Molina Healthcare of Texas, Inc.

2023 Primary Care Provider Pay-For-Quality Bonus Program

I. PCP P4Q Bonus Program Overview.

Molina Healthcare of Texas, Inc. ("Health Plan") is committed to supporting primary care providers ("PCPs"), and specialists serving as PCPs, efforts to provide the highest quality of care for Health Plan Members.

Health Plan's Primary Care Provider Pay-for-Quality Bonus Program ("PCP P4Q Program") is a quality bonus payment program that recognizes Eligible Providers who demonstrate the best quality of care for Health Plan Medicaid PCP P4Q Program Members ("PCP P4Q Program Members"). This PCP P4Q Program is being implemented in accordance with the provision in your Provider Services Agreement ("Agreement") titled "Quality Bonus Payment Program" or equivalent section thereof. All provisions in the Agreement will apply. If there is a conflict between this PCP P4Q Program and any other provision in the Agreement, the provisions in the PCP P4Q Program will control for the PCP P4Q Program.

The objective of this PCP P4Q Program is to reward Eligible Providers for their efforts in providing high-quality care to PCP P4Q Program Members to support optimal care coordination, treatment planning, improved quality outcomes and referrals to specialists or other resources. It is also designed to assist in identifying Members who could potentially benefit from case management or other programs. Our PCP P4Q Program Members benefit from this PCP P4Q Program by receiving more regular and proactive assessments to ensure proper preventive care and care management.

The PCP P4Q Program achieves this goal by: (1) increasing PCP visibility into assigned PCP P4Q Program Members' existing medical conditions for better quality of care for care management; (2) ensuring PCP P4Q Program Members receive the preventive services that are needed; (3) appropriately rewarding PCPs based on quality performance results in the Quality Measures and benchmarks listed in Table 1; and appropriately rewarding PCPs based on administrative measures outlined in Table 2.
The Quality Measures are consistent with Program Year NCQA, HEDIS®, and Medicaid national quality performance standards.

II. Definitions.

Capitalized terms used in this PCP P4Q Program will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this PCP P4Q Program.

A. **Administrative Data** means healthcare data captured in industry standard, structured formats such as claims data, inclusive of Current Procedural Terminology ("CPT") II and Social Determinant of Health ("SDOH") Z codes, encounters, or relevant clinical documents shared in Clinical Document Architecture ("CDA"), Continuity of Care Document ("CCD"), or Consolidated Clinical Data Architecture ("CCDA") format.

B. **Administrative Measures** mean additional measures to reward PCPs for delivering improved access to care and providing additional services to PCP P4Q Program Members as outlined in Table 2.
C. **Admission, Discharge, Transfer** ("ADT") means an event that occurs when an PCP P4Q Program Member is admitted to, discharged from, or transferred from one care setting to another care setting or to the PCP P4Q Program Member's home. For example, an ADT event occurs when an PCP P4Q Program Member is discharged from a hospital and sent home. An ADT event also occurs when an PCP P4Q Program Member arrives in a care setting such as a health clinic or hospital.
D. **ADT Notification** means an electronic notification that an PCP P4Q Program Member has undergone an ADT event.
E. **Applicable Member** means a PCP P4Q Member that meets the inclusion criteria for a specific Quality Measure.
F. **Bonus** means a bonus payment an Eligible Provider may be eligible to receive if the PCP P4Q Program requirements are met. A bonus will be paid for each Quality Measure that the Eligible Provider qualifies for.
G. **Eligible Provider** means the assigned primary care provider ("PCP"), or specialist serving as a PCP, for a PCP P4Q Program Member, who has an active Agreement with Health Plan. PCP's who are in practice together using the same tax identification number with an active Agreement with Health Plan are considered a PCP group and Eligible Providers.
H. **HEDIS®** means the Healthcare Effectiveness Data and Information Set.
I. **NCQA** means the National Committee for Quality Assurance.
J. **PCP P4Q Program Member** means a Member enrolled with the Health Plan, is linked through assignment or attribution to an Eligible Provider and qualifies for one or more Quality Measures.
K. **Program Year** means January 1, 2023, through December 31, 2023, and is the performance period for which Quality Measures for applicable PCP P4Q Program Members will be evaluated and each Bonus payment calculation is performed and processed by Health Plan.
L. **Provider Direct Scheduling** is a program offered by Health Plan to Eligible Providers for Health Plan to gain access to Eligible Provider's scheduling system for the purpose of scheduling appointments for the PCP P4Q Program Member.
M. **Quality Measure** means the measures that are being evaluated as part of the PCP P4Q Program and that are listed in Table 1.

