AMENDMENT TO THE VALUE BASED CARE AGREEMENT

THIS AMENDMENT TO THE VALUE BASED CARE AGREEMENT ("Amendment") is made and entered by and between Molina Healthcare of Washington, Inc. ("Health Plan") and Providence St. Joseph Health ("Provider 1"), Swedish Health Services ("Provider 2"), Providence Health and Services, Washington ("Provider 3"), Kadlec Regional Medical Center ("Provider 4"), and PacMed Clinic dba Pacific Medical Centers ("Provider 5"). Provider 1, Provider 2, Provider 3, Provider 4, and Provider 5 may be collectively referred to as "Providers". Health Plan and Providers may be collectively referred to as the "Parties" or individually as "Party".

Whereas, Health Plan and Provider 2 entered into a Combined Provider Services Agreement, effective February 10, 2021; and

Whereas, Health Plan and Provider 3 entered into a Combined Provider Services Agreement, effective February 10, 2021; and

Whereas, Health Plan and Provider 4 entered into a Hospital Services Agreement, effective February 10, 2021; and

Whereas, Health Plan and Provider 5 entered into a Provider Services Agreement, effective February 10, 2021; and

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

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

1. Exhibit 1-F (Medicare Quality Bonus Program) is added to the Agreement, attached hereto.
2. Effective Date. This Amendment shall become effective 1/1/2022 and renew with and under the terms of the Agreement.
3. Use of Defined Terms. Terms utilized in this Amendment shall have the same meaning set forth in the definitions to the Agreement.
4. Full Force and Effect. Except as specifically amended by this Amendment, the Agreement shall continue in full force and effect.

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

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

Providence St. Joseph Health

By: DocuSigned by: Robert Sheveland 5BC97F299A6E43C...
Robert Sheveland

Its: Regional VP, Payer Cont

Date: 8/29/2022

Molina Healthcare of Washington, Inc.

By: DocuSigned by: Kevin Phelan 9680411CF1E546D...
Kevin Phelan

Its: VP, Network Management

Date: 9/8/2022

Swedish Health Services

By: DocuSigned by: Robert Sheveland 5BC97F299A6E43C...
Robert Sheveland

Its: Regional VP, Payer Cont

Date: 8/29/2022

Providence Health & Services

By: DocuSigned by: Robert Sheveland 5BC97F299A6E43C...
Robert Sheveland

Its: Regional VP, Payer Cont

Date: 8/29/2022

Kadlec Regional Medical Center

By: DocuSigned by: Robert Sheveland 5BC97F299A6E43C...
Robert Sheveland

Its: Regional VP, Payer Cont

Date: 8/29/2022

PacMed Clinic dba Pacific Medical Centers

By: DocuSigned by: Robert Sheveland 5BC97F299A6E43C...
Robert Sheveland

Its: Regional VP, Payer Cont

Date: 8/29/2022

EXHIBIT [1-F]
Medicare Quality Bonus Program

I. Medicare Quality Program Definitions

A. **Quality Program** means a program where Provider has agreed to share with Health Plan accountability for improving quality outcomes for Quality Program Assigned Members in exchange for a Quality Performance Bonus.

B. **Quality Program Assigned Members** ("Assigned Members") means Health Plan's Medicare members that are assigned to Provider for the Quality Program.

C. **Quality Performance Bonus** means an incentive payment to reward Provider for meeting certain quality measure benchmarks.

D. **Quality Incentive Measures (QIMs)** means quality measures and targets for which Provider is eligible to earn the Quality Performance Bonus. The QIMs are identified in Section III, Quality Performance Bonus Payments, Data Collection, Determining Final HEDIS® Scores and Quality Incentive Measures.

E. **Missing Services** means the Covered Services that Assigned Members have yet to receive to satisfy a Quality Incentive Measure.

