Washington State Health Care Authority	**CONTRACT AMENDMENT**	HCA Contract Number: **K1469** Amendment No.: **Amendment 1**

THIS AMENDMENT is between the Washington State Health Care Authority, hereinafter referred to as "HCA," and the party whose name appears below, hereinafter referred to as the "Contractor."

CONTRACTOR NAME **University of Washington for the** **UW Medicine Accountable Care Network**	CONTRACTOR doing business as (DBA)	
CONTRACTOR ADDRESS **1959 NE Pacific Street, C-314** **Box 356350** **Seattle, WA 98195-6350**	WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) **178019988**	
CONTRACTOR CONTACT **Jacque Cabe, Chief Financial Officer**	CONTRACTOR TELEPHONE **(206) 616-9886**	CONTRACTOR E-MAIL ADDRESS **Jlcabe@uw.edu**
HCA PROGRAM TITLE **PEBB**	HCA DIVISION/SECTION **PEBB Contracts**	
HCA CONTACT NAME AND TITLE **Louis McDermott, PEBB Division Director**	HCA CONTACT ADDRESS **626 8th Avenue SE** **Olympia, WA 98504**	
HCA CONTACT TELEPHONE **(360) 725-0891**	HCA CONTACT E-MAIL ADDRESS louis.mcdermott@hca.wa.gov	
IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT? ☐YES ☒NO	CFDA NUMBER(S) ; ; ; ;	FFATA Form Required ☐YES ☒NO

AMENDMENT START DATE	**AMENDMENT END DATE**	**CONTRACT END DATE**
Date of Execution (DOE)	December 31, 2019	December 31, 2019
PRIOR MAXIMUM CONTRACT AMOUNT	**AMOUNT OF INCREASE OR DECREASE**	**TOTAL MAXIMUM CONTRACT AMOUNT**
N/A	N/A	N/A

REASON FOR AMENDMENT: To amend various terms through the UW ACP contract, to include the Exhibits listed below.

ATTACHMENTS/EXHIBITS. When the box below is marked with an X, the following Exhibits/Attachments are attached and are incorporated into this Contract Amendment by reference:
☒ Exhibit(s) (specify): Exhibits 1.1, 1.2, 1.3, 1.4, 2.1, 2.5, 3.3 and 5.

This Contract Amendment, including all Exhibits and other documents incorporated by reference, contains all of the terms and conditions agreed upon by the parties as changes to the original Contract. No other understandings or representations, oral or otherwise, regarding the subject matter of this Contract Amendment shall be deemed to exist or bind the parties. All other terms and conditions of the original Contract remain in full force and effect. The parties signing below warrant that they have read and understand this Contract Amendment, and have authority to enter into this Contract Amendment.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
HCA SIGNATURE	**PRINTED NAME AND TITLE**	**DATE SIGNED**

This Contract between the State of Washington Health Care Authority (HCA) and the Contractor is hereby amended to as follows:

1. **Section 2.2, subsection A is hereby modified to read as follows:**

   A. HCA will perform the Pre-Launch Period activities as described in Exhibit 2.1 and Exhibit 2.5 2017 Expansion. To the extent there are further expansions in counties after 2017, the Pre-Launch activities will be described in an exhibit for any expansion year.

2. **Section 2.2, subsection D is hereby modified to read as follows:**

   D. HCA will promote ACP Plan enrollment by creating a financial differential and/or benefit enhancement, compared to UMP Classic. Plan design will incentivize PEBB Members enrolled in the ACP Plan to seek services within the Contractor's network and promote and further the goal of medically appropriate utilization. HCA has sole discretion on benefit design decisions.

3. **Section 2.3, subsection A is hereby modified to read as follows:**

   A. **Organizational Structure, Partners, and Commitment to Accountable Care. Contractor will provide a comprehensive clinically integrated network that includes**:

      (i) Adequate geographical coverage across multiple counties. Initial coverage must be provided across the five (5) county Puget Sound Region, including King, Thurston, Pierce, Snohomish, and Kitsap Counties. Contractor will offer coverage in the following counties beginning in Plan Year 2017: Skagit County and Grays Harbor County. For each Plan Year, enrollment in the ACP product will only be offered to Members with an address in the PEB Division's system of record that reflects residency in any of these counties in which Contractor has a sufficient number of ACP Program Providers; Members with an address in the PEB Division's system of record that reflects residency outside of counties in which Contractor has ACP Program Providers cannot enroll in an ACP Product but may be attributed to the ACP. The HCA reserves the right to seek an amendment to this Contract to extend coverage to additional Washington State Counties to meet the operational and strategic objectives of the PEBB Program and its Members. Any such amendment shall require mutual, written agreement of the parties as provided in Section 3.3 below.

      (ii) A broad spectrum of services that assure high-quality delivery of HCA's Covered Services, and data and clinical systems that support the delivery of evidence-based care.

(iii) A single, unified vision and leadership structure, with commitment of senior leaders, backed by the required resources to implement and support the vision.

(iv) In order to align resources to fulfill the triple aim, Contractor may include provisions in its care transformation plans that permit a limited number of smaller organizations, as defined below, to stage their participation in Exhibit 1.2 by providing additional time to make the transformation, provided all ACP Program Providers participate fully by January 1, 2019. Exhibit 4.4 defines those Partner Providers who will be permitted additional time to participate fully, as described herein and as may be amended from time to time. With regard to Affiliate Providers who began participation in 2016, the following schedule shall apply:

(a) By January 1, 2017, all Affiliate Providers with seven (7) or more provider Full-Time Equivalents (FTEs) shall participate fully;

(b) By January 1, 2018, all Affiliate Providers with four (4) to six (6) provider FTEs shall participate fully;

(c) By January 1, 2019, all Affiliate Providers shall participate fully regardless of size.

(v) For Affiliate Providers who join as ACP Program Providers in 2017, the following schedule shall apply:

(a) By January 1, 2018, all Affiliate Providers with seven (7) or more provider Full-Time Equivalents (FTEs) shall participate fully;

(b) By January 1, 2019, all Affiliate Providers with four (4) to six (6) provider FTEs shall participate fully;

(c) By December 31, 2019, all Affiliate Providers shall participate fully regardless of size.

4. Section 2.3, section B is hereby modified to read as follows:

B. **Coordinating and Standardizing Care: Improving Outcomes and Lowering Costs.** Contractor shall be accountable for managing all aspects of ACP Members' care starting on January 1, 2016. Under this Contract, Contractor will manage HCA's total per member per year costs while delivering high quality care and will share the Gross Deficit or Gross Savings with HCA to the extent provided in this Contract. Contractor will work with HCA to implement care coordination and care transformation strategies that will achieve the following goals:

(i) Work to improve ACP Members' health;

(ii) Address chronic conditions and major acute conditions through effective prevention and screening;

(iii) Coordinate the care of ACP Members with chronic conditions, particularly for complex ACP Members with physical and behavioral health conditions;

(iv) Implement Bree Collaborative recommendations and HCA clinical policies that have been approved by HCA's Chief Medical Officer.

(a) HCA's Chief Medical Officer will collaborate with Contractor by September 30 of each year to identify any changes to implementing Bree Collaborative recommendations or other emerging best practices as agreed to by the parties and HCA clinical policies at the start of the next Plan Year. HCA will give notice to Contractor by October 1 of each year of any Bree Collaborative recommendations or other emerging best practices as agreed to by the parties and HCA clinical policies that must have a care transformation plan, with the same information and parameters required for other care transformation plans in this Contract, developed for the next Plan Year;

(b) If HCA's Chief Medical Officer determines that delaying implementation to the start of the next Plan Year may have adverse consequences for ACP Members or HCA, HCA will work collaboratively with Contractor to expedite implementation during a Plan Year.

(v) Participate with the TPA of UMP in implementation of mandatory Health Technology Clinical Committee (HTCC) coverage determinations on a date determined by HCA.

5. Section 2.3, subsection E is hereby modified to read as follows:

E. **Pre-Launch Period Requirements.** The Contractor will fulfill the Pre-Launch Period requirements as stated in Exhibit 1.1 and Exhibit 1.4 2017 Expansion and any future agreed-upon expansion in counties memorialized in an exhibit. HCA can terminate this Contract for cause under Section 3.34(A) if Contractor fails to fulfill a Pre-Launch Period requirement (subject to the notice and cure provisions set forth in Section 3.34(A)).

6. Section 2.3, subsection F(vii) is hereby included to read as follows:

(vii) When an ACP Program Provider is in multiple PEBB ACPs, the protocol for ACP communication during open enrollment is as follows:

(1) The ACP that the Designated Member selected during the prior open enrollment is the only ACP who will communicate directly with the Designated Member during open enrollment concerning re-enrollment in the ACP. The scope of the communication may include all topics reasonably related to a Designated Member's decision-making on enrollment.

(2) When an Attributed Member is contacted by a provider who is in multiple ACPs, each provider may communicate with the Attributed Member on behalf of one ACP or multiple ACP's provided that any communication contains a paragraph approved by the HCA that informs the Attributed Member that they may receive a communication on behalf of the other network from the same provider and/or the other ACP about the option to select the other ACP during annual or special open enrollments.

(3) As additional counties are added for which there is no designated population, communication with the Attributed Member during open enrollment will follow the criteria described in above in section (2).

