immediately alert Optum of any missing appeals. These Services are provided by Optum solely for the convenience of Customer. Accordingly, Optum disclaims any and all liability associated with Optum's failure to obtain any appeal documentation directly from Customer's information system and Customer acknowledges and accepts such disclaimer upon selection of this Service.

F. Paper/CD/DVD Appeal Submission. The appeal Services above assume an electronic submission of the case to Optum for appeal purposes. Submission of paper charts, or charts on CD/DVD will result in an additional fee.

G. Expedited Appeals. Appeals submitted less than fifteen (15) days prior to the appeal deadline ("Expedited appeals") will result in an additional fee. Optum shall make a reasonable attempt to gather all documentation from Customer needed to process a timely and complete appeal.

VI. Appeals Data Tracking Service.

A. Appeals Data Tracking Service - Data Entry. Optum will work with Customer to data enter the status and update of status of each appeal in Customer's information system through remote log-in capabilities. This includes remote log-in to one information system for each hospital set forth in Section 1 of this Exhibit A.

B. Appeals Data Tracking Service - Optum Standard Reports. Optum will provide to Customer Optum standard reports that include the data and information needed for tracking the status of appeals. The standard reports are provided on a monthly basis.

C. Appeals Data Tracking Service - File Updates Through "Optum Integrated" Technology Vendors. Optum has established relationships with various providers of tracking software and has certified these vendors as "Optum Integrated" if they were able to meet minimum data exchange requirements. This Service enables Optum and Customer to seamlessly exchange data about appeals. If Customer chooses to work with an Optum Integrated technology vendor, the need for data entry should be eliminated. The list of Optum Integrated technology vendors is available upon request.

VII. Analysis and Review Services.

A. Analytics. Customer will periodically send or permit Optum to retrieve directly from Customer's system(s) billing (claim data in 835/837 format) and case management system data for all payers for on-going program monitoring. Optum will provide Customer with performance reviews and/or key metric analysis. Optum will evaluate health plan observation rates, reimbursements, and denial activity, along with other payer activity and trends, to determine the impact and value of the Services. Optum will also perform statistical analysis of billing, remittance advice, and screening criteria results data for commercial and government payers that has been aggregated across participating Optum customers in order to facilitate a comparison of experience among hospitals ("Key Metrics"). Optum will not disclose Customer's individual performance measures or Customer's identity (name, location, etc.) when Customer's information is aggregated as part of a Key Metric statistic. Customer may request that Optum perform an analysis that is unique to Customer or outside Optum's standard Services. If a unique analysis is requested, the parties shall mutually agree by separate written instrument on the scope of such Services and the fees associated if applicable.

B. Compliance Integrity Review and Analytics. Customer will periodically send billing and case management data to Optum for on-going compliance monitoring. Optum will provide Customer with a compliance performance review and/or key metric analysis. Optum will assist participating hospitals in the following three core areas: (i) first level screening – are all Medicare admissions screened and documented; (ii) second level status – are all failed first level screens being reviewed by a physician; and (iii) billing status – does the bill accurately reflect the decisions made at the first and second level review. Optum will also perform the Key Metrics as defined above. Optum will not disclose Customer's data, individual performance measures, or Customer's identity (name, location, etc.) when Customer's information is aggregated as part of a Key Metric statistic. Customer may request that Optum perform an analysis that is unique to Customer or outside Optum's standard Services. If a unique analysis is requested, the parties shall mutually agree by separate written instrument on the scope of such Services and the fees associated if applicable.

VIII. Implementation Services.

A. Initial Implementation. Optum will work with designated Customer staff to ensure adequate and appropriate implementation of the Services. This will include the collection and transfer of appropriate information between Customer and Optum, initial case management, Physician Documentation Services (if applicable) and physician education, meeting with appropriate members of Customer hospital and medical staff, and introducing the program to designated executives at Customer and hospital. Standard implementation includes an Optum Implementation Director on-site at Customer or hospital for one to two days as well as remote coordination, data management, and set-up. This also includes one dedicated calendar day of medical staff and executive staff education by a Senior Optum Physician Advisor. An implementation fee, set forth in Table 1 of Attachment 2, shall be charged for each Customer hospital implemented. Telephonic implementation is available.

B. Additional Services After Initial Implementation. This applies when (1) Customer purchases additional services after Customer has already been implemented or (2) Customer has purchased a Service but at Customer's request, the Service was not implemented at the initial implementation. An implementation fee, set forth in Table 1 of Attachment 2, shall be charged for each Customer hospital receiving additional Services after initial implementation.

C. Re-Implementation. Re-implementation Services are the same as the initial implementation Services described in A above; except these Services are provided as a refresher to Customer personnel at the request of Customer. An implementation fee, set forth in Table 1 of Attachment 2, shall be applied for each Customer hospital re-implemented.

D. Vendor Registration and Registration Maintenance. If Customer requires Optum to register through Customer's vendor registration system (whether internal or external), Optum will charge Customer a registration fee and an annual maintenance fee. Customer, however, agrees that Optum shall not be required to provide Optum's financial or other confidential information or Optum employees' personal information through this registration process.