F. **Supplemental Data Feed** means an automated data feed that includes data elements that might not otherwise be collected on claims or encounters but that are necessary to prove compliance with HEDIS® measure technical specifications (i.e. historical data). The Supplemental Data Feed is formatted to allow Health Plan to load the data to its HEDIS® accredited/certified database to satisfy the National Committee for Quality Assurance (NCQA) HEDIS® administrative specifications for data collection. Health Plan will review the format requirements for the Supplemental Data Feed with provider annually to account for any changes in contracted measures, NCQA technical specifications, and/or data collection requirements.

G. **Contract Period** means a twelve (12) month period. The Contract Period for the Medicare Quality Bonus Program is January 1, 2022 through December 31, 2022.

II. Termination and Eligibility

A. **Termination.** Either party shall have the right to terminate this Quality Program in the event of a material breach of the Medicare Quality Bonus Program Amendment by either party. Termination shall be effective within thirty (30) days after the party claiming the breach provides the other party written notice specifying the material default, and the other party fails to cure such default within such thirty (30) day notice period. Should the underlying Agreement terminate for any reason specified therein, this Exhibit shall terminate concurrently with the Agreement. In the event the Quality Program is terminated during a Contract Period, the quality incentive payment will be determined pro rata.

B. **Eligibility**. To remain eligible for any payment under the Program, Provider must: (i) have an active Agreement; and (ii) be a participating provider with Molina at the time payment under the Program is issued to qualifying providers. The parties recognize that payments may be subject to adjustments due to retroactive changes in Assigned Members' enrollment with Molina. Such adjustment will be, as applicable, added to or deducted from payments due under the Program.

III. Quality Performance Bonus Payments, Data Collection, Determining Final HEDIS® Scores, and Quality Incentive Measures

A. Quality Performance Bonus Payments.

1. **Care Gap Closure Bonus**.

   A. Provider is eligible to receive Quality Performance Bonus payments for each Quality Incentive Measure care gap that is closed for eligible Assigned Members during the Contract Period in the amount described in Table 1, Quality Incentive Measures and Bonus Payments. A care gap is considered closed when a Quality Program Assigned Member meets the HEDIS® or Pharmacy Quality Alliance (PQA) definition of a compliant member for a given Quality Incentive Measure.

   B. Provider is eligible to receive Quality Performance Bonus payments in the amount described in Table 2 Quality Incentive Measures Medication Adherence and Bonus Payments. A Bonus payment will be made for each of the Quality Incentive Measure Part D Medication Adherence measures for eligible Assigned Members during the Contract Period who (1) by the end of the measurement year are receiving 90-day fills of their eligible medication impacting the medication adherence measure, and (2) maintain a compliant level of adherence (greater than or equal to 80%) for the year.

2. **4 or 5 STAR Bonus**. Provider is eligible for additional Quality Performance Bonus payments for meeting the 4 or 5 STAR target during the Contract Period for each Quality Incentive Measure in Tables 1 and 2 in the amount described in Tables 1 and 2. Targets will be determined by CMS upon the release of the Medicare 2024 Part C and D Star Rating Technical Notes, expected in October 2023. If Provider meets the 5 STAR target, Provider will receive the Bonus amount only for the 5 STAR target, not the 4 and 5 STAR amounts.

3. **Member Retention Bonus**. Provider is eligible to receive a Quality Bonus payment for 5-STAR attainment on the "Members Choosing to Leave the Plan" metric in the amount described in Table 3 Quality Incentive Measures Member Retention and Bonus Payment. This measure will be calculated as number of Assigned Members who voluntarily disenroll during the Contract Period divided by the total number of Assigned Members on the signature date Amendment is signed by Health Plan plus new additions of Provider Assigned Members during the Contract Period). Voluntary disenrollment will be identified through disenrollment reason codes provided by CMS. Target will be determined by CMS upon the release of the Medicare 2024 Part C and D Star Rating Technical Notes, expected in October 2023.