7. Section 2.3, subsection G, the Data/Reports table is hereby struck in its entirety and replaced as follows:

Data/Reports	**Source**	**Frequency**
Financial Performance Year to date of the Designated and Attributed Cohorts (for each substantial variance, Contractor will also report details of leading cost drivers and other pertinent information).	Claims data	Quarterly
Key Utilization Metrics • Inpatient and Emergency Department (ED) usage by ACP Members • Out of network usage (based on reports from the TPA of UMP) • All Rx usage (including high cost)	Claims data	Quarterly

Data/Reports	Source	Frequency
Key Metrics – Care Coordination for High-Risk ACP Members (see Exhibit 1.2) • # of ACP Members eligible for high-risk care management • # of ACP Members engaged in high-risk care management	Claims, and other data sources mutually agreed upon by Contractor and HCA CMO	Quarterly
Member experience reporting as described in Exhibit 1.3(1)(a): (1) Clinician and Group Consumer Assessment of Health Care Providers and Systems (CG-CAHPS) reporting including all additional questions measured and reported by the Washington Health Alliance (WHA) and (2) "Time to appoint" appointments. Contractor shall identify performance themes and proposed corrective actions.	Survey results (administered by ACP)	Quarterly (internal patient access data); Annually (CG-CAHPS survey results)
Aggregated semi-annual, trended data for each of the Quality Measures in Exhibit 5, along with an identification of performance themes and proposed corrective actions	Claims (for process measures) and clinical data from ACP	Semi-Annually
Cardiac, Spine and Obstetric (OB) Program metrics • Clinical Outcomes Assessment Program (COAP) (www.coap.org) • Spine Surgical Care and Outcomes Assessment Program (Spine SCOAP) (www.scoap.org) • Obstetrics Clinical Outcomes Assessment Program (OBCOAP) (www.qualityhealth.org/obcoap)	Clinical (chart and registry)	Semi-Annually

Data/Reports	Source	Frequency
Report Patient-Centered Medical Home (PCMH) progress towards HCA goal (see Exhibit 1.2)	Various (from Contractor)	Semi-Annually
CT Report – Care Coordination for High-Risk ACP Members (see Exhibit 1.2)	Various (claims and clinical)	Annually (update on plan metrics Semi-Annually)
CT – Obstetrics (see Exhibit 1.2)	Various (claims and clinical)	Annually (update on plan metrics Semi-Annually)
CT – Potentially Avoidable Hospital Admissions (see Exhibit 1.2)	Various (claims and clinical)	Annually (update on plan metrics Semi-Annually)
CT – Total Knee Replacement (TKR) and Total Hip Replacement (THR) Surgery Bundle (see Exhibit 1.2)	Various (claims and clinical)	Annually (update on plan metrics Semi-Annually)
CT – Spine Fusion Bundle (see Exhibit 1.2)	Various (claims and clinical)	Annually (update on plan metrics Semi-Annually)
CT – Cardiology (see Exhibit 1.2)	Various (claims and clinical)	Annually (update on plan metrics Semi-Annually)
CT – Low Back Pain (see Exhibit 1.2)	Various (claims and clinical)	Annually (update on plan metrics Semi-Annually)

Data/Reports	Source	Frequency
CT - End of Life Care (see Exhibit 1.2)	Various (claims and clinical)	Annually (update on plan metrics Semi-Annually)
Any other reports reasonably requested by HCA (see Exhibit 1.2)	TBD	TBD

8. Section 2.3, Subsection I is hereby modified to read as follows:

I. **Network.** The Contractor will disclose its network of ACP Program Providers (Partner and Affiliate to include hospitals, facilities, clinics, and physicians), type of services provided, and whether ACP Program Providers are employed or non-employed by the Contractor. For the 2016 Plan Year, Contractor must provide an initial list of all ACP Program Providers by June 15, 2015, an updated list of all ACP Program Providers on June 30, 2015 and July 15, 2015, and a final list of all ACP Program Providers by July 31, 2015 to the TPA of UMP in a format provided by HCA. The HCA file format must be received by Contractor on or before May 22, 2015. Deadlines for disclosure of the network for 2017 Expansion are found in Exhibit 1.4 2017 Expansion. Deadlines for any subsequent county expansions will be memorialized in a similar exhibit.

The parties agree that the ACP is governed by the following relationship designations:

(i) Partner Providers are the core hospitals, facilities, clinics, and physicians, including radiology, that are critical to the success of the ACP and satisfying network requirements because of the number of PEBB Members receiving primary care in King, Pierce, Thurston, Snohomish, and Kitsap Counties. Contractor must execute Partner Provider Agreements with the Partner Providers listed in Exhibit 4.1 that, at a minimum, includes the terms included in Exhibit 4.2.

In the event that additional Washington State Counties are added pursuant to Section 2.3(A)(i) of this Contract, the parties will amend Exhibit 4.1 to include any providers that will be designated Partner Providers. Within sixty (60) days of the amendment's execution, Contractor will execute a Partner Provider Agreement that meets the minimum requirements identified in Exhibit 4.2.

(ii) Affiliate Providers are those hospitals, facilities, clinics, and physicians, including radiology, that are individually contracted with Contractor to ensure access to providers. Contractor must execute Affiliate Provider Agreements that, at a minimum, include the terms included in Exhibit 4.3.

(iii) Ancillary Providers are those non-hospital providers that are in the TPA of UMP's network, that do not have any provider agreement with Contractor, and that have been designated by HCA as an Ancillary Provider type. By June 1, 2015, HCA will provide Contractor with the Ancillary Provider list for Plan Year 2016. It is HCA's intent to update the Ancillary Provider list annually. Each year thereafter, HCA will provide Contractor with the Ancillary Provider list by June 30 for the subsequent Plan Year.

The Ancillary Provider list includes the following categories of facilities/services and providers and is subject to change annually:

- Facilities/Services – DMEs, hearing aid dispensary, home health, hospice, lab, skilled nursing facility, skilled rehab facility, Urgent Care Centers, dialysis centers, birth centers and inpatient and outpatient behavioral health services.
- Providers – acupuncture, anesthesiologists, audiologists, chiropractors, Christian Science practitioners, dieticians, licensed massage therapists, maxillo-facial surgeons, naturopaths, nutritionists, physical therapists, occupational therapists, speech therapists, behavioral health providers, pathologists and licensed midwives.

Before Plan Year 2017 HCA intends to work with the Contractor to fully incorporate behavioral health providers into their networks as Affiliate Providers or Partner Providers to achieve integration of behavioral and physical health services.

9. Section 2.3, subsection J is hereby modified to read as follows:

J. **Monthly Provider Roster Updates**. Starting in 2016, the Contractor will provide to HCA a list of additions or removals of ACP Program Providers. The list must include all components of the provider roster specifications provided by HCA and as further described in the Operations Manual.

10. Section 2.3, subsection K is hereby modified to read as follows:

K. **Exclusivity**. Contractor must ensure ACP Program Providers that are participating in multiple PEBB ACPs declare a single ACP that all Attributed ACP Members will attribute to for evaluating Quality Measures and for the Financial Reconciliation. The attribution designation for each ACP Program Provider (at the Taxpayer Identification Number level) will remain in place each Plan Year but may be changed as described in Section 2.3(J). The attribution process is set forth in Exhibit 3.5.

11. Section 2.3, subsection L is hereby modified to read as follows:

L. **Changes to ACP Program Providers.** The Contractor shall provide notification to HCA of any potential changes to any Partner Providers or Affiliate Providers from the Contractor's network according to the following timelines:

(i) The Contractor shall have the opportunity to add ACP Partner Providers to its network, up to two (2) times a Plan Year, unless otherwise mutually agreed to by the Parties. The Contractor shall have the opportunity to add ACP Affiliate Providers to its network, on a monthly basis.

The Contractor must give written notice to the HCA Contract Manager of Contractor's intent to contract with the provider; the notice to the HCA Contract Manager must indicate whether the Contractor's intent is to add the new provider as a Partner Provider or an Affiliate Provider.

HCA will have three (3) Business Days, starting the Business Day after the notice is received, to decline to allow Contractor to add the provider to the ACP's network or object to the intended Partner Provider or Affiliate Provider designation. If HCA objects to Contractor's intended Partner Provider or Affiliate Provider designation, the parties must reach agreement on the provider designation before Contractor executes an agreement with the new provider. If HCA declines to allow Contractor to add the provider to the ACP's network, HCA shall inform Contractor of the specific bases for its decision. The parties agree that HCA may only decline to allow Contractor to add a provider to the ACP's network if (a) the provider is not a Preferred Provider or, (b) HCA determines in good faith that the addition of the provider to the ACP's network would compromise the safety or quality of care provided to the ACP Members,. This Section 2.3 (L) shall not apply to the addition of a provider to a Partner Provider or Affiliate Provider that is clinically integrated network organized as a separate legal entity.

For any new Partner Providers the parties will amend Exhibit 4.1 of this Contract within fifteen (15) Business Days after the Contractor executes

the Partner Provider Agreement with the new Partner Provider. Before any Partner Provider listed on Exhibit 4.1 can be removed from the Contractor's network, Contractor must give written notice to the HCA Contract Manager. If notice is provided between January 1 and June 30, then the Partner Provider can leave the network at the start of the next Plan Year. If notice is provided between July 1 and December 31, the Partner Provider cannot leave the network until the start of the second Plan Year after the notice is effective.

For example, if notice is effective on June 1, 2015, then the Partner Provider may leave the Contractor's network effective January 1, 2016. If the notice is effective on September 1, 2015, then the Partner Provider may not leave the Contractor's network until January 1, 2017.

If HCA determines that the departure of one or more Partner Providers from the Contractor's network will result in a failure to satisfy network requirements, HCA will notify Contractor of this determination within ten (10) business days of receiving the Contractor's notice to remove a Partner Provider. Contractor will have thirty (30) calendar days from the date it receives HCA's notice to propose a corrective action plan identifying the provider or providers who Contractor proposes to add to its network to maintain a sufficient number of providers to assure that Covered Services are accessible to the relevant PEBB population. HCA will consider the Contractor's corrective action plan in good faith and notify Contractor within thirty (30) calendar days of receipt whether the corrective action plan is acceptable. If HCA determines in good faith that the Contractor's corrective action plan is inadequate, HCA may terminate this Contract for cause under Section 3.34(A) of this Contract.

Notwithstanding the provisions of this subsection, the parties may mutually agree, in writing, to a mid-Plan Year termination date of a Partner Provider Agreement.