IX. Other Services.

A. Customized Education.

1. Customized Case Manager Education. Upon request, Optum will prepare and provide didactic case management education in the form of lectures, handouts and informal group sessions. The venues and subjects discussed will be at the discretion of Customer and will be determined jointly by Optum and Customer.

2. Customized Physician Education. Upon request, Optum will prepare and provide didactic physician education in the form of lectures, handouts, and informal group sessions. The venues and subjects discussed will be at the discretion of Customer and will be determined jointly by Optum and Customer.

3. Customized Executive Education. Upon request, Optum will prepare and provide formal didactic education or present summary information to members of Customer and/or hospital's board of directors or executive team. The content and venue of these presentations will be at the discretion of Customer and the date will be determined jointly by Optum and Customer.

B. Consultative Services. Upon request, Optum will take part in committees, meetings, or task forces dealing with particular issues facing Customer. The purpose of Optum's involvement will be to leverage the operational expertise and experience of Optum to contribute to the discussion. Optum will also, when requested, take part in additional projects such as contract negotiation and review, form review, and quality assurance. Optum's initiation of and participation in such projects will be at the discretion of Customer and will be determined jointly by Optum and Customer.

C. Electronic Referral Case Submission. Optum offers a number of options for Customer to electronically submit cases for review by Optum Physician Advisors, including, but not limited to, (i) having Optum staff remotely access Customer's system in order to retrieve all relevant patient information (e-Referral); (ii) using the Optum Exchange; and (iii) facsimile transmission. In the event that Customer is interested in utilizing one of Optum's electronic referral case submission methods, Optum and Customer will ensure users execute the appropriate authorization forms and/or related documentation, the content of which will be mutually acceptable to both parties. Customer shall provide not less than 15-25 available unique user log in credentials (dependent upon hospital bed size and volume) unless otherwise directed by Optum.

X. Appeals Support. In order for Customer to receive Appeals Support Services, Customer must submit the appeal case file to Optum electronically. The electronic submission to Optum must include all necessary case materials to process the appeal no less than fifteen (15) business days prior to the appeal deadline. Submission of paper charts, or charts on CD/DVD, and/or failure to submit all required documentation will result in a documentation fee, as set forth in Table 1 of Attachment 2. Expedited Appeals (those received less than 15 business days prior to the appeal deadline) will result in an expedited fee, as set forth in Table 1 of Attachment 2. Optum shall use commercially reasonable efforts to gather all documentation from Customer needed to process a timely and complete appeal. In the event that Optum is not able to obtain the necessary documents to effectuate a timely appeal, either as a result of insufficient documentation or an appeal being submitted too close to the deadline, Optum will notify Customer that it is unable to process the appeal. In addition, Appeals Support Services will only apply to those cases which have been reviewed by Optum. From time to time Customer may submit a case for appeal which includes days that were not concurrently reviewed by Optum, along with dates and/or time periods that were reviewed by Optum. In these circumstances, Optum reserves the right to determine, in its sole discretion, whether it will be able to address those days not concurrently reviewed. If Optum decides to move forward with appealing the days not concurrently reviewed, the appeal of those extra days may be subject to an additional charge and Optum will notify Customer of any additional charges prior to performing the Services. Optum will use commercially reasonable efforts to appeal those days requested by Customer. The extended hearing support for no additional cost is effective for Medicare and Commercial Concurrent cases (not applicable to Medicaid cases) referred on or after the Amendment Effective Date.

A Appeals Support Related to Commercial Services. For so long as a Customer hospital is contracted for concurrent Commercial Admission Review Services, and pursuant to the documentation submission requirements, including a timely submission of documentation necessary to Optum in order to effectuate a timely appeal, as set forth in Section XI, Optum will appeal to the commercial payer, on a concurrent and/or retrospective basis, cases reviewed by Optum pursuant to this Exhibit A at the Identified Case Levels (as defined below) without additional charge (excluding external reviewer filing fees or a Documentation or Expedited Fee), provided that: (a) Optum performs a concurrent commercial admission review of such case, (b) the case is not currently being audited or under investigation by CMS, OIG, DOJ or other government entity, or any of their related contractors, (c) for retrospective denials only, a bill has been submitted prior to the issuance of the denial where the bill status matches Optum's recommended medical necessity determination for such case, (d) for retrospective denials only, a denial contradicting Optum's recommended medical necessity determination is issued on or after the date Optum sends its recommended medical necessity determination letter to Customer, (e) Customer provides a copy of Optum's recommended medical necessity determination report with the patient chart to the entity reviewing the claim when that entity has requested a copy of the medical record, and (f) the denied services are those having been reviewed by Optum (e.g. for per diem cases, Appeals Support will only apply to the days reviewed by Optum, not for days prior to or following the dates reviewed). For purposes of this paragraph, "Identified Case Levels" means any internal level of appeal offered by the payer, an external level of appeal (excluding arbitration) or at the ALJ level of appeal for non-contracted Managed Medicare care cases. Should Customer desire to have legal representation at the hearing, Customer must secure its own legal counsel.

