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-D (Value Based Care Program) of the Agreement is deleted and replaced with Exhibit 1-D (Value Based Care Program), 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: Susan Klarner 29C106E1459B430...
Susan Klarner

Its: SVP, Contracting

Date: 3/7/2022

Molina Healthcare of Washington, Inc.

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

Its: VP, Network Management

Date: 3/16/2022

Swedish Health Services

By: DocuSigned by: Susan Klarner 29C106E1459B430...
Susan Klarner

Its: SVP, Contracting

Date: 3/7/2022

Providence Health & Services

By: DocuSigned by: Susan Klarner 29C106E1459B430...
Susan Klarner

Its: SVP, Contracting

Date: 3/7/2022

Kadlec Regional Medical Center

By: DocuSigned by: Susan Klarner 29C106E1459B430...
Susan Klarner

Its: SVP, Contracting

Date: 3/7/2022

PacMed Clinic dba Pacific Medical Centers

By: DocuSigned by: Susan Klarner 29C106E1459B430...
Susan Klarner

Its: SVP, Contracting

Date: 3/7/2022

EXHIBIT 1-D
Value Based Care Program

I Value Based Care Program Definitions

A. Value Based Care Program ("VBC") means a program where Provider has agreed to share with Health Plan accountability for total cost and quality of care for VBC Assigned Members in exchange for a Shared Savings opportunity.

B. Medicaid Program (collectively Medicaid Programs) means the Medicaid coverage categories including: Integrated Managed Care Apple Health Adult (IMC-AHA), Integrated Managed Care Apple Health Blind Disabled (IMC-AHBD), Integrated Managed Care Apple Health Family (IMC-AHFAM) and Integrated Managed Care Apple Health Premium (IMC-AHPREM).

C. VBC Assigned Members means members enrolled in a Medicaid Program with Health Plan that are assigned to Provider for primary care services. Assigned Member Months means the aggregate number of months that VBC Assigned Members are assigned to Provider for primary care services during the Contract Period.

D. Contract Period means a twelve (12) month period. The specific Contract Period(s) during the VBC Program are defined as follows:

1. Contract Period 1: January 1, 2021 – December 31, 2021

2. Contract Period 2: January 1, 2022 – December 31, 2022

E. Contract Period Total Cost of Care means any and all amounts paid by Health Plan during the Contract Period and within six months after the end of the Contract Period ("runout") for any Covered Service that is rendered to VBC Assigned Members during each Contract Period, including any amounts paid by Health Plan for capitation, invoices, pay for performance bonus payments or any type of quality bonus payment program separate from this VBC program. The Contract Period Total Cost of Care will be calculated separately for each Medicaid Program.

F. Earned Premium: Earned Premium for Assigned Members is based on Health Plan's premium rates in its Washington State Health Care Authority ("HCA") contracts for IMC Apple Health (Medicaid). The Earned Premium for each Member is calculated using the base premium, age/gender, risk and geographical factors provided by HCA under the terms of Health Plan's HCA Contract for IMC Apple Health. Earned Premium includes Delivery Case Rate ("DCR") for the VBC Assigned Members. Earned Premium does not include fixed PMPM funding paid by HCA to the Health Plan which the Health Plan must pay in full to the appropriate provider such as: Safety Net Assessment Fund ("SNAF"), Professional Access Payment ("PAP"), and Federally Qualified Health Center ("FQHC") and Rural Health Clinic ("RHC") enhancement payments. Further, Earned Premium will be adjusted to reflect any payments made to or received from CMS or HCA, either directly attributed to each member or allocated if the payment is not directly attributed to each member by CMS or HCA.

G. Medical Cost Ratio ("MCR") means the percentage of the Earned Premium Health Plan received that is spent on Contract Period Total Cost of Care. The MCR will be calculated separately for each Medicaid Program.