(ii) Before an Affiliate Provider can be removed from the Contractor's network, the Contractor must give written notice to the HCA Contract Manager at least two (2) full calendar months prior to the last day of the Affiliate Provider's network status with Contractor.

Notwithstanding the provisions of this subsection: (a) an Affiliate Provider may be immediately removed from the Contractor's network if the Affiliate Provider fails to maintain appropriate licensure, has relevant privileges suspended or terminated, is excluded from Medicare, Medicaid or other government programs, is convicted of a felony, or otherwise fails to satisfy the credentialing requirements of its Affiliated Provider

Agreement with Contractor or its Participating Provider Agreement with the applicable TPA; and (b) the parties may mutually agree, in writing, to an earlier termination date of an Affiliate Provider Agreement.

(iii) All notices under Section 2.3(L) shall be sent to the HCA Contract Manager shall be deemed given if emailed or mailed by United States Postal Service, registered or certified mail, return receipt requested, postage prepaid and addressed as described in Section 2.12(A). Notice shall be effective on the date delivered, as evidenced by the return receipt.

12. Section 2.3, subsection M is hereby modified to read:

M. **Health Information Technology to Improve Quality**. Contractor must have certified Electronic Health Record (EHR) systems as defined by the Office of the National Coordinator. Contractor must contribute clinical data from its EHR system to the state Health Information Exchange hosted by OneHealthPort, when such clinical data repository service is offered. Additionally, any ACP Program Providers that have a certified EHR system, or establish a certified EHR system, must agree to contribute clinical data from its EHR system to Washington State's Health Information Exchange hosted by OneHealthPort, when such clinical data repository is offered.

13. Section 2.3, subsection Q Operations Manual is hereby struck in its entirety from the Contract. Section 2.3, subsection R Covered Services is renumbered as subsection Q.

14. Section 2.3, subsection R is hereby added to read as follows:

R. **Foundation for Health Care Quality (FHCQ) Programs:** For any Contract provisions relating to COAP, Spine SCOAP and OB COAP obligations, ACP Program Providers are not required to comply with the Contract provision if an ACP Program Provider does not offer or perform services addressed by those programs; for example if an ACP Program Provider does not perform spinal surgical services, they will not be required to participate in Spine SCOAP.

15. Section 2.4, subsection C is hereby modified to read as follows:

C. When an ACP Member requires a Covered Service, which is medically necessary or legally mandated, and the ACP determines it is in the patient's best interest to receive such Covered Services out-of-network, then the ACP Program Provider shall contact the TPA of UMP for an exception authorization

(i.e. “out-of-network consent” form). All authorized consents will be considered an in-network Covered Service and included in the Financial Reconciliation.

16. Section 2.6, subsection F is hereby modified to read as follows:

F. Contractor will ensure that all communications comply with the Americans with Disabilities Act (ADA), all subsequent amendments to the ADA and implementing regulations of the ADA.

This Section of the Contract does not apply to Contractor’s or Subcontractors’ patient communications for treatment, payment, and health care operation purposes. Nor does this Section apply to communications that are not targeted solely at ACP Members for disease management (e.g. communications by Contractor or Subcontractors to patients who have high cholesterol, including ACP Members who have high cholesterol, information about the impacts of high cholesterol and how to manage high cholesterol).

17. Section 2.7, subsection B is hereby modified to read as follows:

B. On an annual basis, a Financial Reconciliation will be conducted for each Cohort to determine whether there are Net Deficits for the Designated Cohort and/or Net Savings based on the requirements set forth in Exhibit 3.3. Examples of Calculations for Net Savings and Net Deficits are provided in Exhibit 3.4

(i) HCA will consider quality and Member satisfaction when calculating the Contractor’s share of the Gross Savings and Gross Deficits as described in the Exhibit 3 Series and Exhibit 5.

(ii) The Financial Reconciliation will be performed separately for each Cohort and include a complete accounting of the aggregate Allowed Amounts for all Considered Amounts furnished to the ACP Members, including medical, pharmacy, and behavioral health claims. Not all Covered Services will be considered in Financial Reconciliation. Exhibit 3.3 provides details for which services are not included in Considered Amounts.

(iii) The Financial Reconciliation will be done on an incurred claims basis with three (3) months run-out with no adjustment for claims incurred but not paid. This applies to both the Adjusted Base Cost PMPM and the Target Cost PMPM.

(iv) For each Performance Year and Cohort, the Unadjusted Base Cost PMPM will be the average of each participating ACP Member’s 2015 Considered Amounts. This will serve as the starting point from which increases or

decreases in the Performance Year average Considered Amounts PMPM will be measured during the Financial Reconciliation.

(v) The Adjusted Base Cost PMPM will be calculated by multiplying the Unadjusted Base Cost PMPM by the ratio of the Performance Year Risk Score to the Base Year Risk Score.

(vi) The Target Cost PMPM will be the Adjusted Base Cost PMPM trended forward using the Benchmark Trend Rates and the Annual Trend Guarantee Rates for each year. For each Performance Year the Aggregate Target Cost will be computed as the Performance Year Member Months multiplied by the Target Cost PMPM.

(vii) The Aggregate Considered Amount for the Performance Year for each Cohort will be compared to the Aggregate Target Cost to calculate the Gross Deficits or Savings.

(viii) For each Performance Year and Cohort, the difference between the Aggregate Considered Amount and the Aggregate Target Cost will be a Gross Deficit if the Aggregated Considered Amount is more than the Aggregate Target Cost, or a Gross Savings if the Aggregate Considered Amount is less than the Aggregate Target Cost.

(ix) For each Performance Year and Cohort the Gross Savings or Gross Deficits are multiplied by the Savings Share percentage or the Deficit Share percentage, respectively to calculate Net Savings or Net Deficits. The Savings Share or Deficit Share are determined based on the descriptions in Exhibit 5 and the overall Quality Improvement Score. Net Savings can be achieved on both the Attributed and Designated Cohort, while Net Deficits can only be achieved on the Designated Cohort.

18. Section 2.8, subsection A is hereby modified to read as follows:

A. If there are Gross Savings in a Performance Year, the Contractor will receive the Net Savings (i.e. the percentage of Gross Savings as described in Exhibit 5 as Savings Share). In no instance shall the Contractor receive more than [redacted] of the Gross Savings.

For both the Designated Cohort and Attributed Cohort, after the Net Savings payment is determined according to all other provisions of this Contract, the Net Savings payment may be reduced by up to [redacted] for failure to meet the performance criteria for ACP Member experience. This Net Savings payment reduction is applied after the calculation of Gross Savings multiplied by Savings

Share. As an illustration, assuming (1) the Gross Savings is $1,000,000.00, (2) the overall Quality Improvement Score results in the Full Savings Share of [redacted] and (3) Full [redacted] reduction for ACP Member experience applies, then the Net Savings payment would be $1,000,000.00 x [redacted] x (1 - [redacted] = [redacted]. The Net Savings payment reduction for performance criteria for ACP Member experience, as described in Section 2.3(F) of this Contract and Exhibit 1.2, is as follows:

Performance Criteria	**Net Savings Payment Reduction in Performance Year 2016**	**Net Savings Payment Reduction in Performance Year 2017+**
After-hours access requirements in Exhibit 1.3(1)(b)	[redacted]	
HCA dedicated Contact Center performance guarantees in Exhibit 1.3(2)(c)		
ACP benefit fair requirements in Contract Section 2.3(F)(iii)		
Welcome packet mailing requirements in Contract Section 2.3(F)(iv)		
Demonstrated progress of ACP Program Providers toward meaningful adoption and use of electronic health records as required in Exhibit 1.1		

Performance Criteria	Net Savings Payment Reduction in Performance Year 2016	Net Savings Payment Reduction in Performance Year 2017+
An HCA Dedicated Contact Center Services by November 1, 2015 that meets the requirements in Exhibit 1.3	[redacted]	
A Website/Portal by November 1, 2015 that meets the requirements in Exhibit 1.3(d)		
Received HCA approval of the master implementation work plan required in Exhibit 1.1		
Received HCA approval of the ACP communication plan required in Exhibit 1.1		
Received HCA approval of the CG-CAHPS methodology and sampling plan and plan for reporting on access and timeliness metrics as required in Exhibit 1.1		
Participate in review of Operations Manual as required by Contract Section 2.15.		
TOTAL		

19. Section 2.8, subsection F is hereby included in Section 2.8 to read as follows:

F. [redacted]

[redacted]

20. Section 2.11, subsection A, the Contract Manager table is struck in its entirety and replaced with the following:

Contractor Contract Manager	HCA Contract Manager
Jacque Cabe Chief Financial Officer UW Medicine 1959 NE Pacific Street, C-314 BOX 356350 Seattle, WA 98195-6350 Phone: 206-616-9886 Email: jlcabe@uw.edu	Lou McDermott Assistant Director of PEB Washington State Health Care Authority 626 8th Ave SE Olympia, WA 98504 Phone: (360) 725-0891 Email: louis.mcdermott@hca.wa.gov

21. Section 2.12, subsection A is hereby modified to read as follows:

A. In the case of notice to the Contractor, notice will be sent to:

Attention: Lori Oliver
UW Medicine
1959 NE Pacific Street, C-315
BOX 356340
Seattle, WA 98195-6350

22. Section 2.15, Operations Manual is hereby added to the Contract to read as follows:

A. HCA will take the lead in creation and maintenance of the Operations Manual. HCA and Contractor will begin using an initial version of the Operations Manual by an agreed upon date.

B. Thereafter HCA and Contractor will collaboratively work on revisions on the operations manual and agree to the effective date of any revisions.

C. The HCA and Contractor will follow the procedures and requirements written in the most recently agreed upon operations manual, which is incorporated by reference into this Contract.

23. Section 3.23 Public Records Act is hereby modified to read:

The parties acknowledge that each party is subject to chapter 42.56 RCW and that this Contract, and exhibits, are public records as defined in chapter 42.56 RCW. To the extent consistent with chapter 42.56 RCW, each party shall maintain the confidentiality of all such information.

