DIRECT CONTRACTING ENTITY
PARTICIPANT PROVIDER AGREEMENT

This Direct Contracting Entity Participant Provider Agreement ("**Agreement**") is by and between [Practice/Provider Legal Name] ***or*** [Parent Legal Name, on behalf of itself and its subsidiaries and affiliates set forth on Schedule 1] ("**Provider**"), and Accountable Care Coalition of Southeast Texas, Inc. ("**DCE**"). Provider and DCE may be referred to herein individually as a "Party" and collectively as the "Parties." This Agreement, effective January 1, 2022 ("**Effective Date**"), allows Provider to participate in DCE's network of participant providers and suppliers, according to the terms of DCE's agreement ("**CMS Agreement**") with the Center for Medicare & Medicaid Innovation within the Centers for Medicare & Medicaid Services (collectively "**CMS**") for the Direct Contracting Model ("**Direct Contracting Model**") created under CMS' waiver authority under Section 1115A of the Social Security Act (the "**Act**").

DCE and Provider agree as follows:

1. **Definitions.** Capitalized terms not defined herein shall have the meanings ascribed to such terms in the CMS Agreement.

a. **"Beneficiary"** means an individual who is properly enrolled in fee-for-service ("**FFS**") Medicare and is aligned with the DCE by CMS.

b. **"Covered Services"** means the scope of health care benefits described in Sections 1812 and 1832 of the Act for which payment is available under Part A or Part B of Title XVIII of the Act.

c. "**Participant Provider**" means an individual or entity that: (1) is a Medicare- enrolled provider or supplier (as described in 42 C.F.R. § 400.202); (2) is identified on the DCE's list of Participant Providers by name, individual National Provider Identifier ("**NPI**"), tax identification number ("**TIN**"), Legacy TIN or CMS Certification Number ("**CCN**") (if applicable); (3) bills for items and services it furnishes to Medicare FFS beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations; (4) is not a Preferred Provider nor a Prohibited Participant (as defined below); and (5) has agreed to participate in the Direct Contracting Model pursuant to a written agreement with the DCE.

d. "**Practice Provider**" means any physician or other licensed health care provider who is employed by or who is contracted with Provider and who has agreed to provide Covered Services under this Agreement and who bills for items and services furnished to Medicare FFS Beneficiaries under the Medicare billing number assigned to the TIN of Provider.

e. "**Preferred Provider**" means any physician or other licensed health care provider who (1) is a Medicare-enrolled provider (as defined at 42 C.F.R. § 400.202) or supplier (as defined in 42 C.F.R. § 400.202); (2) is identified on the DCE's list of Preferred Providers by name, NPI, TIN, Legacy TIN or CCN (if applicable); (3) bills for items and services it furnishes to Medicare FFS beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations; (4) is not a Participant Provider nor a Prohibited Participant (as defined below); and (5) has agreed to participate in the Direct Contracting Model pursuant to a written agreement with the DCE.

2. **Provider Services**. Provider agrees to be a Participant Provider and to require Practice Providers to furnish all Medically Necessary Covered Services to Beneficiaries that are within the scope of the Practice Provider's license and qualifications. All Covered Services shall be provided in accordance with all applicable provisions of law, all applicable generally accepted professional standards, and the terms of this Agreement.

3. **Delegation**. DCE or its designee may, but is not obligated to, delegate certain administrative services such as care coordination, provider relations, or other functions or services necessary or desirable by DCE to fulfill the DCE's mission. Any such delegation shall be set forth in a signed addendum to this Agreement.

4. **Schedules and Exhibits.** **Schedule 1**, Provider Subsidiaries and Affiliates; **Exhibit A**, Standard Terms and Conditions; **Exhibit B,** CMS Requirements; **Exhibit C**, Business Associate Addendum; **Exhibit D**, Provider Performance Standards; **Exhibit E,** Compensation; **Exhibit F,** Form of Direct Contracting Model: Fee Reduction Agreement; **Exhibit G,** Quality Incentive Program; and **Exhibit H,** Care Coordination Compensation are attached hereto and incorporated herein. Provider expressly agrees to comply with the terms of Exhibits A, B, C, D, E, F, G and H.

5. **Compensation**. DCE shall compensate Provider for Covered Services rendered by Provider and Practice Providers to Beneficiaries under this Agreement in accordance with Exhibit E hereto. Provider acknowledges and agrees that Provider and Practice Providers may receive reduced or no payment from CMS separate from what Provider and Practice Providers receive from DCE for the provision of certain Covered Services, as further described in the form of Direct Contracting Model: Fee Reduction Agreement attached hereto as Exhibit F.