B. Appeals Support Related to Medicare Services. For so long as a Customer hospital is contracted for Medicare concurrent or post-discharge (pre-claim submission) Admission or Readmission Review services, and pursuant to the documentation submission requirements, including the timely submission of documentation necessary to Optum in order to effectuate a timely appeal, as set forth in Section XI, Optum will appeal QIO/RAC/MAC/SMRC medical necessity denials of traditional fee-for-service Medicare cases reviewed by Optum pursuant to this Exhibit A at the Identified Case Levels (as defined below) without additional charge (excluding any Documentation or Expedited Fee), provided that: (a) Optum performs a concurrent or post-discharge Medicare Admission or Readmission Review of said case, where Customer hospital is contracted for such Services, (b) the case is not then currently being audited or under investigation by CMS, OIG, DOJ or other government entity, or any of their related contractors, (c) a bill has been submitted prior to the issuance of the denial where the bill status matches Optum's recommended medical necessity determination for such case, (d) a denial contradicting Optum's recommended medical necessity determination is issued on or after the date Optum sends its recommended medical necessity determination letter to Customer, (e) Customer provides a copy of Optum's recommended medical necessity determination report with the patient chart to the entity reviewing the claim when that entity has requested a copy of the medical record, and (f) the denied services are those having been reviewed by Optum (e.g., for per diem cases, Appeals Support will only apply to the days reviewed by Optum, not for days prior to or following the dates reviewed). For purposes of this paragraph, the "Identified Case Levels" means the following levels: (i) Redetermination, (ii) Reconsideration, and (iii) ALJ. Should Customer desire to have legal representation at the hearing, Customer must secure its own legal counsel.

C. Appeals Support Related to Medicaid Services. For so long as a Customer hospital is contracted for concurrent Medicaid Admission Review or Readmission Review Services, and pursuant to the documentation submission requirements, including the timely submission of documentation necessary to Optum in order effectuate a timely appeal, set forth in Section XI, Optum will appeal medical necessity denials of traditional fee-for-service Medicaid cases and Managed Medicaid cases reviewed by Optum pursuant to this Exhibit A at the Identified Case Levels (as defined below) without additional charge (excluding any Documentation or Expedited Fee), provided that: (a) Optum performs a concurrent Medicaid Admission or Readmission Review of such cases, (b) the case is not then currently being audited or under investigation by CMS, OIG, DOJ or other government entity, or any of their related contractors, (c) a bill has been submitted prior to the issuance of the denial where the bill status matches Optum's recommended medical necessity determination for such case, (d) a denial contradicting Optum's recommended medical necessity determination is issued on or after the date Optum sends its recommended medical necessity determination letter to Customer, (e) Customer provides a copy of Optum's recommended medical necessity determination report with the patient chart to the entity reviewing the claim when that entity requested a copy of the medical record, and (f) the denied services are those having been reviewed by Optum (e.g., for per diem cases, Appeals Support will only apply to the days reviewed by Optum, not for days prior to or following the dates reviewed). For purposes of this paragraph, the "Identified Case Levels" means any level of appeal prior to the Hearing Level, as identified in section V.A.3 of this Attachment. Should Customer desire to have legal representation at the hearing, Customer must secure its own legal counsel.

D. Extended Hearing (ALJ/Commercial External Hearing) Support Eligible Cases. The extended hearing support for no additional cost is effective for Medicare and Commercial Concurrent cases (not applicable to Medicaid cases) referred on or after the Amendment Effective Date.

E. Appeals Support and Concurrent Reimbursement Medical Necessity Denials Review and Appeals. In order to qualify for these Appeals Support services, a Concurrent Reimbursement Medical Necessity Denials Appeal must (i) be referred for either Commercial Admission Review – Concurrent, as defined above or Other Commercial Admission Review – Concurrent as defined above.

XI. Impact of Termination on Appeals. Upon termination of this Exhibit A all appeals related Services will also terminate, and Optum will no longer perform any appeals-related Services. Customer shall, within ten (10) calendar days of the effective date of termination submit a Revocation of Appointment of Representation (the "Revocation") to each judge assigned to Customer's case, if known. Customer shall also submit a copy of the Revocation to Optum so that Optum can inform the judge of such revocation upon receipt of correspondence from the judge or the judge's office. Customer's failure to provide the required Revocation within ten (10) calendar days will result in Optum advising the judge that the denied case will rest on the record, Optum will not provide testimony or attend hearings to provide testimony, or waive the right to a hearing.

XII. Services Not Included. The case types below are not included in the Services hereunder and, if requested by Customer, will require a separate services schedule.

A. Case reviews that are to be performed under the attorney-client privilege or peer-review privilege.

B. Case reviews to support an active investigation by Program Safeguard Contractors ("PSCs"), Zone Program Integrity Contractors ("ZPICs"), the Department of Justice ("DOJ"), Federal Bureau of Investigation ("FBI"), Office of Inspector General ("OIG"), U.S. Attorney's office, including expert witness work.