If a public disclosure request is made and this Contract is identified as a responsive document, the party in receipt of the request will notify the other party of the request and of the date that records will be released to the requester unless a court order from a court of competent jurisdiction enjoins disclosure of some or all of the Contract; if the court order enjoining disclosure is not obtained, the party in receipt of the public disclosure request will release the requested information on the date specified in its notice to the other party.

24. Section 3.24, subsection A is hereby modified to read:

A. HCA shall own all right, title and interest in its data (including but not limited to administrative data, claims and encounter data, and eligibility data), whether confidential or otherwise, and regardless of whether that data is provided to Contractor directly by HCA or by a Plan Supplier. HCA also shall own all right, title and interest in all deliverables provided to HCA under Section 2.3(G) (Data and Reporting Requirements), the care transformation plans created (but not any underlying research upon which a care transformation plan is based) under Exhibit 1.2 and Section 2.3(B)(iv)(a), communication materials created under Section 2.3(F) and Section 2.6 (except for communications described in Section 2.6(G)), and the operations manual created under Section 2.3(Q). HCA hereby grants to Contractor a nonexclusive, royalty-free, irrevocable license (with rights to sublicense to others) to translate, reproduce, distribute, prepare derivative works, publicly perform, and publicly display all such data and deliverables described in the preceding two sentences. HCA agrees that in the exercise of its ownership rights, HCA will not share materials subject to this paragraph that are created by one ACP with another ACP or prospective ACP without permission of the ACP that created the materials. Notwithstanding anything to the contrary herein, HCA shall not have any ownership interest in any data that is created, generated, collected, maintained, processed, or otherwise held by Contractor or ACP Program Providers or their agents or Subcontractors as part of their respective treatment, payment, and health care operations activities or any data shared with Contractor or ACP Program Providers by HCA or its vendors under this Contract that is stored in Contractor's or any ACP Program Provider's systems for its treatment, payment or healthcare operations.

25. Section 3.36, is hereby modified to include the following Definitions:

“Benchmark PEBB Trend Rates” means the risk adjusted trend for the average PMPM Considered Amount for the PEBB Medical Plans for the non-Medicare risk pool Members excluding those individuals designated for an ACP.

26. Exhibit 1.1 is hereby struck in its entirety and replaced with Exhibit 1.1 – Contractor Pre-Launch Activities to read as follows:

Acceptance of Deliverables

Upon receipt of a deliverable submitted by Contractor, HCA will have an initial period of ten (10) Business Days to review and evaluate the Deliverable for deficiencies. The HCA will provide written acceptance of the deliverable if it has no deficiencies.

If a deficiency is found, the HCA will notify the Contractor of any deficiencies in writing. Contractor will have five (5) Business Days to correct any deficiencies, unless a longer timeframe is mutually agreed to by the parties, and submit the corrected deliverable to HCA. Upon receipt of the corrected deliverable, HCA will have five (5) Business Days to review and evaluate the deliverable for deficiencies. This process will be repeated until the HCA provides written acceptance of the deliverable.

Once a deliverable has been accepted by HCA, the obligations described in the deliverable will be enforceable subject to HCA's rights and remedies contained in this Contract for Contractor's failure to perform.

June 15, 2015

1. Provide to the TPA of UMP an *initial* list of ACP Program Providers, including all components of the provider roster specifications provided by HCA. The specifications will include each provider's designation of an ACP for purposes of attribution.
2. Develop detailed master implementation work plan (including key milestones).

June 30, 2015

1. Provide to the TPA of UMP an *updated* list of ACP Program Providers including all components of the provider roster specifications provided by HCA. The specifications will include each provider's designation of an ACP for purposes of attribution.
2. Identify program gaps in ACP services based on implementation plan and present action plan (include assessment of reporting capabilities, care management capabilities, and Network Adequacy).
3. The Contractor to execute Data Sharing Agreements with Plan Suppliers and the Contractor's Data Intermediary.
4. The Contractor to set up Secure File Transfer sites (SFTs) with Plan Suppliers and the Contractor's Data Intermediary

July 15, 2015

1. Provide to the TPA of UMP an *updated* list of ACP Program Providers including all components of the provider roster specifications provided by HCA. The specifications will include each provider's designation of an ACP for purposes of attribution.

July 31, 2015

1. Sign contracts with qualified member survey vendor(s).
2. Submit report on ACP clinic status on achieving Patient Centered Medical Home (PCMH) equivalency to 2011 National Committee for Quality Assurance (NCQA) PCMH Level III standards (identify number and percentage of clinics with seven (7) or

more primary care clinician equivalents and their status in achieving 2011 NCQA PCMH accreditation equivalency, including clinics that are on the path to achieve Level III accreditation).

3. The ACP communication plan that contains:
    a. Participation plans for Contractor's ACP representative attending scheduled PEBB Annual Open Enrollment benefit fairs;
    b. Producing written materials including ACP Members welcome packet and other written materials;
    c. Web portal functionality for HCA user testing/review; and
    d. Customer service staffing and orientation strategy.
4. Provide to the TPA of UMP a *final* list of ACP Program Providers including all components of the provider roster specifications provided by HCA. The specifications will include each provider's designation of an ACP for purposes of attribution.
5. Provide proof of signed Partner Provider Agreements, or provide proof of existing contracts, with Partner Providers listed in Exhibit 4.1 that contain terms and conditions in Exhibit 4.2.
6. Signed letters of intent for ACP Program Providers to actively join and participate in the following Foundation for Health Care Quality (FHCQ) programs: COAP, Spine SCOAP and OBCOAP.

<u>September 1, 2015</u>

1. Begin providing monthly update list (roster) of Partner Providers and Affiliate Providers, including tax identification numbers and facility names.

<u>September 30, 2015</u>

1. Submit the following care transformation plans: Care Coordination for high-risk ACP Members and Potentially Avoidable Hospital Readmission to Chief Medical Officer.
2. Phase I – HCA Designated Contact Center (staffed with experienced customer service reps).
   Services must include the following:
    a. Contact Center available to educate ACP Program Providers and their staff about the ACP, outlining expectations for Member experience (share education materials with HCA);
    b. Contact Center available to answer ACP Member questions about ACP Program Providers and clinics;
    c. Contact Center available to refer ACP Members to other experts as appropriate;
3. Phase I – HCA dedicated customized website/portal for Designated ACP Members (extended deadline to October 9, 2015).
   The website/portal must include the following functionality:
    a. Promotion of ACP services, programs, partners and providers
    b. Provider search capability of all currently available ACP Program Providers
    c. Ability to be embedded in select HCA sites
    d. Ability to link to select HCA sites

<u>November 1, 2015</u>

1. Submit CG-CAHPS methodology and sampling plan, and plan for reporting on access and timeliness metrics. Submit specific details (i.e., data sources, measurement

period, etc.) for each report listed in Section 2.3(G) to be finalized by the HCA and Contractor.

2. Submit test file of actual data on metrics tied to financial incentives except for access and timeliness metrics.
3. Phase II – HCA dedicated customized portals.
    a. The website/portal for Designated ACP Members must include the following functionality:
        i. All Phase I functionality
        ii. Online welcome kit
        iii. Administrative support for ACP Members using site (i.e., navigation and website issues)
        iv. Links to agreed-upon cost and quality websites
    b. The ACP Program Provider will have an electronic health record and/or patient portal, which must include the following functionality:
        i. User login
        ii. Registration for access to a patient's electronic patient health records (i.e. MyChart)
        iii. Appointment scheduling requests, where available
        iv. Secure messaging with ACP Program Providers
        v. Prescription refills
        vi. Administrative support for ACP Members using site (i.e., password reset, navigation, and website issues)

        In circumstances where an ACP Program Provider does not currently have an electronic health records and/or patient portal that contains all the requirements in subsection 3(b), Contractor shall demonstrate progress of the ACP Program Provider toward meaningful use adoption or provide rationale to HCA for why participation of the provider as a contracted ACP Program Provider is appropriate. The date of measurement for progress for 2015 is December 31, 2016. Documentation of progress will be as agreed to by the Parties and may take the form of an email summarizing progress.

4. Phase II – HCA Designated Contact Center (staffed with experienced customer service representatives).
   Services must include the following:
    a. All Phase I services
    b. Integrated with all ACP Program Providers and clinics
    c. Extended hours of operation
    d. Support ACP Members with appointment scheduling (centralized or warm transfer)
    e. Triage and refer ACP Members to the 24/7 nurse line
    f. Triage and refer ACP Members to Plan Suppliers in Exhibit 6

<u>December 15, 2015</u>

1. List of extended hours for primary care clinics.

<u>December 31, 2015</u>

1. Submit care transformation plan for obstetrics.

27. Exhibit 1.2 is hereby struck in its entirety (except for Attachment 1) and replaced with Exhibit 1.2 - Care Transformation to read as follows:

With direction from HCA, the Contractor will operationalize care transformation strategies within the ACP and across all ACP Program Providers. However, the Contractor must complete the following activities for non-pediatric populations

1) **Advancing Primary Care/Patient Centered Medical Home (PCMH)**.

a) By the end of the Contract, all ACP Program Provider clinics and medical groups with seven (7) or more full time primary care clinician equivalents must achieve PCMH equivalency by meeting 2011 NCQA PCMH Level III Status standards (for example, achieve an overall score of 85 or higher – see attachment 1). The Contractor's list of ACP Program Provider clinics and medical groups with seven (7) or more full time primary care clinician equivalents will be updated annually by October 31, and every October thereafter until October 31, 2018. The Contractor's list, updated annually, will be used by HCA to define target percentages, in November 2015 for 2016, and every November thereafter, based on clinic and medical groups with seven (7) or more full time primary care clinician equivalents identified October 31 of each year. In determining the target percentage, clinics that have achieved 2011 NCQA PCHM Level III accreditation or PCMH equivalency, would be given a "pass". The Contractor will be required to report Semi-Annually on its progress towards annual goals set by HCA.