H. VBC Benchmark means the negotiated Medical Cost Ratio ("MCR") Targets for the Medicaid Programs shown below for VBC Assigned Members. The VBC Benchmarks shall be compliant with any applicable federal or state law requirements. The Medicaid Program-specific MCR Targets are listed in Table 1 below.

Table 1: Medicaid Program - Specific MCR Targets

Medicaid Program	PMG PHC MCR Targets	Rest of Providence St. Joseph Health MCR Targets
IMC-AHA	90.0%	87.0%
IMC-AHBD	90.0%	87.0%
IMC-AHFAM	90.0%	87.0%
IMC-AHPREM	90.0%	87.0%

I. Quality Incentive Measures (QIMs) means the quality measures and targets that are established for the Contract Period to ensure that cost efficiencies are achieved while improving the quality and outcomes of VBC Assigned Members. The specific QIMs for the VBC are defined in Section II, Quality Incentive Measures, Data Collection, and Determining Final HEDIS® Scores.

J. Shared Savings

1. Surplus is when the VBC Benchmark minus the Contract Period MCR is a positive number. Deficit is when the VBC Benchmark minus the Contract Period MCR is a negative number. Surpluses and Deficits, which are computed as percentages of Earned Premium, will be calculated, for each listed Medicaid Program, separately for PMG PHC and the Rest of Providence St. Joseph Health. Health Plan will aggregate the Surpluses and Deficits for PMG PHC and the Rest of Providence St, Joseph Health to a single Shared Surplus/Deficit.

2. Shared Surplus/Deficit means the portion of the Surplus and Deficit that is eligible to be shared with Provider. The Shared Surplus/Deficit will be calculated for each Medicaid Program as follows: Surplus/Deficit multiplied by the Earned Premium, multiplied by fifty percent (50%).

3. Maximum Surplus/Deficit means the maximum Surplus and/or Deficit that is included in the calculation of Shared Savings. Health Plan will withhold the difference between Providers' base rates and 105% of the Medicaid Fee-For-Service rates for inpatient and outpatient services, and 107% of the Medicaid Fee-For-Service rates for professional services for both Health Plan Apple Health SSQ&P Assigned Members and for Health Plan members not included in the SSQ&P program to determine the Maximum Surplus/Deficit.

4. Earned Surplus/Deficit means the Surplus/Deficit provider is eligible to share after applying the Maximum Surplus/Deficit.

   i. If the Shared Surplus is equal to or greater than the Maximum Surplus, then Provider's Earned Surplus is the Maximum Surplus. If Shared Surplus is less than the Maximum Surplus, then Shared Surplus is the Earned Surplus.

   ii. If the Shared Deficit is equal to or less than the Maximum Deficit, the Earned Deficit is the Maximum Deficit. If the Shared Deficit is greater than the Maximum Deficit, the Shared Deficit is the Provider's Earned Deficit.

5. Shared Savings means the aggregated Earned Surplus/Deficit for Providers and all Medicaid Programs, as adjusted by Quality Incentive Measure achievement, that will be shared with Provider. The Shared Savings calculation is detailed in Section III. Shared Savings Reconciliation Process, and Exhibit 1-D-2 Shared Savings Reconciliation Example.

II Quality Incentive Measures, Data Collection, and Determining Final HEDIS® Scores

A. Quality Incentive Measures (QIMs). QIMs and Targets for the first Contract Period are displayed in Table 2a, below and QIMs and Targets for the second contract period are displayed in Table 2b, below. Provider and Health Plan have jointly selected QIMs that have the most direct impact on CMS and/or State required HEDIS® measures. The QIMs and targets apply to all VBC

Assigned Members and QIM performance will be evaluated for all VBC Assigned Members in aggregate.

1. Health Plan has selected additional quality measures for data tracking only. These measures will be shared with Provider on a monthly basis as part of the monthly VBC report. These tracking measures are not a part of the VBC Shared Savings incentive.

B. Health Plan and Provider will make reasonable efforts to assess QIMs within sixty (60) days prior to the end of the current Contract Period to determine appropriate QIMs for the subsequent Contract Period. QIMs shall carry over to the subsequent Contract Period should QIMs not be modified via amendment.