6. **Shared Savings and Shared Losses**. All expenses incurred for Covered Services furnished to Beneficiaries, including the monthly cash flow received by the DCE through its selected Direct Contracting Model Payment Mechanism, will be compared against the DCE's Performance Year Benchmark to determine savings and losses. DCE may earn shared savings ("**Shared Savings**"), or be required to repay shared losses resulting from an excess in expenditures over DCE's Performance Year Benchmark ("**Shared Losses**") depending on the DCE's performance. Following receipt of any Shared Savings or notice of obligation to repay Shared Losses from CMS, DCE's governing body ("**Governing Body**") shall determine whether, to what extent, and in what manner to distribute any Shared Savings to, or to impose any Shared Losses repayment obligation on, Provider. DCE will bare responsibilities for downside losses. At no time is the provider required to pay any sums related to payment made by the DCE to CMS for healthcare expenditures above the Performance Year benchmark, otherwise known as "downside risk" or shared losses. DCE and Provider acknowledge that the opportunity to receive Shared Savings will encourage Provider to adhere to the quality assurance and improvement program and evidence-based medicine guidelines established by DCE.

7. **Care Coordination Activities.** Provider shall, and shall ensure its Practice Providers engage in the care management of Beneficiaries in accordance with the terms of this Agreement, including the activities set forth in Exhibit H. In connection with such care management activities, Provider shall be eligible for care coordination-related payments in accordance with Exhibit H.

IN WITNESS WHEREOF, the foregoing Agreement between DCE and Provider is entered into exclusively by and between the undersigned parties executed by their duly authorized representatives, to be effective as of the date first written above. By signing below, Provider acknowledges receipt of a copy of the CMS Agreement [and to the extent applicable, a copy of the 3-Day SNF Rule Waiver].

DCE

Authorized Signature: _____

Printed Name: _____

Title: _____

Date: _____

Address for Notices:

_____

_____

_____

PROVIDER

Authorized Signature: _____

Printed Name: _____

Title: _____

Date: _____

Specialty: _____

County: _____

Phone: _____

DBA (if applicable): _____

Address for Notices:

_____

_____

Attn: _____

Participant TIN/SSN: _____

(as shown in PECOS and/or Addendum 2)

SCHEDULE 1
PROVIDER INFORMATION

A. The following affiliates and subsidiaries of Provider are incorporated into this Agreement:

B. The following TINs are incorporated into this Agreement:

C. The following NPIs are incorporated into this Agreement:

Practice Provider Name	E-mail Address	NPI	Specialty

C. The following office locations are incorporated into this Agreement:

Office Name	Address	State	ZIP

(Or See Attached Spreadsheet)

EXHIBIT A
DCE PARTICIPANT
STANDARD TERMS AND CONDITIONS

DCE and Provider agree as follows:

1. Provider Obligations.

a. Compliance with DCE Policies and Procedures. Provider agrees, and shall require Practice Providers to agree, to comply with all of DCE's applicable Policies and Procedures (as defined in Section 2 of **Exhibit B**) and with the Provider Performance Standards set forth at **Exhibit D**. DCE may amend the Policies and Procedures at any time, but will use reasonable efforts to provide notice at least thirty (30) days prior to the amendment effective date. The Parties agree that any Policies and Procedures necessary to effect compliance with laws do not require thirty (30) days' prior notice and shall be effective as stated in such notice.

b. Credentialing. Provider must be credentialed and eligible to participate in Medicare as an enrolled provider or supplier as defined at 42 C.F.R. § 400.202. Provider shall cooperate with DCE's credentialing process, including by timely submitting all information necessary for credentialing and recredentialing, as and when required under DCE's Policies and Procedures. Provider shall comply, and Provider shall ensure that its Practice Providers comply, with all aspects of such credentialing and re-credentialing Policies and Procedures.

c. Provider Availability. Provider shall ensure that Covered Services, when necessary, or when Practice Provider is otherwise absent, are available twenty-four (24) hours a day, seven (7) days a week.

d. Disciplinary Action. Subject to any limitations or restrictions imposed by law on Provider, Provider shall notify DCE within seven (7) days of Provider's actual knowledge, or awareness, of any of the following:

(i) any investigation or action taken by any governmental authority to restrict, suspend, sanction, or revoke Provider's, or any Practice Provider's, license, certification or other approvals (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of Medicare billing privileges) necessary to provide Covered Services;

(ii) any cancellation or material modification of Provider's general or professional liability insurance; or

(iii) any disciplinary action involving Provider, or any Practice Provider, by any administrative agency or accreditation body which directly relates to the provision of Covered Services, or any investigation of the same.

e. Referrals.

(i) Consistent with Section 1802(a) of the Act, neither DCE nor Provider nor other individuals or entities performing functions or services related to the Direct Contracting Model, shall commit any act or omission, nor adopt any policy, that inhibits Beneficiaries from exercising their freedom to obtain health services from providers and suppliers who are not Participant Providers or Preferred Providers. This prohibition shall not apply to referrals made by employees or contractors who are operating within the scope of their employment or contractual arrangement with the

employer or contracting entity, provided that the employees and contractors remain free to make referrals without restriction or limitation if a Beneficiary expresses a preference for a different provider or supplier, or the referral is not in the Beneficiary's best medical interests in the judgment of the referring party.