Annually, the Contractor will designate a dedicated team with appropriate expertise to audit at least three (3) clinics selected by HCA that the Contractor attested to meeting Level 3 standards. If any clinic fails the audit, then the Contractor will create a corrective action plan and re-evaluate its attestation processes to assure compliance with the attestation process for primary care clinics, working towards meeting applicable NCQA Patient Centered Medical Home Level III Status equivalency standards; in addition, the corrective action plan must include an audit of three (3) clinics not previously audited. If all clinics passed the audit, the Contractor will be allowed to continue to conduct and report internal audits.

b) PCMH in above Section 1A does not apply to University of Washington's Hall Health Center.

2) **Submit Care Transformation Plan on Select Topics**. The Contractor will be responsible for submitting a care transformation plan to improve quality within and across the ACP on specific topics listed below. Each plan must include goals, milestones, appropriate metrics and the following components specified below. The Contractor will be responsible for presenting plans and progress on meeting goals laid out in the plans at the quarterly meetings with HCA (schedule of topics to be determined by the HCA Chief

Medical Officer (CMO)). The format of the plans is to be determined jointly by the ACP and HCA Chief Medical Officer (CMO).

Care transformation plans should not exceed twenty (20) pages, single side, and should include the following:

(1) Quality Improvement goals;
(2) Milestones and timeline;
(3) High-level report on achieving goals and milestones (identify which have been achieved; and if not, provide detail on why milestones have not been achieved, what course corrections have been implemented, address operational concerns);
(4) Dashboard of appropriate metrics results (defined in Contract, by clinic/medical group and hospital level results by ACP Program Provider);
(5) Other topic-specific components specified in the Contract; and
(6) Comparison of past care transformation plans if scope, goals or other changes were made from previous year(s).

Contractor may attach appendices as necessary.
Contractor will be responsible for integrating Program Providers who participate in the ACP for the 2017, or subsequent year, expansion. Contractor shall have discretion to stage integration of new Program Providers into ongoing care transformation plans; however, all Program Providers will be integrated into existing plans as described in Section 2.3.

a) Care Coordination for High-Risk ACP Members

i) The Contractor will utilize a mutually agreed upon protocol to identify ACP Members with multiple chronic conditions and/or advanced illness who are at high risk of poor outcomes and would benefit from planned care management interventions. The Contractor will: 1) pro-actively reach out to ACP Members identified as high risk to assure that they are empaneled with a primary care home; and 2) connect them with a care coordinator who is part of the patient's primary care clinic team. Together with the primary care team, the care coordinator will support ACP Members and care givers by:

(1) Performing a comprehensive assessment of care needs and gaps;
(2) Developing a trusting relationship through the use of evidence-based and patient-centered engagement methods, such as motivational interviewing;
(3) Developing a care plan that takes into account gaps in care as well as functional status, patient activation, behavioral health and social service needs, and barriers to care. The plan and associated goals should reflect the patient's priorities and goals, and be available to and shared with other members of the care team across primary and specialty care;

(4) Working closely with patients and their family members and caregivers, as well as primary, specialty, behavioral health and social service providers to assure adherence to the care plan through clear and consistent communication and coordination of efforts on behalf of the ACP Members;
(5) Assuring timely (within 30 minutes) after-hours phone access to a primary care team member who can connect electronically to the ACP Member's medical record and care plan;
(6) Rapidly and effectively responding to changes in a ACP Member's condition to avoid use of unnecessary services, particularly emergency department visits or hospitalizations by serving as a primary point of contact for patients and their families and caregivers;
(7) Coordinating transitions of care from hospital (ED or inpatient) to home or the next appropriate level of care (e.g. skilled nursing);

ii) HCA recognizes that the needs of ACP Members being served and the nature of the clinic setting (e.g. urban vs. rural; large vs. small) will determine the composition and roles of the primary care management team, physical location of care coordinators and the number of ACP Members assigned to a care coordinator at any point in time. Program protocols and the clinical judgment of care coordinators and primary care team members should dictate the frequency of scheduled interactions, as well as whether such interactions should be by phone or in person.

iii) The Contractor will provide HCA with a full description of its plan for managing high risk ACP Members consistent with the principles outlined above prior to September 30, 2015. The Contractor will also report quarterly on the number of ACP Members eligible for high-risk care management; the number of ACP Members engaged in high-risk care management. The precise content of such reports will be agreed upon by HCA and the Contractor prior to August 1, 2015.

b) <u>Obstetrics/Maternity Care Improvement Plan</u>

i) This plan must align with the Bree Collaborative obstetrics recommendations, and demonstrate how each recommendation will be implemented.

ii) A strategy to decrease C-Sections, including use of evidence-based labor and delivery guidelines for C-Sections referenced by the Bree Collaborative.

iii) Contractor must participate in OBCOAP.

iv) Contractor will begin implementing shared decision making strategies for all VBAC eligible women at one pilot site where deliveries occur by July 1, 2016. The Contractor must develop a shared decision making model for the pilots that include:
(1) Training ACP Program Providers in the shared decision making model;
(2) A process for how ACP Members will be engaged in shared decision making using patient decision aids; and

(3) The type of provider engaging with the ACP Members during shared decision making.

v) The first plan must be submitted to the HCA CMO by December 31, 2015, and updated on an annual basis thereafter by each September 1.

c) Potentially Avoidable Hospital Readmission Strategies and Improvement Plan

i) This plan must align with the Bree Collaborative Potentially Avoidable Hospital Readmission Strategies and recommendations and include adoption of care transition processes that are in alignment with the WSHA Care Transitions Toolkit.

ii) Must measure, report, and discuss plans for improvement on Bree Collaborative recommended measures (by an ACP Program Provider): percent of inpatients with diagnosis of acute myocardial infarction (AMI), heart failure (HF), community acquired pneumonia, chronic obstructive pulmonary disease (COPD), and stroke for which there is:

(1) Patient discharge information provided to the primary care provider (PCP) or aftercare provider within three Business Days of discharge, and

(2) A documented follow-up phone call after discharge within three (3) Business Days.

iii) The first plan must be submitted to the HCA CMO by September 30, 2015, and updated on October 1 on an annual basis thereafter.

d) Total Knee and Hip Replacement (TKR and THR) Surgery Bundle

i) Must address plans and timeline to implement TKR and THR surgery Bundle according to the Bree Collaborative recommendations. This plan must be submitted to the HCA Chief Medical Officer by March 31, 2016.

ii) Must include progress on measuring and reporting on the detailed quality standards identified by the Bree Collaborative: appropriateness, evidence-based surgery, ensuring rapid return to function, patient care experience, and patient safety and affordability.

iii) Contractor is required to provide a detailed progress report on their progress in meeting their goals at each quarterly meeting.

iv) Contractor will begin implementing shared decision making strategies for all persons eligible for joint replacement surgery at two pilot sites where such surgeries take place by January 1, 2017. The Contractor must develop a shared decision making model for the pilots that include:

(1) Training ACP Program Providers in the shared decision making model;

(2) A process for how ACP Members will be engaged in shared decision making using patient decision aids; and

(3) The type of provider engaging with the ACP Members during shared decision making.

v) The first plan must be submitted to the HCA CMO by March 31, 2016 updated on April 1 on an annual basis thereafter.

e) Spinal Fusion Bundle
   i) Must address plans and timeline to implement a spinal fusion Bundle according to the Bree Collaborative recommendations. This plan must be submitted to the HCA Chief Medical Officer by June 30, 2016, and updated on July 1 on an annual basis thereafter.
   ii) Must include progress on measuring and reporting on the detailed quality standards identified by the Bree Collaborative: appropriateness, evidence-based surgery, ensuring rapid return to function, patient care experience, and patient safety and affordability.
   iii) Contractor is required to provide a detailed progress report on their progress in meeting their goals annually at one of the quarterly meetings with the HCA ACP Leadership Team.
   iv) Contractor will begin implementing shared decision making strategies for all persons eligible for spinal fusion surgery at two pilot sites where such surgeries take place by January 1, 2017. The Contractor must develop a shared decision making model for the pilots that include:
      (1) Training ACP Program Providers in the shared decision making model;
      (2) A process for how ACP Members will be engaged in shared decision using patient decision aids; and
      (3) The type of provider engaging with the ACP Members during shared decision making.

f) Cardiology Improvement Plan
   i) Must address plans and timeline to implement strategies to increase appropriateness of percutaneous coronary interventions according to the Bree Collaborative recommendations within and across ACP Program Providers.
   ii) Each ACP Program Provider must participate or show evidence on intent to participate in COAP by January 1, 2016.
   iii) The first plan must be submitted to the HCA CMO by March 31, 2016, and updated on April 1 on an annual basis thereafter.

g) Low Back Pain Improvement Plan
   i) Must address plan to incorporate individual delivery system elements of the Bree Collaborative recommendations.
   ii) Must include approach to reduce the misuse of opiates for non-malignant chronic pain consistent with the most recent guidelines from the Agency Medical Directors' Group (AMDG), which are available at http://www.agencymeddirectors.wa.gov/guidelines.asp.

iii) Each ACP Program Provider must participate or show evidence on intent to participate in Spine SCOAP by January 1, 2016.
iv) The first plan must be submitted to the HCA CMO by June 30, 2016, and updated on July 1 on an annual basis thereafter.

h) End of Life Care Improvement Plan
i) Must detail how ACP Program Providers' end of life strategies align with the Bree Collaborative recommendations including but not limited to, integration of evidence-based, culturally appropriate advanced care planning into clinical care, use of advanced care planning tools and Physician Orders of Life-Sustaining Treatment (POLST) when appropriate, designation of legal durable power of attorney for health care.
ii) Contractor will begin implementing shared decision making strategies for all persons eligible for end of life care by January 01, 2018. The Contractor must develop a shared decision making model that includes:
(1) Training ACP Program Providers in the shared decision making model;
(2) A process for how ACP Members will be engaged in shared decision making using patient decision aids; and
(3) The type of provider engaging with the ACP Members during shared decision making.
iii) The first plan must be submitted to the HCA CMO by June 30, 2016, and updated on July 1 on an annual basis thereafter.

i) Addiction and Dependence Treatment Improvement Plan
i) Must detail how an ACP Program Provider's addiction and dependence treatment plan align with the Bree Collaborative recommendations.

ii) The first plan must be submitted to the HCA CMO by June 30, 2016, and updated on July 1 on an annual basis thereafter.

j) Future Bree Collaborative Recommendations Selected by HCA
i) Contractor must submit care transformation plans on future Bree Collaborative topics selected by HCA and detail how plans align with Bree Collaborative recommendations.
ii) Contractor must submit plans within six (6) months of adoption by the Bree Collaborative, and a yearly basis thereafter (e.g., if recommendations are adopted on January 1st, Contractor has until June 1st to submit a report, and must submit updated reports on June 1 on an annual basis thereafter).

k) Pediatric Populations

The Contractor will implement a Care Transformation Project for children with persistent asthma. The pediatric population will be defined using the age and asthma-identified diagnostic code criteria consistent with NQF 1799 (Washington Core Measure Set). The first Care Transformation plan must be submitted to the HCA CMO by October 31, 2016 and updated on November 1, 207 on an annual basis thereafter.