C. 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.

D. 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 2a: Contract Period 1 Quality Incentive Measures and Targets

HEDIS® Measure ID	HEDIS® Sub Measure ID	QIM Descriptions	Target
CDC	HBA1C8	Comprehensive Diabetes Care - HbA1c Adequate Control (<8)	51.73%
WCV	3-11 YEARS	Child and Adolescent Well-Care Visits: 3 - 11 years	Improvement over 2020 performance
AMM	EAPT	Antidepressant Medication Management - Effective Acute Phase Treatment	53.57%
AMM	ECPT	Antidepressant Medication Management - Effective Continuation Phase Treatment	38.18%
CIS	CO10	Childhood Immunization Status - Combination 10 Immunizations	3% Improvement over 2020 performance

Table 2b: Contract Period 2 Quality Incentive Measures and Targets

HEDIS® Measure ID	HEDIS® Sub Measure ID	QIM Descriptions	Target
HBD*	HBA1C8	Hemoglobin A1c Control for Patients with Diabetes - HbA1c Adequate Control (<8)	51.34%
WCV	3-11 YEARS	Child and Adolescent Well-Care Visits: 3 - 11 years	58.00%
AMM	EAPT	Antidepressant Medication Management - Effective Acute Phase Treatment	61.83%
AMM	ECPT	Antidepressant Medication Management - Effective Continuation Phase Treatment	45.61%
BCS	TOTAL	Breast Cancer Screening	58.70%

*Per Measurement Year 2022 NCQA HEDIS® Technical Specifications, the Hemoglobin A1c Control for Patients with Diabetes (HBD) measure has replaced the HbA1c component of the Comprehensive Diabetes Care (CDC) measure. The CDC measure has been retired for MY2022. The measure specifications of the A1c measure have not changed.

III Shared Savings Reconciliation Process

A. For Shared Savings Reconciliation Example, see Exhibit 1-D-2.

B. Health Plan will calculate the Shared Savings based on Section I.J above.

C. To determine Shared Savings, Health Plan will aggregate the Earned Surplus/Deficit for all Medicaid Programs and all Provider entities. If the aggregate is zero or less than zero, no Shared Savings will be distributed to Provider. Provider is not at risk for aggregate losses for the VBC Program. If the aggregate is greater than zero and two or more of the QIM Targets are achieved, Health Plan will adjust the aggregate in accordance with the number of QIM Targets achieved. Each QIM target is worth twenty percent (20%) of the aggregate. The aggregate will be adjusted per the following formula. (Table 3 illustrates the Percent of Shared Savings Provider is Eligible to Receive based on its QIM Target performance):

Shared Savings = (Aggregated Earned Surplus/Deficits) * (number of QIM Targets Achieved) * (20%)

Table 3: Percentage of Shared Savings Provider is Eligible to Receive

Quality Incentive Measures Achieved in Contract Period	Percentage of Aggregated Earned Surplus/Deficit to be Paid to Provider as Shared Savings
0-1	0%
2	40%
3	60%
4	80%
5	100%

IV Reporting Obligations and Shared Savings Settlement Timing

A. Health Plan Reporting Obligations

1. Health Plan will make reasonable efforts to supply Provider with a Value Based Care Summary Report on or before the fifteenth (15th) of each month. The report will include the following elements:

i. VBC Assigned Members Roster

ii. Summary of Contract Period Total Cost of Care and MCR calculation

iii. Claims data for VBC Assigned Members

iv. Performance report and missing services list for Quality Incentive Measures

2. Health Plan will make reasonable efforts to submit a "Final Shared Savings Calculation Report" to Provider within nine (9) months after the end of the Contract Period.

