VALUE BASED CARE AGREEMENT

THIS VALUE BASED CARE AGREEMENT ("Agreement") is made and entered among Molina Healthcare of Washington, Inc. ("Health Plan"), University of Washington Physicians ("Provider 1") and Valley Medical Center ("Provider 2"). Provider 1 and Provider 2 may be collectively referred to as "Providers". Health Plan and Providers may be collectively referred to as the "Parties" or individually as "Party".

Whereas, Providers are components of UW Medicine, a clinical enterprise of the University of Washington, an institution of higher education and agency of the state of Washington, consisting of the following components: University of Washington Medical Center, Harborview Medical Center, Valley Medical Center, The Association of University Physicians dba UW Physicians, the University of Washington School of Medicine, The UW Physicians Network dba UW Neighborhood Clinics, and Airlift Northwest (collectively, "UW Medicine Component Units");

Whereas, Health Plan and Provider 1 entered into a Provider Services Agreement, effective November 1, 2020; and

Whereas, Health Plan and Provider 2 entered into a Combined Provider Services Agreement, effective November 1, 2020; and

Whereas, Providers would like to enter into an Agreement where Providers are collectively part of one agreement for a Value Based Care Program and Providers' data and results will be collectively added and combined into one score to determine whether Shared Savings achieved.

Now, therefore, in consideration of the rights and obligations contained herein, Health Plan and Providers agree as follows:

1. The Provider Services Agreement entered into on November 1, 2020 with Provider 1 and Health Plan is incorporated by reference into this Agreement. All the terms in the Provider Services Agreement shall apply to this Agreement for Provider 1. Any quality incentive, shared savings, or value based care programs that are part of the Provider Services Agreement are not incorporated by reference into this Agreement and will not be applicable to this Agreement. In the event of a conflict between this Agreement and the Provider Services Agreement, the terms of this Agreement will control.
2. The Combined Provider Services Agreement entered into November 1, 2020 with Provider 2 and Health Plan is incorporated by reference into this Agreement. All the terms in the Combined Provider Services Agreement shall apply to this Agreement for Provider 2. Any quality incentive, shared savings, or value based care programs that are part of the Combined Provider Services Agreement are not incorporated by reference into this Agreement and will not be applicable to this Agreement. In the event of a conflict between this Agreement and the Combined Provider Services Agreement, the terms of this Agreement will control.
3. Each Party agrees that the terms set forth in this Agreement are strictly confidential and no Party shall disclose such terms to any person or entity for purposes other than the administration of the Agreement without receiving prior written consent of all Parties, except as required by law or government programs.
4. In order to be eligible and remain eligible for the Value Based Care Program, Providers must remain in full compliance with Health Plan in accordance with the terms and conditions of this Agreement and each Provider's Combined Provider Services Agreement, Hospital Services Agreement, or Provider Services Agreement.
5. **Entire Agreement**. This Agreement, together with the Addendum, Attachments, Amendments, and incorporated documents or materials, contains the entire understanding between Health Plan and Providers relating to the rights granted and obligations imposed. Additionally, as to the Medicaid products offered by Health Plan, the Government Contracts are incorporated herein by reference and will be the guiding and controlling document when interpreting the terms of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, between the Parties and relating to the subject matter of this Agreement are of no force or effect. All article, section, subsection,

addendum, and attachment titles and headings are for informational purpose and are not terms or conditions of this Agreement.

6. **Governing Law.** This Agreement will be governed by the Laws of Washington state. Venue for any action(s) related to this Agreement shall be in King County, Washington.

7. **Relationship of the Parties.** Nothing contained in this Agreement creates, nor is it construed to create, any relationship between the Parties other than that of independent Parties contracting solely for effectuating this Agreement. This Agreement does not create a relationship of agency, representation, joint venture, or employment between the Parties. Each of the Parties will maintain separate and independent management and will be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor will be construed to create, any right in any third party. This includes, but is not limited to, Members. Nor will any third party have any right to enforce the terms of this Agreement.

8. **Severability.** If a court of competent jurisdiction holds that any term, provision, covenant, or condition of this Agreement is invalid, void, or unenforceable, the remaining provisions will remain in full force and effect and will in no way be affected, impaired, or invalidated because of such holding.

9. **Non-exclusivity.** This Agreement is not an exclusive Agreement between Health Plan and Providers for the provision of Covered Services. Nor is it an Agreement requiring Health Plan to refer Members to Providers for health care services.

10. **Indemnification.** Each Party will indemnify and hold harmless the other Party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying Party and its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

11. **Force Majeure.** Neither Party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of a public enemy, war, accident, fire, explosion, earthquake, flood, strikes by either Party's employees, or any other similar cause beyond the reasonable control of such Party.

12. **Authority.** Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and proper authorization to act on behalf of Providers and does so freely after having fully reviewed the entirety of this Agreement and after having the opportunity to consult with counsel.

13. **Assignment.** Providers may not assign, transfer, subcontract, or delegate, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Health Plan and Providers and their respective successors in interest and assignees. Health plan shall not assign this Agreement to a competitor of Provider. Neither the acquisition of Health Plan nor a change of its legal name is an assignment.