3) Participation in Accountable Communities of Health.

a) Contractor and Partner Providers must demonstrate, on an ongoing basis, active participation in Accountable Communities of Health in regions where Contractor is providing an ACP option.

4) Active Participation with Purchasers on Strategies & Participation in Multi-Payer & Multi-Stakeholder Activities.

a) Contractor must actively participate in multi-payer and multi-stakeholder activities. Actively participating is defined as incorporating recommendations produced by community collaboratives and quality improvement programs including Accountable Communities of Health, the Health Technology Clinical Committee, Dr. Robert Bree Collaborative, and the Foundation for Health Care Quality programs, COAP, Spine SCOAP and OBCOAP.

b) Contractor must assist in replicating or extending HCA's ACP model and requirements with other interested purchasers by attending meetings and/or conferences requested by HCA. Contractor will not be requested to share financial Contract details nor other terms deemed proprietary with other purchasers.

28. Exhibit 1.3 is hereby struck in its entirety and replaced with Exhibit 1.3 Member Services & Member Experience to read as follows:

The Contractor is responsible to create a high quality Member experience. At a minimum, the Member experience is to include:

1. Provider Access

(a) **Timely Access**

Contractor shall make reasonable efforts to provide ACP Members with timely and convenient access to ACP Program Providers in accordance with the specifications set forth in Table I. As noted in Section 2.3(F)(v) of the Contract, the specifications in Table I are desired objectives and will not be used to determine the Contractor achievement of any Quality Measures, reduction in Net Savings, or in Financial Reconciliation. At the same time, Contractor will provide reports per Section 2.3(G) and 2(e)(iv) below, demonstrating adequacy of timely access (subject to ACP Member preferences) for the ACP Program Providers in the aggregate.

For the purposes of Section 1(a) of this Exhibit only the following definitions supplement Contract Section 3.36's definitions and these supplemental definitions do not apply to any other part of this Contract or any other Exhibit:

i) *"Primary Care Physician (PCP) Visit"* means a visit with a practitioner in one of the following specialties: general practice, family practice, internal medicine, general pediatric medicine (excluding all pediatric subspecialists), geriatric medicine and preventive medicine. The practitioner may be a physician, primary care nurse practitioner, primary care physician assistant, or certified clinical nurse specialist.

ii) *"PCP Routine and Non-Urgent Care"* means a visit that is not considered urgent or emergent. Examples include: preventive care, ongoing management of chronic conditions and health education.

iii) *"PCP Acute and Urgent Care"* means a visit for an illness or injury that will not cause further disability or death if not treated immediately but could become worse without treatment. Examples include: minor lacerations, urinary tract infections, earaches, migraine headaches and rising fever.

iv) *"Specialist Visit"* means a visit with a physician who is considered a medical specialist.

v) *"Specialist Routine and Non-Urgent Care"* means a visit for an initial consult or procedure that is not considered urgent or care visit for specialty follow-up of a chronic condition. Examples include: initial consultation of a non-urgent surgical problem, such as asymptomatic inguinal hernia, or mildly decreased but stable kidney function.

vi) *"Specialist Acute and Urgent Care"* means a visit for an illness or injury that will not cause further disability or death if not treated immediately but could become worse without treatment. Examples include: symptomatic inguinal hernia, acute exacerbation of chronic condition, request by PCP or medical specialist for urgent surgical consultation.

Table I

Category	Criteria	Designated	Attributed
		2016+	2016+
PCP Visits for acute and urgent problems	Same or next day PCP visits with PEBB Member's PCP, covering PCP, a new PCP (for those without an existing PCP relationship), or at an Urgent Care clinic.	[redacted] of the time	[redacted] of the time
PCP Visits for non-urgent and routine problems	Within ten (10) Business Days, with PEBB Member's PCP, or for those without an existing PCP relationship, or a new PCP. The visit may be with a covering PCP if the PEBB Member's PCP is unavailable to do protracted absence from the office.	[redacted] of the time	[redacted] of the time
Specialist Visits for acute and urgent problems	Within three (3) Business Days.	[redacted] of the time	[redacted] of the time

Category	Criteria	Designated	Attributed
		2016+	2016+
Specialist Visits for non-urgent and routine problems	Within ten (10) Business Days. For ACP Members with an ongoing relationship with a specialist, the appointment will be with that specialist (if the condition is related to the original condition), or a covering practitioner in the same practice.	[redacted] of the time	[redacted] of the time

(b) **After Hours Access**

Contractor must maintain primary care sites in King County (minimum 60 hours), Snohomish County (minimum 12 hours), Pierce County (minimum 24 hours), and Thurston County (minimum 12 hours) that collectively offer care accessible to ACP Members until at least 7:00 p.m. four (4) nights a week and provide at least four (4) hours of access on Saturday or Sunday. In addition, Contractor supports working with its Program Providers to increase the number of sites that offer after-hours primary care access based on ACP Members demands for such services by the end of the Contract Term. Contractor commits to communicate with ACP Members about using primary care appropriately and the availability of after-hours care locations.

In addition, Urgent Care sites shall be made available for acute, Urgent Care access. 24/7 consulting nurse and tele-urgent care services will be available to all ACP Members.

2) Administrative and Clinical Assistance/Services

Contractor shall provide enhanced administrative and clinical assistance/services to ACP Members in accordance with the following specifications:

(a) HCA Dedicated Contact Center Services. Contractor will have a well-functioning, centralized call center (or subset of current call center) dedicated to ACP Members in place by November 1, 2015 for Designated ACP Members (the "HCA Designated Contact Center").

The HCA Designated Contact Center will be integrated with the ACP Program Providers, have extended hours of operation (Monday through Saturday 6:30am-8:00pm Pacific Time; Sunday 8:00am-5:00pm Pacific Time[1]) and have the following services:

i) Appointment scheduling weekdays (centralized or warm transferred), referral coordination and system navigation support

ii) Triage capabilities to a 24/7 nurse line or elsewhere as appropriate;

iii) Access to on-line prescription refill request through EHR;

iv) Additional triage capabilities to other Plan Suppliers, as specified in the Contract; and

v) Administrative issue resolution (i.e., website functionality to remind ACP Members who have forgotten their web portal log in, etc.).

(b) HCA Dedicated Contact Center Advocates. HCA Designated Contact Center advocates will have customer service experience in a health care or health insurance environment and will provide the following essential functions:

i) Receive, research and process queries and information from ACP Members to determine needs/wants and ensure their issues are resolved;

ii) Analyze inquiries and determine path to be taken to respond in a prompt and accurate manner; and

iii) Demonstrate flexibility in meeting ACP Member needs including addressing deviations from normal practices or procedures.

iv) Use an escalation process with the ability for a warm transfer to the TPA of UMP.

(c) HCA Dedicated Contact Center Performance Guarantees. Contractor shall meet the following monthly standard call center performance guarantees:

i) *Average speed of answer:* ≥ 80% of calls answered within thirty (30) seconds or less

ii) *Abandonment rate:* ≤ 5% of calls abandoned

iii) *First call resolution:* ≥ 90% of calls resolved during first call

(d) Website/Portal for Designated ACP Members. Contractor will have a well-functioning, customized HCA dual-branded, Member portal that provides access to the Designated ACP Member's EMR in place by November 1, 2015, with the following requirements:

i) The Phase I and Phase II requirements included in Exhibit 1.1;

[1] Such hours may be adjusted by mutual agreement. HCA's agreement shall not be unreasonably withheld.

ii) Updates electronically available ACP tools, that support decision-making on clinical options or provides information on how to access such tools through the ACP;

iii) Contractor will expand the portal to allow access from smart phones by January 1, 2017;

iv) Links to Plan Supplier websites, when they are available, for the Plan Suppliers included in Exhibit 6; and

v) Contractor will make best efforts to add newly subcontracted ACP Program Providers to the website/portal concurrent with the effective date of provider agreement which requires HCA's approval as described in Section 2.3(L) of this Contract.

(e) Member Access and Member Experience Reporting. Contractor will report on Member experience by ACP Program Provider annually each September. The report will include:

i) Adherence levels to each of the standards in Section (1)(b) and Section 2(c) of this Exhibit.

ii) An action plan for those areas where standards are not met.

iii) Evidence of compliance to Sections (2)(a), (2)(b),(2)(d) and (2)(e) of this Exhibit.

iv) A description of what is working particularly well within the ACP and what areas of improvement will be the focus over the next twelve (12) month period. Provider access results: (1) CG-CAHPS reporting including all additional questions measured and reported by the Washington Health Alliance (WHA) and (2) quarterly internal monitoring of patient access "time to appoint."

v) Contractor will also report quarterly per 2.3(G)). Contractor shall identify gaps in provider access and plans to resolve such gaps (Contractor will also report quarterly per 2.3(G)).

vi) By December 15 each year, update the original after-hours access information for primary care sites that was provided during original contract negotiations as related to Exhibit 1.3, 1(b).