(ii) Provider shall use its best efforts to make referrals of Beneficiaries to Practice Providers and other providers/suppliers within the DCE in accordance with the voluntary referral policies established by DCE. Notwithstanding the foregoing, DCE, Provider and Practice Providers will not: (i) condition the participation in the DCE of providers, suppliers, or other individuals or entities performing functions or services related to DCE activities, on referrals of federal health care program business; or (ii) require that Beneficiaries be referred only to Practice Providers or other DCE providers/suppliers, except that the prohibition does not apply to referrals made by employees or contractors who are operating within the scope of their employment or contractual arrangement to the employer or contracting entity, provided that the employees and contractors remain free to make referrals.

(iii) Provider shall ensure that neither Provider nor Practice Providers give or receive remuneration in return for, or to induce or reward, any Federal health care program referrals or business generated outside of the Direct Contracting Model.

f. Financial Incentive Plans. If Provider and Practice Providers meet the requirements contained herein, Provider and/or Practice Providers may be entitled to a distributable amount of Shared Savings, if any after taking into account DCE expenses, as determined by DCE's Governing Body in accordance with the DCE's Bylaws. The distributable amount of Shared Savings, if any, will take into consideration a Provider and Practice Provider's individual performance, efficiency, attributed membership, and such other criteria as the DCE may reasonably determine; provided, however, Provider and Practice Providers shall not be entitled to any portion of Shared Savings if (i) this Agreement is terminated prior to the date distribution of Shared Savings are made; or (ii) Provider and/or Practice Providers are not in good standing with the DCE (e.g., under a corrective action plan or subject to other remedial action(s)). Notwithstanding the foregoing, in the event Provider or a Practice Provider receives from DCE a "**Financial Incentive**" (as defined under applicable law or DCE's Policies and Procedures) related to the performance of Provider's or Practice Provider's duties under this Agreement, Provider agrees that no payments shall be made directly or indirectly to Provider or any Practice Provider as an inducement to reduce or limit medically necessary services. Both Provider and DCE agree that an intended consequence of the Direct Contracting Model is to align and encourage Beneficiaries, Provider, and Practice Providers to adhere to the quality assurance programs, quality improvement programs, and evidence-based clinical guidelines adopted by the DCE.

g. Beneficiary Questions. Provider and each Practice Provider shall instruct Beneficiaries to call the DCE with questions about how to make changes to a Voluntary Alignment Form or how to designate a primary care clinician on MyMedicare.gov.

h. Medically Necessary Services. Provider shall make Medically Necessary Covered Services available to Beneficiaries in accordance with applicable laws, regulations and guidance. Beneficiaries and their assignees retain their right to appeal claims determinations in accordance with 42 CFR Part 405, Subpart I. Provider shall not take any action to avoid treating Beneficiaries or to target certain Beneficiaries for services for the purpose of trying to affect the population of Beneficiaries aligned to the DCE for a subsequent Performance Year.

i. Voluntary. Provider acknowledges that consent to participate in the Primary Care Capitation mechanism is voluntary and is not contingent on, or related to, receipt of referrals from the DCE, its Participant Providers or Preferred Providers.

j. Provider Rosters. Provider hereby authorizes DCE and CMS to include Provider's name and the name and likeness or photograph of each of its Practice Providers, and their office addresses, telephone numbers, credentials, areas of practice and willingness to accept new patients, in any roster of providers utilized by DCE or CMS including without limitation, those used for marketing and advertising purposes or with Beneficiaries or prospective Beneficiaries. Provider acknowledges and agrees that DCE shall be required to publicly report information regarding DCE's organizational structure, including identifying the Provider.

2. Provider Representations and Notification. Provider represents and warrants that:

a. Provider is a Medicare-enrolled provider (as defined at 42 CFR § 400.202) or supplier (as defined at 42 CFR § 400.202) as of August 14, 2020, or such other later date as may be specified by CMS;

b. Provider and each Practice Provider satisfy all eligibility and other criteria for participation set forth in the CMS Agreement;

c. Provider and each Practice Provider shall bill for items and services furnished to Beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations;

d. Provider is not a Preferred Provider;

e. Provider and each Practice Provider is not: (i) a Durable Medical Equipment, Prosthetics, Orthotics and Supplies supplier, (ii) an ambulance supplier, (iii) a drug or device manufacturer, or (iv) excluded or otherwise prohibited from participation in Medicare or Medicaid (a "**Prohibited Participant**");

f. Provider and each Practice Provider, if applicable, is currently, and for the duration of this Agreement shall remain, licensed, enrolled under the Medicare program, accredited or certified, as applicable, in accordance with the laws of the state in which such provider renders Covered Services;

