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"), UW Physicians and Valley Medical Center ("Providers").

Whereas, Health Plan and Providers entered into a Value Based Care Agreement ("Agreement"), January 1, 2021, as amended.

Whereas, Health Plan and Providers 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 (Marketplace Quality Program) is added to the Agreement, attached hereto.
2. Effective Date. This Amendment shall become effective on the date this Amendment is signed by Health Plan, 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 Providers 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.

UW Medicine

By: DocuSigned by: Jacqueline Cabe CE33C798B1A0425...

Jacqueline Cabe

Its: CFO, UW Medicine

Date: 3/23/2022

Molina Healthcare of Washington, Inc.

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

Andrew Nelson

Its: VP, Network Management

Date: 3/31/2022

UW Physicians

By: DocuSigned by: Anthony Dorsch 0A27340ECA6041D...

Anthony Dorsch

Its: Executive Director

Date: 3/23/2022

Valley Medical Center

By: DocuSigned by:
0F08F467FE114E4...

Jeannine Grinnell

Its: CEO

Date: 3/24/2022

EXHIBIT [1-F]
Marketplace Quality Program

I. Quality Program Definitions

A. **Quality Program** means a program where Provider has agreed to share with Health Plan accountability for quality of care for Quality Program Assigned Members in exchange for a quality incentive opportunity.

B. **Marketplace Program** (collectively Marketplace Programs) means the Marketplace (or Health Benefit Exchange) products including: Molina Choice Gold, Molina Constant Care Silver, Molina Core Care Bronze, Molina Cascade Gold, Molina Cascade Silver, Molina Cascade Bronze.

C. **Quality Program Assigned Members** means members enrolled in a Marketplace Program with Health Plan that are assigned to Provider for primary care services.

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

1. Contract Period 1: January 1, 2022-December 31, 2022.

E. **Quality Incentive Measure (QIM)** means the quality measure and target that are established for the Contract Period to ensure that cost efficiencies are achieved while improving the quality and outcomes of Quality Program Assigned Members. The specific QIM for the Quality Program are defined in Section II, Quality Incentive Measure, Data Collection, and Determining Final HEDIS® Scores.

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

A. **Quality Incentive Measure (QIM).** QIM and Target for the Contract Period are displayed in Table 1, below. The QIM and target apply to all Quality Program Assigned Members and QIM performance will be evaluated for all Quality Program Assigned Members in aggregate.

B. **Data collection for QIM.** 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. Health Plan will provide final HEDIS® scores for target Quality measure as determined by claims (and/or encounters). Health Plan will not review medical charts.

C. **Determining final HEDIS® score**. Both Parties acknowledge and agree that:

1. Health Plan will provide final HEDIS® score for QIM as determined by claims (and/or encounters).

2. Health Plan will not review medical charts to determine QIM score.

Table 1: Contract Period 1 Quality Incentive Measure and Target

HEDIS® Measure ID	HEDIS® Sub Measure ID	QIM Descriptions	Target
PCR	Total	Plan All Cause Readmission	Provider's 2021 PCR Rate

III. Quality Program Budget

A. Quality Incentive Program Budget is twenty-five thousand dollars ($25,000).

B. Provider is eligible to receive one hundred percent (100%) of the Quality Program Incentive Budget if Provider achieves or improves (lower than 2021 PCR rate) upon the Quality Incentive Measure target.

IV. Reporting Obligations and Quality Program Settlement Timing

A. Health Plan Reporting Obligations

1. Health Plan will make reasonable efforts to supply Provider with a Quality Program Summary Report on a quarterly basis. The report will include the following elements:
   i. Quality Program Assigned Members Roster
   ii. Performance report for Quality Incentive Measure
2. Health Plan will make reasonable efforts to submit a "Final Quality Program Calculation Report" to Provider within nine (9) months of the end of the Contract Period.

B. Quality Program Settlement Timing. Within thirty (30) days of receipt of the "Contract Period Final Quality Program Calculation 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 Provider 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 to Provider if there is a quality incentive payment.

V. Miscellaneous

A. Term and Termination

1. Effective Date and Term. This Quality Program shall commence on January 1, 2022 and shall be in effect for twelve (12) months. The Quality 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 Quality Program in the event of a material breach of the Quality 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 Quality Program is terminated during a Contract Period, the quality incentive payment will be determined pro rata.

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 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 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.