29. Exhibit 1.4, 2017 Expansion is hereby included in the Contract to read as follows:

Contractor Pre-Launch Activities for 2017 Service Area Expansion

Acceptance of Deliverables

Upon receipt of a deliverable submitted by Contractor, HCA will have an initial period of ten (10) Business Days to review and evaluate the Deliverable for deficiencies. The HCA will provide written acceptance of the deliverable if it has no deficiencies.

If a deficiency is found, the HCA will notify the Contractor of any deficiencies in writing. Contractor will have five (5) Business Days to correct any deficiencies, unless a longer timeframe is mutually agreed to by the parties, and submit the corrected deliverable to HCA. Upon receipt of the corrected deliverable, HCA will have five (5) Business Days to review and evaluate the deliverable for deficiencies. This process will be repeated until the HCA provides written acceptance of the deliverable.

Once a deliverable has been accepted by HCA, the obligations described in the deliverable will be enforceable subject to HCA's rights and remedies contained in this Contract for Contractor's failure to perform.

June 15, 2016

1. Provide notice to HCA of new Partner Providers contracted for 2017 Expansion.
2. Provide to HCA an initial list of ACP Program Providers for the expansion counties including all components of the provider roster specifications provided by HCA. The specifications will include each provider's designation of an ACP for purposes of attribution.

June 30, 2016

1. Provide to HCA an updated list of ACP Program Providers for the expansion counties, including components of the provider roster specifications provided by HCA. The specifications will include each provider's designation of an ACP for purposes of Attribution.

July 15, 2016

1. Sign contracts with qualified member survey vendor(s) for expansion counties or provide confirmation that current vendor will serve expansion counties.
2. For Partner Providers in expansion counties, provide proof of signed Partner Provider Agreements, or provide proof of existing contracts, with Partner Providers listed in Exhibit 4.1 that contain terms and conditions in Exhibit 4.2.

3. For ACP Program Providers in expansion counties, signed letters of intent for ACP Program Providers to actively join and participate in the following Foundation for Health Care Quality (FHCQ) programs: COAP, Spine SCOAP and OB COAP.

July 31, 2016

1. Provide to HCA a final updated list of ACP Program Providers for the expansion counties including components of the provider roster specifications provided by HCA. After providing the final provider roster, ACP will use the Change Roster process to update HCA with ACP Program Providers.

August 31, 2016

1. Update HCA Designated Contact Center to include ACP Program Providers in Expansion Counties.
2. Update HCA dedicated customized website/portal for Designated ACP Members to include ACP Program Providers in Expansion Counties.
3. For expansion counties, confirm that previous CG CAHPS methodology and sampling plan applies to expansion counties. If not, resubmit CG-CAHPS methodology and sampling plan, and plan for reporting on access and timeliness metrics. Submit specific details (i.e., data sources, measurement period, etc.) for each report listed in Section 2.3(G) to be finalized by the HCA and Contractor.

September 30, 2016

1. Provide HCA with a plan to integrate new providers into ongoing care transformation activities as described in Exhibit 1.2.
2. For providers in expansion counties, submit report on ACP clinic status on achieving Patient Centered Medical Home (PCMH) equivalency to 2011 National Committee for Quality Assurance (NCQA) PCMH Level III standards (identify number and percentage of clinics with seven (7) or more primary care clinician equivalents and their status in achieving 2011 NCQA PCMH accreditation equivalency, including clinics that are on the path to achieve Level III accreditation).

November 1, 2016

1. Phase II – HCA dedicated customized portals.
    a. The website/portal for Designated ACP Members must include the following functionality:
        i. All Phase I functionality
        ii. Online welcome kit
        iii. Administrative support for ACP Members using site (i.e., navigation and website issues)
        iv. Links to agreed-upon cost and quality websites
    b. The ACP Program Provider will have an electronic health record and/or patient portal, which must include the following functionality:

i. User login
ii. Registration for access to a patient's electronic patient health records (i.e. MyChart)
iii. Appointment scheduling requests, where available
iv. Secure messaging with ACP Program Providers
v. Prescription refills
vi. Administrative support for ACP Members using site (i.e., password reset, navigation, and website issues)

In circumstances where an ACP Program Provider does not currently have an electronic health records and/or patient portal that contains all the requirements in subsection 1(b), Contractor shall demonstrate progress of the ACP Program Provider toward meaningful use adoption or provide rationale to HCA for why participation of the provider as a contracted ACP Program Provider is appropriate. The date of measurement for progress for 2016 is December 31, 2107. Documentation of progress will be as agreed to by the Parties and may take the form of an email summarizing progress.

2. Phase II – HCA Designated Contact Center (staffed with experienced customer service representatives).
   Services must include the following:
   a. All Phase I services
   b. Integrated with all ACP Program Providers and clinics
   c. Extended hours of operation
   d. Support ACP Members with appointment scheduling (centralized or warm transfer)
   e. Triage and refer ACP Members to the 24/7 nurse line
   f. Triage and refer ACP Members to Plan Suppliers in Exhibit 6

30. Exhibit 2.1 is hereby struck in its entirety and replaced with Exhibit 2.1, HCA Pre-Launch Activities to read as follows:

For HCA to deliver any of the reports set forth below by the corresponding due date, Contractor must cooperate with HCA and any applicable Plan Supplier in a timely fashion and sign off on data formats for each report and other requirements. Notwithstanding anything in the Contract to the contrary, HCA will not be penalized for any report delivered past its due date if, despite diligent and good faith efforts, Contractor and HCA have been unable to agree on the report format and other applicable requirements.

May 22, 2015

1. Deliver provider roster specification template to ACP.

June 1, 2015

1. Initiate meetings with Contractor to discuss the vendors identified for integration, data and reporting requirements, HCA expectations of ACP care management model, and HCA expectations for Member experience.
2. Develop and share with Contractor a Communications Plan.

June 15, 2015

1. Deliver claims extract and supplemental reporting specifications template to ACP.

July 31, 2015

1. Finalize Member incentives for October 2015 open enrollment (through plan design and contributions).
2. HCA will provide Contractor with the Ancillary Provider List for Plan Year 2016.
3. Provide Contractor with initial statewide ancillary network. HCA will collaborate with the Contractor to determine changes to the statewide ancillary network. Changes shall be completed no later than August 31, 2016.

Tentatively August 1, 2015

1. Provide historical data feed to ACP's Data Intermediary reflecting claims incurred in Plan Year's 2012, 2013, and 2014, for members likely to be attributed to the ACP. The exact deadline for HCA to provide this data feed is within forty-five (45) calendar days of receipt of validated provider roster specifications from Contractor.

August 31, 2015

1. Direct the Plan Suppliers to begin to deliver to Contractor's Data Intermediary monthly claims files for medical and pharmacy, assuming the appropriate Data Sharing Agreements have been executed.

September 30, 2015

1. Begin delivery of monthly attribution reports to Contractor.

October 31, 2015

1. Establish monthly supplemental reports by Plan Suppliers.
2. HCA loads final statewide ancillary network.

November 30, 2015

1. Establish PCMH target percentages for 2016.

31. Exhibit 2.5 – HCA Pre-Launch Activities for 2017 Service Area Expansion is hereby included in the Contract to read as follows

For HCA to deliver any of the reports set forth below by the corresponding due date, Contractor must cooperate with HCA and any applicable Plan Supplier in a timely fashion and sign off on data formats for each report and other requirements. Notwithstanding anything in the Contract to the contrary, HCA will not be penalized for any report delivered past its due date if, despite diligent and good faith efforts, Contractor and HCA have been unable to agree on the report format and other applicable requirements.

June 1, 2016

1. Provide summary of Member incentives for open enrollment performed in 2016 (through plan design and contributions) that are different from the prior year.

June 15, 2016

1. Develop and share with Contractor a Communications Plan.

July 31, 2016 (or within one week of approval by the PEB Board, whichever is later)

1. Finalize Member incentives for the open enrollment performed in 2016 (through plan design and contributions).
2. Provide Contractor with initial statewide ancillary network. HCA will collaborate with the Contractor to determine changes to the statewide ancillary network. Changes shall be completed no later than August 31, 2016.

August 31, 2016

1. Direct the Plan Suppliers to begin to deliver to Contractor's Data Intermediary monthly claims files for medical and pharmacy in the expanded counties, assuming the appropriate Data Sharing Agreements have been executed.
2. HCA finalizes changes to statewide ancillary network, including memorializing any agreed-upon suppression of certain providers.

October 31, 2016

1. Establish PCMH target percentages for new geographic regions.
2. HCA loads final statewide ancillary network.

November 30, 2016

1. Establish PCMH target percentages for 2016.

32. Exhibit 3.3 is hereby struck in its entirety and replaced with Exhibit 3.3 Financial Terms to read as follows:

1. General

1.1. Accounting of Allowed Amounts and Considered Amounts

After the close of each Performance Year, HCA shall perform a complete accounting of the aggregate Allowed Amounts for the Designated Cohort for a Performance Year by comparing the Aggregate Considered Amounts to the Aggregate Target Cost to determine if there is either Gross Savings or a Gross Deficit and to calculate the resulting Net Savings or Net Deficit. The Financial Reconciliation shall be calculated on a PMPM basis using claims incurred during the Performance Year with a three (3) month claims run out period during the following Plan Year without adjustment for claims incurred but not paid. With the exception for the accounting and calculation of Gross Deficits, the same process will be followed for the Attributed Cohort.