g. Provider and each Practice Provider, if applicable, holds and shall maintain a current and valid federal Drug Enforcement Agency ("**DEA**") number where applicable;

h. Provider shall update its Medicare enrollment information (including the addition and deletion of individuals that have reassigned to the Provider their right to Medicare payment) on a timely basis in accordance with Medicare program requirements;

i. Provider shall give notice to DCE within thirty (30) calendar days in the event of any change in the following: (i) any and all demographic information contained in the Medicare Provider Enrollment, Chain, and Ownership System ("**PECOS**") with respect to Provider and each Practice Provider; (ii) the roster of Practice Providers participating in the DCE, including any addition of or termination of any Practice Provider or other individual or entity, that bills for items and services furnished to Medicare fee-for-service beneficiaries under a billing number assigned to the TIN of Provider; (iii) any information contained in Schedule 1 as well as phone number, business hours, licensure, certification, accreditation, Medicare or Medicaid qualification, medical staff privileges at either a participating or non-participating hospital, or DEA status; (iv) any Provider

representations or warranties in this Section 2; (v) any update to Provider's Medicare enrollment information (including, but not limited to, any addition of or termination of any Practice Provider billing through the TIN of Provider, or the addition and deletion of individuals that have realigned to the Participant Provider their right to Medicare payment), on a timely basis in accordance with Medicare program requirements; and (vi) the foregoing with respect to a Practice Provider. Provider and each Practice Provider shall ensure CMS is notified of any change to the Provider or a Practice Provider that is required to be reported in connection with participation in the Medicare program, within thirty (30) days of its occurrence;

j. Provider represents and warrants to DCE that neither Provider, Practice Provider, nor any of their respective Affiliates (for purposes of this Agreement, "**Affiliate**" means, with respect to a Party, an entity that, directly or indirectly, owns or controls, is owned or controlled by, or is under common ownership or control with such Party) are an Excluded Individual, as defined in Section 9 of **Exhibit B**;

k. Provider is authorized to act on behalf of its Practice Providers and shall provide, upon request, evidence of such authority. The Provider signatory to this Agreement is authorized to bind Provider and its Practice Providers to this Agreement;

l. Provider is prohibited from, and shall ensure Practice Providers are prohibited from, providing gifts or other remuneration to Beneficiaries as inducements for receiving items or services from, or remaining in, DCE or with DCE providers/suppliers in a particular DCE or receiving items or services from DCE participants or providers/suppliers; provided, however, Provider and Practice Providers may provide in-kind items or services to Beneficiaries if there is a reasonable connection between the items and services and the medical care of the Beneficiary and the items or services are preventive care items or services, or advance a clinical goal for the Beneficiary, including adherence to a treatment regime, adherence to a drug regime, adherence to a follow-up care plan, or management of a chronic disease or condition;

m. Provider and other individuals or entities performing functions or services related to DCE activities, including Practice Providers, are prohibited from directly or indirectly, committing any act or omission, or adopting any policy, that coerces or otherwise influences a Beneficiary's decision to complete or not complete a Voluntary Alignment Form or a MyMedicare.gov designation, such as: (i) completing a Voluntary Alignment Form on behalf of the Beneficiary, (ii) designating a clinician on MyMedicare.gov on behalf of the Beneficiary, (iii) including the Voluntary Alignment Form and instructions with any other materials or forms, including but not limited to materials requiring the signature of the Beneficiary, and (iv) withholding or threatening to withhold medical services or limiting or threatening to limit access to care.

n. Provider agrees to timely participation in all programs, processes, and requirements of DCE relating to Group Practice Reporting Option, Merit-based Incentive Payment System ("**MIPS**") or other similar programs as may be adopted by CMS from time to time. At the sole election of the DCE or its designee, Provider shall allow the DCE, or its designee (e.g., Collaborative Health Systems, LLC ("**CHS**")), access to any necessary medical records or documents, whether electronic or paper, relating to reporting requirements of the DCE. Provider agrees that access shall include, but is not limited to, an ability to independently access the appropriate sections of the Provider's electronic health record;

o. In order to support care coordination, Provider agrees that CHS is authorized to outreach to various facilities and other health care providers to identify any Beneficiaries or patients that are (a) associated with Provider; and (b) receiving services from such locations, facility(ies), or other health care providers. CHS will report to Provider each patient or Beneficiary identified and the

location where services are being rendered. This section will apply to patients associated with Provider who have original Medicare;

p. In order to fulfill care coordination requirements, Provider authorizes CHS to perform any and all necessary outreach to the attributed Beneficiaries. Provider further agrees that CHS may indicate that such outreach is done at the direction of, or on behalf of, the Provider or an individual Practice Provider.

q. Provider will promptly disclose to DCE the existence of any proceeding against any Practice Provider which involves any allegation of substandard care or professional misconduct raised against Practice Provider;

r. Provider shall comply with, and cause Practice Providers to comply with, that certain Data Use Agreement between DCE and CMS, if so required; and

s. Provider shall ensure that Provider and each Practice Provider that is an eligible clinician use certified electronic health record technology ("**CEHRT**") to document and communicate clinical care to their patients or other health care providers. For the purpose of this paragraph, the terms "eligible clinician" and "certified electronic health record technology" have the definitions provided at 42 C.F.R. § 414.1305. Provider shall also ensure that Provider and all Practice Providers comply with applicable federal regulations on interoperability and patient access, as referenced in the CMS Agreement.