III. General Guidelines to be an Eligible Provider.

In addition to the definition of Eligible Provider, the Eligible Provider must meet the following requirements to be considered an Eligible Provider:

A. PCPs must be the assigned Eligible Provider for PCP P4Q Program Members included in the PCP P4Q Program.

B. To remain eligible for any Bonus payment under the PCP P4Q Program, Eligible Provider must have an active Agreement with Health Plan, be in compliance with their Agreement and be a Participating Provider with Health Plan at the time the Bonus payment under the PCP P4Q Program is issued to Eligible Provider, as determined by Health Plan.

IV. Health Plan Responsibilities.

A. Health Plan will supply the Eligible Provider with a list of its PCP P4Q Program Members, which includes the identification of needed Quality Measures for Applicable Members through the Provider Portal.

B. Beginning each Program Year, Health Plan will select the applicable Quality Measures, requirements, and benchmarks to be included in the PCP P4Q Program that have the most direct impact on CMS and/or Payor Contract HEDIS® required measures. Health Plan will use best efforts to finalize the Quality Measures thirty (30) days prior to the start of each Program Year. If Eligible Provider has the minimum number of Applicable Members for at least one Quality Measure, Eligible Provider will automatically be considered as participating in the PCP P4Q Program.

C. The Parties acknowledge future Laws may require changes to the PCP P4Q Program. Additionally, changes to the PCP P4Q Program may be required by a Government Agency. If a change occurs, Health Plan agrees to provide notice of the change to Eligible Provider. Health Plan will use best efforts to minimize the impact of the change to the PCP P4Q Program.

V. Eligible Provider Responsibilities and Payment.

A. Eligible Providers may be eligible for a Bonus for each Quality Measure if: (1) the minimum number of Applicable Members is met for each Quality Measure, as listed in Table 1; (2) the Eligible Provider achieves the NCQA Medicaid HMO percentile or applicable Health Plan supplied benchmark as set forth in Table 1 for the Quality Measure; (3) achievement of administrative measures as set forth in Table 2 for the Administrative Measures; and (4) all other requirements of the PCP P4Q Program are met. Eligible Provider will be paid for the highest percentile they achieve for all Applicable Members and will not be paid for all percentiles. For example, if Eligible Provider achieves the 90th percentile, they will receive the applicable Bonus payment for the 90th percentile for all Applicable Members for the Quality Measure and not for any other percentiles. A Bonus is only paid for Applicable Members for each Quality Measure.

B. Each Quality Measure is evaluated independently.

C. For Administrative Measures, please contact your Molina Provider Relations Representative to discuss how you will receive credit for achievement of the Administrative Measures outlined in Table 2 below.

D. All HEDIS® measures follow the Program Year HEDIS® technical specifications and requirements.

E. Eligible Provider will submit Administrative Data within thirty (30) days of the Date of Service, but in no event later than one (1) month following the end of Program Year. For example, if the

Program Year is January 1, 2023, through December 31, 2023, Eligible Provider must submit Administrative Data by January 31, 2024. Eligible Provider recognizes and agrees that untimely submitted Administrative Data may be excluded from the Program Year PCP P4Q Program and its calculations.

F. Health Plan may request additional documentation such as medical records if unable to verify information for Applicable Members using Administrative Data.

G. Data Sharing.

a. Eligible Provider shall deliver all relevant clinical documents electronically in a format stated in the Provider Manual or otherwise agreed to by Health Plan.
b. Eligible Provider will also enable ADT Notification feed in a format stated in the Provider Manual or otherwise agreed to by Health Plan for all health care events for PCP P4Q Program Members to the interoperability vendor designated by Health Plan.
c. Eligible Provider will participate in Health Plan's program to communicate clinical information using the format stated in the Provider Manual or otherwise agreed to by Health Plan.
d. Eligible Provider agrees to grant Health Plan remote access to the Electronic Medical Record ("EMR") for the purpose of HEDIS data collection and to support successful performance in the program.
e. Eligible Provider's mechanism for exchanging health information will comply with the Health Insurance Portability and Accountability Act ("HIPAA") and will be approved by the Office of the National Coordination of Health Information Technology ("ONC").

H. Earned Bonuses are paid to the Eligible Provider that is on record as the assigned provider for the PCP P4Q Program Member as of the end of the Program Year.

I. Earned Bonus payments will be made based on the current Tax ID information on file for the Eligible Provider. Per the Agreement, it is the Eligible Provider's responsibility to ensure that W-9 information is current with Health Plan prior to any Bonus payment distribution.