Considered Amounts will be adjusted for individual Members with Allowed Amounts over $[redacted] in a Plan Year. Allowed Amounts in excess of $[redacted] will have [redacted] excluded from Financial Reconciliation and [redacted] included in the Financial Reconciliation as a Considered Amount up to $[redacted] in total Allowed Amounts. All Allowed Amounts in excess of $[redacted] will be excluded from the Financial Reconciliation. Considered Amounts will also exclude from Financial Reconciliation Allowed Amounts pertaining to episodes of care for the following procedure codes for [redacted] costs that are not performed at either a Partner Provider or an Affiliate Provider:

[redacted]

The Parties will need to agree on a reasonable method of excluding [redacted] when performed by Ancillary Providers from Financial Reconciliation.

If for some reason the procedure codes representing [redacted] are modified over the course of the Contract, the parties will meet and HCA will determine whether to use the aforementioned list or substitute a new or modified procedure code list for [redacted] The intent of this procedure code list is to capture those services which are performed at Centers of Excellence.

It should be noted that by definition Members excludes all those identified with end-stage renal disease. Considered Amounts do not include Allowed Amounts for beneficiaries when UMP is the secondary payor.

1.2. Assignment of Plan Year Allowed Amounts

For Covered Services spanning more than one (1) day, the Allowed Amounts will be assigned to a Plan Year based on the day of admission, or first day of service.

2. Financial Reconciliation

2.1. Pre-Launch

The parties will use best efforts to complete their respective obligations to provide the data elements (including collection and reporting of complete Quality Measures pursuant to Exhibit 5) required to complete a test Financial Reconciliation for 2015. No party will have any financial obligations to the other party based on the results of this test Financial Reconciliation for 2015.

2.2. Determining Adjusted Base Costs PMPM.

For each Performance Year, the Unadjusted Base Cost PMPM will be calculated separately for each Cohort. In order to account for changes in the risk status of ACP

Members from the Base Year to the Performance Year, the Unadjusted Base Cost PMPM will be multiplied by the ratio of the Performance Year Risk Score to the Base Year Risk Score to calculate the Adjusted Base Cost PMPM. In the calculation of Risk Scores the diagnosis codes associated with all Considered Amounts will be processed through the Risk Model.

2.3. Determining Aggregated Target Costs

The Target Cost PMPM for each Performance Year will be equal to the Adjusted Base Cost PMPM, multiplied by Benchmark Trend Rates and Annual Trend Guarantee Rates from the Base Year to the Performance Year. The adjustments will apply separately to the Attributed and Designated Cohorts. Illustrative values for components of the Benchmark trends are displayed below in Table 2.3(a) with the final values being calculated during the Financial Reconciliation process. The Aggregate Target Costs are calculated on a multiplicative basis for the values determined in each Performance Year as the Target Cost PMPM multiplied by the Performance Year Member Months.

The Benchmark Trend Rates will consider two components:

(a) Benchmark PEBB Trend Rates will be the risk adjusted Performance Year Considered Amount PMPM for all Members who are not Designated ACP Members (across all ACP systems) during the Performance Year divided by the risk adjusted Base Year Cost PMPM for all Base Year Members who are not Designated ACP Members (across all ACP systems) during the Performance Year. This will be the sole component of the Benchmark Trend Rates until the Designated enrollment (across all ACP systems) exceeds [redacted] of all Members.

(b) Benchmark S&P Trend Rates will be averaged with the Benchmark PEBB Trend Rates for all prior years once the Designated enrollment exceeds [redacted] of the total population.

Table 2.3(a)

	ILLUSTRATION of Benchmark Trend Rates		
	Designated Cohort Percentage	Hypothetical Benchmark PEBB Trend Rates	Hypothetical S&P Trend Rates
2015	[redacted]	n/a	n/a
2016	[redacted]	[redacted]	[redacted]
2017	[redacted]	[redacted]	[redacted]
2018	[redacted]	[redacted]	[redacted]
2019	[redacted]	[redacted]	[redacted]

In addition to the application of Benchmark Trend Rates, the Annual Trend Guarantee Rates from the Base Year to the Performance Year will be applied to the Aggregate Adjusted Base Cost. Using the Annual Trend Guarantee Rates in Table 2.3(b) below, the 2018 Target Cost PMPM will be equal to the Adjusted Base Cost PMPM multiplied by [redacted] * [redacted] * [redacted] * [redacted] which equals [redacted]. For 2019 the Target Cost PMPM will be equal to the Adjusted Base Cost PMPM multiplied by [redacted] * [redacted] * [redacted] * [redacted] * [redacted] which equals [redacted]

Table 2.3(b)

	Contractor Annual Trend Guarantee Rates	
	Designated Cohort	**Attributed Cohort**
2015	**Adj Base Cost PMPM**	**Adj Base Cost PMPM**
2016	[redacted]	
2017		
2018		
2019		

2.4. **Benefit Design Changes.** HCA agrees to provide Contractor notice of proposed material changes in benefit plan design and discuss the financial impact on Contractor's performance or other concerns.

3. Net Savings and Net Deficits

Contractor shall be eligible to share in up to [redacted] of Gross Savings with HCA and the Contractor shall be responsible for up to [redacted] of Gross Deficits as set forth as follows:

3.1. Calculation of Net Savings and Net Deficits

Contractor shall be eligible to share savings with HCA if the Aggregate Considered Amount is less than the Aggregate Target Cost during the Performance Year, resulting in Gross Savings. Alternatively, for the Designated Cohort, the Contractor will be financially responsible for some or all of the resulting Gross Deficit if the Aggregate Considered Amount exceed the Aggregate Target Cost during the Performance Year. The quality improvement model in Exhibit 5 will calculate the Savings Share and Deficit Share. Net Savings are calculated by multiplying the Gross Savings by the Savings Share. Net Deficits are calculated by multiplying the Gross Deficit by the Deficit Share.

3.2. Separate Calculations for Each Cohort

The Gross Savings for each Performance Year shall be calculated for the Designated Cohort and a separate calculation of Gross Savings will be made for the Attributed Cohort. The Gross Deficit shall be calculated for the Designated Cohort only. Examples of calculations are within Exhibit 3.4. The overall Quality Improvement Score will be the same for all Cohorts. Examples of the Quality Improvement Score are within Exhibit 5.

3.3. Calculation and Payment of Net Savings and Net Deficits

Net Savings or Net Deficits obligations of the Parties will be paid in accordance with the provisions of Sections 2.7, 2.8 and 2.10 of this Contract and this exhibit.

33. Exhibit 5 Quality Achievement Measurement Program is hereby modified by striking Table 1 and replacing Table 1 as follows:

Table I.

Quality Measure	Quality Measure Description	Weight	Target	Mean
NQF 0059	1-Diabetes patients with A1C>9.0%	[redacted]		
NQF 0061	Diabetes patients with BP<140/90			
NQF 0055	Diabetes patients with eye exam			
NQF 0018	HTN patients with BP<140/90			
HEDIS	CAD Statin prescribed			
NQF 0541	CAD Statin adherence			
NQF 0105	Depression Medication Management (12 Weeks)			
NQF 0105	Depression Medication Management (6 Months)			
NQF 0005	Member satisfaction with Timely Care (always)			
NQF 0005	Member satisfaction with Provider Communication (always)			
NQF 0005	Member satisfaction with Office Staff (always)			
NQF 0005	Member satisfaction with Overall Provider Rating (9/10)			
HEDIS/NCQA	Adult BMI Measurement			
NQF 0038	Immunization (child - Combo 10)			

Quality Measure	Quality Measure Description	Weight	Target	Mean
NQF 0032	Cervical Cancer Screening	[redacted]		
NQF 0033	Chlamydia Screening			
NQF 2372	Breast Cancer Screening			
NQF 0034	Colorectal Cancer Screening			
NQF 0471	1-NTSV C-Section			

34. Exhibit 5, Attachment 1 is hereby modified by being struck in its entirety and replaced with Exhibit 5 Attachment 1 to read as follows:

CG-CAHPS: Member Experience Survey performed by Contractor

The Contractor will measure and report on the most current versions of the following four CG-CAHPS Composite Measures and supplemental questions:

1. Getting Appointments and Health Care When Needed (Member Satisfaction w/Timely Care)

This is a composite measure of five CG-CAHPS survey questions asking the Member to respond with "Always, Usually, Sometimes, or Never". The metric reports on the percentage a Member responds "always".

Question 6: Received appointments when needed for care needed right away

Question 8: Received appointments when needed for routine care

Question 10: Received answers to questions as soon as needed when calling during office hours

Question 12: Received answers to questions as soon as needed when calling after office hours

Question 13: Saw provider within 15 minutes of appointment time

2. How Well Providers Communicate

This is a composite measure of six CG-CAHPS survey questions asking the Member to respond with "Always, Usually, Sometimes, or Never". The metric reports on the percentage Members respond "always".

Question 14: Provider explained things in a way that was easy to understand

Question 15: Provider listened carefully to you

Question 17: Provider gave easy to understand information about health questions or concerns

Question 18: Provider seemed to know important information about medical history

Question 19: Provider showed respect for what you had to say

Question 20: Provider spent enough time with you

3. Courteous and Helpful Office Staff

This is a composite measure of two CG-CAHPS survey questions asking the Member to respond with Always, Usually, Sometimes, Never. The metric reports on the percentage Members responding “always”.

Question 24: Clerks and receptionists were helpful

Question 25: Clerks and receptionists treated you with courtesy and respect

4. Overall Provider Rating

This measure reflects patient responses to a single CG-CAHPS survey question in which patients were asked to rate the provider.

Question 23: The metric reports on the percentage of those who rated the provider either a 9 or 10 (on a scale of 0 to 10).

5. Supplemental CG-CAHPS Questions

The Contractor will be responsible for measure and reporting the most current versions of all CG-CAHPS supplemental questions selected by the Washington Health Alliance, starting in 2016.

All other terms and conditions of this Contract remain in full force and effect