3. DCE Representations and Notification. DCE's Governing Body is duly authorized to execute functions of the DCE pursuant to the CMS Agreement for the Direct Contracting Model and the Governing Body is comprised of and controlled in part by DCE participants, or their respective designated representatives. DCE's Governing Body provides meaningful participation in the governance of the DCE. The leadership and management structure (including administrative and clinical) of the DCE aligns with the DCE's mission and the goals of the Direct Contracting Model. Provider or a Practice Provider may be nominated to actively participate in the Governing Body or a subcommittee, and if such nomination is accepted, will serve in such capacity consistent with both the foregoing and the DCE's governing documents.

4. Term and Termination. As between the Parties, the term of this Agreement shall commence on the Effective Date; provided, with respect to the Direct Contracting Model and Provider's eligibility for a portion of Shared Savings, if any, CMS' acknowledgement of effective date shall control with respect to the same. Provider and each Practice Provider that bills under Provider affirmatively agree to participate with DCE under this Agreement for the duration of DCE's contract with CMS, including any renewals thereof. Without limiting the generality of the foregoing, except as provided for in this Agreement, Provider agrees to participate with DCE under this Agreement for all performance years under the Direct Contracting Model. Further, except as otherwise provided in this Section 4, the term of this Agreement shall terminate no later than December 31, 2026.

a. **Immediate Termination**. This Agreement may be terminated immediately for the following reasons:

(i) Insolvency. By either Party if the other commits an act of bankruptcy within the meaning of the bankruptcy, receivership, insolvency, reorganization, dissolution, liquidation or other similar proceedings under either state or federal laws;

(ii) Termination of Provider's Insurance. By DCE, upon the termination, or cancelation without replacement, of Provider's insurance required by this Agreement;

(iii) Loss of Provider's License. By DCE, if at any time during the term of this Agreement, Provider's or a Practice Provider's license to practice medicine, accreditation or certification, as applicable, is suspended, conditioned, or revoked, this Agreement with respect to Provider, or the affected Practice Provider, may be terminated immediately by DCE; or

(iv) Termination of CMS Agreement. Immediately by DCE in the event of DCE or CMS terminates (in CMS' sole discretion), the Direct Contracting Model or the CMS Agreement.

(v) Credentialing. Immediately by DCE in the event of a failure by Provider or any of its Practice Providers to meet DCE's or CMS' then current credentialing or re-credentialing standards.

(vi) Penalty. A Immediately by DCE in the event of any disciplinary action initiated or taken against Provider or any Practice Provider by a governmental agency, the Medicare or Medicaid program, a health care facility or a review organization or professional society.

(vii) Sanctions. Immediately by DCE in the event of a sanction against Provider or any Practice Provider under, or the exclusion of Provider or any Practice Provider from, the Medicare or Medicaid programs;

(viii) Conviction. Immediately by DCE in the event of a conviction of Provider or any Practice Provider for a felony or a crime of moral turpitude, or any crime involving the delivery of health care services;

(ix) Fraud. Participation by Provider or any Practice Providers in any fraud, whether or not involving the provision of health care services;

(x) Patient Safety. An act or omission of Provider or any Practice Provider giving rise to imminent danger to a patient or the public health, safety, and welfare.

b. Termination for Breach. Either Party may terminate this Agreement at any time for a material breach of any term or condition, including, but not limited to, nonconformity with the Provider Performance Standards (**Exhibit D**). Such termination shall be effective only if, after ninety (90) days written notice of intent to terminate is given by the terminating Party, and the breach is not cured by the non-performing Party during such time period; provided, however, if the breach cannot reasonably be corrected within ninety (90) days, and the defaulting Party makes substantial and diligent progress toward correction during such period, this Agreement shall remain in full force and effect; provided, however, if the breach is not or cannot be cured within one hundred twenty (120) days from the date of the notice of breach, either Party may terminate this Agreement after such one hundred twenty (120) day period. The written notice shall set forth the nature and details of the breach with sufficient specificity as to fully describe the nature of the alleged breach.

c. Termination of Individual Practice Provider. DCE retains the right to approve, suspend or terminate the participation status of Practice Providers under this Agreement upon sixty (60) days' prior written notice to Provider.