J. Health Plan will use reasonable efforts to distribute the final earned Bonus to Eligible Providers within seven (7) months, following the completion of the Program Year.

K. PCP P4Q Program Members are identified at the beginning of the Program Year and PCP P4Q Program Members are subject to change in future programs.

VI. Additional Conditions.

Additional conditions for Eligible Provider to receive a payment under this PCP P4Q Program are:

A. If Eligible Provider wishes to not participate in the PCP P4Q Program, Eligible Provider must notify Health Plan within thirty (30) days of receipt of this PCP P4Q Program.

B. The PCP P4Q Program is discretionary and may be modified or cancelled at any time and for any reason by Health Plan. Health Plan will have sole discretion in determining whether the PCP P4Q Program requirements are satisfied, and the earned Bonus will be made solely at Health Plan's discretion. There is no right to appeal any decision made in connection with this PCP P4Q

Program. Health Plan reserves the right to modify the PCP P4Q Program at its sole discretion and if the PCP P4Q Program is revised, Health Plan will send a notice to Eligible Provider by email or other means of notice permitted under the Agreement.

C. Eligible Provider's Agreement with Health Plan must have an effective date before the start of the PCP P4Q Program Year and remain active as of the end of the PCP P4Q Program Year and at the time any earned Bonus is distributed.

D. Any Bonus earned through this PCP P4Q Program will be in addition to the compensation arrangement set forth in Eligible Provider's Agreement, as well as any other Health Plan bonus program in which Eligible Provider may participate. At Health Plan's discretion, Eligible Providers who have a contractual or other quality arrangement with Health Plan, either directly or through another agreement, may be excluded from participation in this PCP P4Q program. For the avoidance of doubt, in no event will Eligible Provider be compensated twice for performing the same services and Eligible Provider will choose which quality program to participate in.

E. Health Plan reserves the right to fully or partially withhold the payment of any Bonus that may have otherwise been paid to Eligible Provider to the extent such Eligible Provider has received or retained an Overpayment, including any money to which Eligible Provider is not entitled. In the event Health Plan determines that Eligible Provider has received an Overpayment, Health Plan may offset any Bonus that may have otherwise been paid to Eligible Provider against the Overpayment, pursuant to the Offset provision or equivalent section(s) thereof, in the Agreement.

F. Quality Measure performance results must be substantiated by qualifying Current Procedural Terminology ("CPT") and International Classification of Diseases, Tenth Revision ("ICD-10") codes as defined by Program Year HEDIS® technical specifications and requirements.

Table 1: Quality Measures and Bonus Amounts

Quality Measure	Minimum # of Applicable Members	NCQA Medicaid HMO Percentile Benchmark			Bonus Per Member		
		Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
IMA Combination 2 – CHIP only	10	90th	95th	NA	$5	$10	NA
CCS – STAR+PLUS only	10	66th	75th	90th	$10	$15	$25
HBD – STAR+PLUS only	10	66th	75th	90th	$15	$25	$50
CIS – STAR and CHIP only	10	50th	66th	75th	$10	$20	$40
PPC- Prenatal – STAR only	10	90th	95th	NA	$15	$25	NA
PPC – Post Partum – STAR Only	10	66th	75th	90th	$15	$25	$50
URI – CHIP only	10	66th	75th	90th	$5	$10	$20
W30 – 0 to 15 months - STAR and CHIP only	10	66th	75th	90th	$5	$10	$20

Table 2: Administrative Measures and Bonus Amounts

Administrative Measure	Description of Measure	Bonus Amount
PCMH Certification	Provider achieves and maintains PCMH certification for the Program Year	$1,000 per year per practice
After Hours Appointment Availability	Provider offers appointment times to Members after normal business hours (8 am to 5 pm M - F) throughout the Program Year	$100 per year per provider

Open Panel	Provider maintains open panel status throughout the Program Year. Health Plan will perform random secret shopper surveys to ensure compliance.	$250 per year per provider
EHR Access	Provider allows access by Health Plan of EHR records to assist Health Plan in HEDIS gap closures	$500 per year per practice
Z code submission	Provider demonstrates a year over year improvement of X % in the submission of Z codes on claims	$1 per claim
Oral Evaluations and Fluoride Varnish	Provide Texas Health Steps dental care for children ages 6 to 35 months old	$10 per claim
Provider Direct Scheduling	Provider participates in Health Plans program for Provider Direct Scheduling	$5,000 per year per practice