14. **Waiver.** A failure or delay of either Party to exercise or enforce any provision of this Agreement shall not be deemed a waiver of any right of that Party. Any waiver must be specifically stated in writing and executed by Health Plan and Providers. A waiver shall not waive any other provision or right of either Party unless specifically stated.

15. **Conflict with Health Plan Product**. Nothing in this Agreement modifies any benefits, terms, or conditions contained in the Member's Health Plan product. In the event of a conflict between this Agreement and the benefits, terms, and conditions of the Health Plan product, the benefits, terms, or conditions contained in the Member's Health Plan product will govern.

16. **Payment.** In the event there is a payment for the Value Based Care Program, payment will be remitted to UW Medicine to be distributed to Providers.

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: 4/30/2021

Molina Healthcare of Washington, Inc.

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

Its: MHW - VP, Network Mgmt & Ops

Date: 6/2/2021

University of Washington Physicians

By: DocuSigned by: Anthony Dorsch 0A27540ECA6041D...

Anthony Dorsch

Its: Executive Director

Date: 5/10/2021

Valley Medical Center

By: DocuSigned by: 7D59DE70DB444DE...

Jeannine Grinnell

Its: Chief Financial Officer

Date: 5/10/2021

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	MCR Targets
IMC-AHA	91.0%
IMC-AHBD	90.0%
IMC-AHFAM	97.0%
IMC-AHPREM	97.0%

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.

2. Shared Surplus/Deficit means a portion of the Surplus or 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 may be shared with Provider. The Maximum Surplus/Deficit for each Medicaid Program is calculated as Earned Premium multiplied by three percent (3%). The net Surplus/Deficit after the application of the Maximum is the Provider's Earned Surplus/Deficit for the particular Medicaid Program.

4. Shared Savings means the aggregated Earned Surplus/Deficit for all Medicaid Programs, and 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. 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. Provider and Health Plan have jointly selected additional quality measures for data tracking only. These are displayed in Table 2b, below. Provider and Health Plan agree that these quality measures are not a part of the 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 1	Target 2
AMM	EAPT	Antidepressant Medication Management - Effective Acute Phase Treatment	53.57%	58.93%
AMM	ECPT	Antidepressant Medication Management - Effective Continuation Phase Treatment	38.18%	43.10%
PPC	TOPC	Prenatal and Postpartum Care - Timeliness of prenatal care	89.05%	92.94%
PPC	PPC	Prenatal and Postpartum Care - Postpartum care	76.40%	80.89%
CDC	POORHB	Comprehensive Diabetes Care: HbA1c Poor Control (>9) (Lower is Better)	37.47%	32.85%
WCV	3-11 YEARS	Child and Adolescent Well-Care Visits: 3 - 11 years	Improvement over 2020 performance	HEDIS 75th Percentile (TBD in Q4 2021)
AMR	5TO64PD50	Asthma Medication Ratio - Total 5 to 64 Ratios > 0.50	62.43%	68.13%

Table 2b: Contract Period 1 Quality measures for data tracking only

HEDIS® Measure ID	HEDIS® Sub-Measure ID	Data Tracking Only Measure Descriptions	HEDIS® 50th Percentile	HEDIS® 75th Percentile
CDC	EYEEXAM	Comprehensive Diabetes Care - Eye Exam	58.64%	64.48%
ADD	INITIATION	Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	42.95%	48.05%
CIS	CO10	Childhood Immunization Status - Combination 10 Immunizations	37.47%	44.77%
CHL	TOTAL	Chlamydia Screening in Women - Total	58.44%	66.26%

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. 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 and tier of QIM Targets achieved. If Provider achieves Target 2, Provider will be paid only the Tier 2 Target share of savings (not Tier 1 and Tier 2). In no event will Shared Savings exceed one hundred percent (100%). The percentage of Shared Savings the Provider is eligible to receive will be determined in accordance with the following formula:

Shared Savings = (Aggregated Earned Surplus/Deficits) * [(number of QIM Target 1 Achieved * 7.14%) + (number of QIM Target 2 Achieved * 14.29%)]

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		Assigned Member Months	100	30	500	10
B		Earned Premium	$10,000	$6,000	$40,000	$600
C		Contract Period Total Cost of Care	$7,400	$6,500	$32,000	$560
D	(C) / (B)	Medical Cost Ratio (MCR)	74%	108%	80%	93%
E		VBC Program Benchmark (Target MCR)	85%	89%	83%	80%
F	(E) - (D)	Difference from Benchmark	11%	-19%	3%	-13%
G	(30%) * (F) * (B)	Shared Surplus/Deficit	$330	($348)	$360	($24)
H	(1%) * (B)	Maximum Shared Surplus (1%)	$100	$60	$400	$6
I	(-1%) * (B)	Maximum Shared Deficits (-1%)	($100)	($60)	($400)	($6)
J		Earned Surplus/Deficits	$100	($60)	$360	($6)
K	(J) AHA+AHBD+ AHFAM+AHPREM	Aggregated Earned Surplus/Deficits	$394			
L	M	Percentage of Quality Measures Achieved	40%			
	(K) * (L)	Shared Savings	$157.60			

	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%
M	Total		40%