d. Termination Required. Provider acknowledges that CMS may require DCE to remove Provider from its Participant List and to terminate this Agreement immediately, or within a timeframe specified by CMS. DCE shall provide reasonable notice to Provider and the effective date of termination of this Agreement shall be as directed by CMS.

e. Remedial Actions. If Provider or a Practice Provider is unable or unwilling to adhere to its obligations under this Agreement, or otherwise breaches the Agreement, to address noncompliance with the requirements of the Direct Contracting Model Participation Agreement and other program integrity issues, including those identified by CMS, DCE may, in addition to its rights under this Section 4, require Provider or Practice Providers, as applicable, to (i) adhere to a corrective action plan developed and monitored by DCE; (ii) deny any payments from DCE to Provider; and/or (iii) terminate this Agreement upon notice to Provider. DCE may also require Provider to take similar remedial action against its Practice Providers. Should a Provider or Practice Provider breach and terminate this Agreement without completing a full performance year in the Direct Contracting Model, such Provider or Practice Provider automatically forfeits its rights to any Shared Savings.

f. Close-Out Obligations/Post-Termination Obligations. Upon termination of this Agreement for any reason, the rights of each Party hereunder shall terminate, except as otherwise expressly provided in this Agreement; provided, however, if this Agreement is not in effect as of the date of distribution of Shared Savings, if any, neither Provider nor Practice Providers shall be entitled to any portion of the Shared Savings. Any such termination shall not release Provider, Practice Provider, or DCE from their respective obligations under this Agreement accruing prior to the effective date of termination, including, but not limited to, those obligations identified in **Exhibit B**, and in particular, the obligation to furnish to DCE all applicable data required by the DCE to participate in the Direct Contracting Model and any data required by CMS to monitor or evaluate the Direct Contracting Model. Provider acknowledges and shall ensure that Practice Providers acknowledge that the early termination of this Agreement, or the failure to provide such data, may adversely affect Provider's or Practice Provider's, reimbursement from CMS under the Medicare fee-for-service program.

5. No Guarantee of Utilization. Provider acknowledges that DCE in no way guarantees that a particular number of Beneficiaries, if any, will be aligned with DCE by CMS **or** will receive Covered Services from Provider.

6. Insurance and Liability.

(a) Insurance. Provider shall secure and maintain for itself and its employees, subcontractors or agents, commercial general liability and professional liability (malpractice) insurance or self-insurance coverage for claims arising out of events occurring during the term of this Agreement and any post expiration or termination activities under this Agreement, in amounts required to meet credentialing criteria and worker's compensation insurance, as required by applicable state laws. Provider shall, upon request of DCE, provide DCE with certificates of insurance or other evidence of coverage reflecting satisfaction of the foregoing requirements of this paragraph. Provider shall provide at least 30 days prior written notice to DCE in advance of any material modification, cancellation or termination of its insurance. Upon termination of any "claims made policy," Provider shall obtain and maintain a "tail" policy for a period of not less than five (5) years following the effective termination date of any "claims made policy." The "tail" policy shall have the same policy limits as Provider's professional liability policy.

(b) Indemnification. Each Party shall be responsible for its own acts or omissions and any and all claims, liabilities, injuries, suits, and demands and expenses of all kinds which may result or arise out of any alleged malfeasance or neglect caused or alleged to have been caused by either Party, their employees, or representatives, in the performance or omission of any act or responsibility of either Party under this Agreement; provided,

however, without limiting the generality of the foregoing, Provider agrees to defend, indemnify, and hold harmless, DCE and its, directors, officers, employees, Affiliates, representatives, and agents against any claims, losses, damages, costs, expenses, or liabilities, including costs and reasonable attorneys' fees resulting from, arising out of, or related to any matters involving the actual or alleged malpractice by Provider, or any Practice Provider or their respective directors, officers, employees, Affiliates, representatives, and agents. This indemnity shall not be construed to limit DCE's rights to common law indemnity. In the event that a claim is made against both Parties, it is the intent of both Parties to cooperate in the defense of said claim and to cause their insurers to do likewise. The provisions of this section shall survive the termination of this Agreement regardless of the reason giving rise to such termination.