B. Shared Savings Settlement Timing. Within thirty (30) days of receipt of the "Contract Period Final Shared Savings Calculation Report", Provider shall review the analysis and determine if it agrees or disagrees 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 Provider Services Agreement, as applicable. If the dispute is not timely submitted for nonbinding mediation, it shall be determined that the Contract Period Final Shared Savings Calculation Report is accepted by Provider. Within thirty (30) days after the expiration of the Review Period, Health Plan shall remit payment to Provider if there are Shared Savings.

V Miscellaneous

A. Term and Termination

1. Effective Date and Term. This VBC Program shall commence on January 1, 2021 and shall be in effect for twenty-four (24) months. The VBC Program may renew upon the written agreement of both parties in the form of an amendment hereto. Unless otherwise agreed to by the Parties, such renewal shall take effect on the day after the prior Contract Period concluded.

2. Termination. Either party shall have the right to terminate this VBC Program in the event of a material breach of the VBC Program 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.

3. Effect of Termination. In the event the VBC Program is terminated during a Contract Period, Shared Savings will be determined pro rata.

B. Legislation Regulating Provider Risk. Distribution of Shared Savings 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 Exhibit. If changes to such laws, regulations or policies occur, then both parties hereby agree to negotiate in good faith to amend this Exhibit 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 Exhibit, 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 Exhibit.

C. Member Care. This VBC 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 VBC Program.

Exhibit 1-D-2
Shared Savings Reconciliation Example (Numbers and Parameters for Illustration Only)

Row	Calculation	Category	AHA	AHBD	AHFAM	AHPREM
A	PMG PHC	Assigned Member Months	50	10	250	6
B		Earned Premium	$5,000	$2,000	$16,000	$400
C		Contract Period Total Cost of Care	$4,400	$2,040	$13,920	$372
D	(C) / (B)	Medical Cost Ratio (MCR)	88%	102%	87%	93%
E		VBC Program Benchmark (Target MCR)	90%	90%	90%	90%
F	(E) - (D)	Difference from Benchmark	2%	-12%	3%	-3%
G	(30%) * (F) * (B)	Shared Surplus/Deficit	$30	($72)	$144	($4)
H	(1%) * (B)	Maximum Shared Surplus (1%)	$100	$60	$400	$5
I	(-1%) * (B)	Maximum Shared Deficits (-1%)	($100)	($60)	($400)	($5)
J		Earned Surplus/Deficits	$30	($60)	$144	($4)
K	(J) AHA+AHBD+ AHFAM+AHPREM	Aggregated Earned Surplus/Deficits PMG PHC				$110

A1	Rest of Providence	Assigned Member Months	200	60	1,000	20
B1		Earned Premium	$23,000	$15,000	$100,000	$3,000
C1		Contract Period Total Cost of Care	$18,400	$16,200	$78,000	$2,400
D1	(C1) / (B1)	Medical Cost Ratio (MCR)	80%	108%	78%	80%
E1		VBC Program Benchmark (Target MCR)	87%	87%	87%	87%
F1	(E1) - (D1)	Difference from Benchmark	7%	-21%	9%	7%
G1	(30%) * (F1) * (B1)	Shared Surplus/Deficit	$483	($945)	$2,700	$63
H1	(1%) * (B1)	Maximum Shared Surplus (1%)	$230	$150	$1,000	$30
I1	(-1%) * (B1)	Maximum Shared Deficits (-1%)	($230)	($150)	($1,000)	($30)
J1		Earned Surplus/Deficits	$230	($150)	$1,000	$30
K1	(J) AHA+AHBD+ AHFAM+AHPREM	Aggregated Earned Surplus/Deficits -Rest of Providence				$1,110

L	K + K1	Aggregate Earned Surplus/Deficits Total		$1,220
M	N	Percentage of Quality Measures Achieved		40%
	(L) * (M)	Shared Savings		$488

	Quality Incentive Measures (QIMs)	Target Met	Bonus
	QIM 1	No	0%
	QIM 2	Yes	20%
	QIM 3	Yes	20%
	QIM 4	No	0%
	QIM 5	No	0%
N	Total		40%