4. **CAHPS/Member Experience Bonus**. Provider is eligible to receive a Quality Bonus payment for achieving the 4-STAR or 5-STAR target during the Contract Period for each Consumer Assessment of Healthcare Providers and Services (CAHPS) measure in Table 4 Quality Incentive Measures CAHPS/Member Experience and Bonus Payments. Provider will share results from Provider's own patient experience survey fielded during the Contract Period. The survey must include questions that align with the measures in Table 4. Provider will only be eligible to receive the bonus payment for measures included in the survey. Survey methodology and questions must be reviewed by Molina to determine if results can be applied to each measure. To qualify for the bonus, there must be a minimum

number of respondents per question at Health Plan's discretion. The targets will be determined by CMS upon the release of the Medicare 2024 Part C and D Star Rating Technical Notes, expected in October 2023. If Provider meets the 5 STAR target, Provider will receive the Bonus amount only for the 5 STAR target, not the 4 and the 5 STAR amounts.

B. **Data Collection for QIMs**. Both Parties acknowledge and agree that:

1. Health Plan will provide necessary information related to HEDIS® measure technical specifications and associated codes from NCQA Value Sets.
2. If applicable, Provider agrees to establish a supplemental data feed with Health Plan no later than six months after the Effective Date.
3. If applicable, Provider will submit supplemental data for hybrid HEDIS® measures to the Health Plan on a monthly basis. The supplemental data will be submitted through a mutually agreed upon Standard HEDIS® Supplemental Data file feed. Health Plan will not accept supplemental data in a non-standard HEDIS® format.
4. Health Plan will provide final HEDIS® scores for target Quality measures as determined by claims (and/or encounters) and supplemental data feeds (if applicable). Health Plan will not review medical charts.

C. **Determining Final HEDIS® Scores**. Both Parties acknowledge and agree that:

1. Health Plan will provide final HEDIS® scores for QIMs as determined by claims (and/or encounters) and automated supplemental feeds if applicable.
2. Health Plan will not accept supplemental data in a non-standard HEDIS® format. Health Plan will not review medical charts to determine QIM scores.

Table 1: Quality Incentive Measures and Bonus Payments

Measure ID	QIM Description*	Amount Per Gap Closed	4-STAR Bonus	5-STAR Bonus
BCS	(BCS) Breast Cancer Screening	$25	$5,000	$10,000
COA	(COA) Care for Older Adults - Medication Review	$25	$5,000	$10,000
COA	(COA) Care for Older Adults - Pain Assessment	$25	$5,000	$10,000
COL	(COL) Colorectal Cancer Screening	$25	$5,000	$10,000
EED	(EED) Eye Exam for Patient With Diabetes	$25	$5,000	$10,000
HBD	(HBD) HbA1c Control for Patients with Diabetes (<9)	$50	$5,000	$10,000
CBP	(CBP) Controlling Blood Pressure	$50	$5,000	$10,000
OMW	(OMW) Osteoporosis Management in Women Who Had a Fracture	$25	$5,000	$10,000
SPC	(SPC) Statin Therapy for Patients with CVD	$25	$5,000	$10,000
FMC	(FMC) Follow-up After ED Visit for Members with Multiple Chronic Conditions	$25	$5,000	$10,000
SUPD	(SUPD) Statin Use in Persons with Diabetes	$25	$5,000	$10,000
PCR	(PCR) Plan All-Cause Readmission (lower is better)	not eligible for Gap	$5,000	$10,000

Measure ID	QIM Description*	Amount Per Gap Closed	4-STAR Bonus	5-STAR Bonus
		Closure incentive		

Table 2: Quality Incentive Measures Medication Adherence and Bonus Payments

Measure ID	QIM Description*	Amount Per Medication Adherence	4-STAR Bonus	5-STAR Bonus
Pharmacy Part D	Medication Adherence for Diabetes Medications	$25	$5,000	$10,000
Pharmacy Part D	Medication Adherence for Hypertension (RAS antagonists)	$25	$5,000	$10,000
Pharmacy Part D	Medication Adherence for Cholesterol (Statins)	$25	$5,000	$10,000

*Note: Quality Incentive Measures are defined in the Medicare Part C and D Star Ratings Technical Notes and developed and/or endorsed by NCQA and/or PQA.