7. Miscellaneous.

a. Other Model Participation. Pursuant to Section 1899(b)(4)(A) of the Act, Provider may not be an ACO participant, ACO provider/supplier, or ACO professional in an accountable care organization in the Medicare Shared Savings Program. Provider may not: (a) be identified as a DC Participant Provider by another Medicare DCE (except as otherwise specified by CMS); (b) participate in another Medicare shared savings initiative, except as expressly permitted by CMS; or (c) participate in the Maryland Total Cost of Care Model, the Primary Care First Model, or the Independence at Home Demonstration.

b. Amendments**.** This Agreement may be amended or modified in writing as mutually agreed upon by the Parties. Notwithstanding the foregoing, amendments necessary to effect compliance with laws do not require the consent of Provider and shall be effective as stated in DCE's notice of amendment.

c. Independent Contractor Relationship. This Agreement is not intended to create nor shall be construed to create any relationship between DCE and Provider other than that of independent entities contracting for the purpose of effecting provisions of this Agreement.

d. Confidentiality/Communications

(i) Confidentiality. Each Party shall, and shall cause its Affiliates to, keep all information concerning this Agreement (collectively, "**Confidential Information**"), strictly confidential. Notwithstanding the foregoing, each Party may disclose Confidential Information: (a) to its directors, employees, consultants, advisors, Affiliates, counsel, and accountants on an as-needed basis to the extent such party agrees to keep such information confidential; (b) in connection with ordinary course investor relations activities of such Party and its Affiliates; and (c) as required by applicable law.

(ii) Communications to Beneficiaries. Nothing in this Agreement shall be interpreted to interfere with the provider-patient relationship. Provider shall provide information regarding treatment options in a culturally competent manner to Beneficiaries, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and/or physical or mental disabilities. DCE does not dictate or control clinical decisions regarding a Beneficiary's medical treatment or care. DCE and Provider shall not take any action to limit the ability of any Participant or Preferred Provider to make decisions in the best interests of a Beneficiary, including the selection of devices, supplies and treatments used in the care of the Beneficiary.

(iii) The term Confidential Information shall not include such portions of the Confidential Information as:

(a) Are or become generally available to the public other than as a result of the disclosure by the receiving Party; or

(b) Was known by the receiving Party prior to disclosure by the non-disclosing Party; or

(c) Become available to the receiving Party on a non-confidential basis from a source other than the disclosing Party (or agent thereof) which is not prohibited from disclosing such Confidential Information to the receiving Party by a legal, contractual or fiduciary obligation to the disclosing Party.

e. Disputes.

(i) In the event of any dispute under this Agreement, the Parties agree that they will initially attempt to resolve their dispute informally by holding not less than three (3) meetings (at least one (1) of which shall be in person) between senior executives of each Party. These individuals shall meet as often as necessary during a thirty (30) day period in an attempt to resolve the dispute, and shall negotiate in good faith. All proposals and information exchanged, as well as discussions undertaken, during this informal process shall be considered settlement discussions and proposals and will be inadmissible in any subsequent proceedings.

(ii) In the event the dispute is not settled by the Parties during the thirty (30) day period identified in Section 4, either Party may, resort to judicial proceedings in the event a good faith effort to resolve the dispute has not produced a mutually agreeable resolution the thirty (30) day period.

f. Notice. All notices and other communications under this Agreement shall be in writing and shall be deemed given when: (a) delivered by hand; (b) transmitted by telecopier with automatic confirmation of transmission; (c) delivered by FedEx or other reputable receipted express delivery service, or registered or certified mail, return receipt requested, postage prepaid; or (d) an attempted delivery by one of the means described in the foregoing subparagraphs (a) through (c) is refused by the addressee, in each case to the Parties at their respective address on the signature page hereto.

g. Assignment. Neither Party to this Agreement shall assign or transfer its rights, duties or obligations under this Agreement without the prior written consent of the other Party. Other than as expressly provided by this Agreement, any attempted assignment, by operation of Law or otherwise, shall be void and unenforceable. This Agreement shall inure to the benefit of and shall bind the successors and permitted assignees of the parties hereto.

h. Force Majeure. Notwithstanding anything in this Agreement to the contrary, the parties shall each be excused, discharged and released from performance under this Agreement to the extent such performance is limited, delayed or prevented in whole or in part for any reason whatsoever not reasonably within the control of the affected Party, including but not limited to any acts of God, war, invasion, acts of foreign enemy, acts of terrorism, hostilities (whether war was declared or not) or by any laws or court order. The foregoing shall not be considered to be a waiver of any continuing obligations under this Agreement, and as soon as such conditions cease, the party affected thereby shall promptly fulfill its obligations under this Agreement.

i. Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same instrument. Signatures to this Agreement which are distributed to the Parties via facsimile or other electronic means (including PDF) shall have the same effect as if distributed in original form to all Parties.

j. Severability. Each provision hereof is intended to be severable. If any term or provision is illegal or invalid for any reason whatsoever, such illegality or invalidity shall not affect the validity of the remainder of this Agreement.

k. Headings. All headings contained in this Agreement are inserted as a matter of convenience and for ease of reference only and shall not be considered in the construction or interpretation of any provision of this Agreement.

l. Governing Law. The execution, performance, interpretation and enforcement of this Agreement shall be governed by and construed in accordance with the laws of the State of Florida. ALL PARTIES HERETO EXPRESSLY WAIVE ANY AND ALL JURY TRIAL RIGHTS IN CONNECTION WITH THIS AGREEMENT AND OF ANY CLAIM, DEMAND, ACTION, PROCEEDING OR CAUSE OF ACTION ARISING UNDER, RELATING TO, OR IN CONNECTION WITH THIS AGREEMENT.