Table 3: Quality Incentive Measures Member Retention and Bonus Payment

Measure ID	QIM Description**	Measure 5- STAR Bonus
	Members Choosing to Leave the Plan	$5,000

**This measures the percentage of members that voluntarily disenroll from Molina Healthcare. Members that move to another provider group's panel but remain with Molina will not negatively impact performance.

Table 4: Quality Incentive Measures CAHPS/Member Experience and Bonus Payment

Measure Description	4-STAR Bonus	5-STAR Bonus
Getting Needed Care	$2,000	$4,000
Getting Appointments and Care Quickly	$2,000	$4,000
Care Coordination	$2,000	$4,000
Annual Flu Vaccine	$500	$1,000

IV. Health Plan Reporting Obligations and Settlement Timing

A. **Reporting Obligations**. Health Plan will make reasonable efforts to supply Provider with a list of eligible Assigned Members, Missing Services list and a Quality Bonus Program Report each month after the date this Amendment is signed by Health Plan. This report will include estimated Bonus Performance payments year to date and opportunity, enrollment information, a scorecard outlining overall performance, HEDIS® Missing Services lists that outline eligible members for each measure and Part D Adherence reporting.

B. **Settlement Timing**

1. Health Plan will make reasonable efforts to submit a "Final Quality Bonus Program Report" within seven (7) months after the Contract Period for the Care Gap Closure Bonuses, and within eleven (11) months after the Contract Period for the 4 or 5 STAR and Member Retention Bonuses. This report will include three (3) months of claims run out.

2. Within thirty (30) days receipt of the "Final Quality Bonus Program Report", Provider shall review the analysis and determine if they agree or disagree with the report ("Review Period"). If no response is received by Health Plan within thirty (30) days after delivery of the report to Provider it shall be determined to be accepted by Provider. If Provider disagrees with the report within the Review Period, Provider shall notify Health Plan, and Health Plan and Provider shall promptly meet and confer to resolve the matter. If Health Plan and Provider are unable to resolve the disagreement through the good faith meeting, Provider may submit the dispute to nonbinding mediation in accordance with the Provider Services Agreement or Combined Services Agreement, as applicable. If the dispute is not timely submitted for nonbinding mediation, it shall be determined that the Contract Period Final Quality Program Calculation Report is accepted by Provider. Within thirty (30) days after the expiration of the Review Period, Health Plan shall remit payment of the applicable Quality Performance Bonus to Provider, if there is a Quality Performance Bonus payment.

V. Compliance with Applicable Laws

A. **Compliance with Laws**. The parties will comply with all laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act.

B. **Legislation Regulating Provider Risk**. Distribution of Quality Program incentive payments to the Provider is limited so as not to create Substantial Financial Risk as described in 42 CFR 422.208 Physician Incentive Plans: Requirements and Limitations. Health Plan and Provider acknowledge that future laws, regulations or policies may require changes to the terms and conditions set forth in this Amendment. If changes to such laws, regulations or policies occur, then both parties hereby agree to negotiate in good faith to amend this Amendment to conform with any such changes. Each party shall make best efforts to minimize any (i) impact to the intent of the terms and conditions of the terms and conditions set forth in this Amendment, and/or (ii) harm to each other. Health Plan represents that as of the effective date of this Amendment, it is not aware of any laws, administrative rulings or other position statements from applicable regulatory agencies that would subject provider to insurance obligations for the activities undertaken by Provider pursuant to this Amendment.

VI. **Member Care**. This Quality Program does not provide incentives, monetary or otherwise, for withholding Medically Necessary Covered Services. Provider is required to provide all Medically Necessary Covered Services. If it is determined that the Provider has reduced, limited, or not provided all Medically Necessary Covered Services, Provider will not be eligible for payment under the Quality Program.