m. Non Waiver. No course of dealing between the Parties, and no delay by either Party in exercising any right, power or remedy, shall operate as a waiver or otherwise prejudice the exercise by the Party of that right, power or remedy against that or any other Party.

n. Third Party Rights. This Agreement is entered into by and between DCE and Provider for their benefit. Except as specifically provided herein, no third party shall have any right to enforce any right or enjoy any benefit created or established under this Agreement.

o. Entire Agreement. This Agreement, including all exhibit hereto, constitutes the entire agreement of the parties hereto with respect to the subject matter hereof and supersedes any prior or contemporaneous oral and written understandings or agreements. All exhibits that are annexed or attached to this Agreement are expressly made a part of this Agreement as fully as though completely set forth herein, and all references to this Agreement herein or in any of such exhibits shall be deemed to refer to and include all such exhibits.

p. Compliance with Laws. Provider acknowledges that DCE receives federal funds and that DCE's payments to Provider or Practice Providers under this Agreement are, in whole or in part, from federal funds. Provider and Practice Providers shall follow and adhere to all Applicable Requirements as set forth in Section 11 of **Exhibit B**. Provider shall notify DCE in writing if (i) Provider is, or Provider knows or has a good faith belief that, a Practice Provider, is in violation of any such laws.

q. Audits and Fraud, Waste, and Abuse. Consistent with federal regulations, Provider shall fully cooperate with DCE's initiatives, policies, procedures, processes, and programs relating to (i) DCE's auditing and oversight obligations, including, without limitation, audits of Provider's and Practice Providers' books and records relating to hierarchical condition categories; and (ii) the identification of and remediation of identified instances or patterns of fraud, waste, and abuse (collectively "**FWA Program**"). Provider acknowledges and agrees that DCE's FWA Program may include any process, procedure, or program that has been adopted by or contemplated by CMS or its designees, including, but not limited to, Program Safeguard Contractors, Zone Program Integrity Contractors, Carriers, Fiscal Intermediaries, Medicare Drug Integrity Contractors, Recovery Audit Contractors, and Medicaid Integrity Contractors.

r. Remedies. Each of the Parties agrees that irreparable damage would occur in the event that any of the provisions of this Agreement were not to be performed in accordance with the terms hereof and that the Parties shall be entitled to specific performance of the terms hereof, in addition to any other remedies at law or in equity.

EXHIBIT B
CMS REQUIREMENTS

As part of Provider's obligations under this Agreement, Provider shall comply, and shall contractually require its Practice Providers and Suppliers (as such term is defined in the CMS Agreement) to comply, with the requirements set forth in this **Exhibit B** with respect to the provision of Covered Services to Beneficiaries under this Agreement.

1. DCE Mission. Provider and each Practice Provider agrees to engage in DCE activities, as defined in the CMS Agreement, and to use commercially reasonable efforts to assist DCE in fulfilling its purpose (the "**DCE Mission**") under the Direct Contracting Model of providing better care for individuals, improved health for populations and lower per capita growth in expenditures for Medicare Beneficiaries, and will demonstrate meaningful commitment (e.g., through financial investment and human capital in the form of time and effort) to the DCE's success. DCE shall enable Provider to provide feedback on quality and cost metrics.

2. Policies and Procedures. Provider and each Practice Provider shall follow and adhere to all of DCE's standards, corrective action plans, remedial processes and penalties, policies, procedures, programs, rules, and regulations (including, but not limited to, participant exclusivity, quality measure reporting, and continuous care improvement objectives for DCE Participants; Voluntary Alignment Activities; Marketing Activities; Beneficiary freedom of choice, Benefit Enhancements and Beneficiary Engagement Incentives; participation in evaluation, shared learning, monitoring, and oversight activities; the DCE's compliance plan, audit and record retention requirements, credentialing/re-credentialing, case management, care coordination, referral guidelines, quality assurance, quality improvement, and clinical integration policies and programs (collectively "**Policies and Procedures**"), any or all of which DCE may amend from time-to-time in connection with the CMS Agreement. Provider and each Practice Provider shall comply with the patient-centered care processes of DCE, including:

a. Promotion of evidence-based medicine, such as through the establishment and implementation of evidence-based guidelines.

b. Beneficiary/caregiver engagement, and the use of shared decision making processes that take into account Beneficiaries' unique needs, preferences, values, and priorities. Measures for promoting Beneficiary engagement include, but are not limited to, the use of decision support tools and shared decision making methods with which the Beneficiary can assess the merits of various treatment options in the context of his or her values and convictions. Beneficiary engagement also includes methods for fostering what might be termed "health literacy" in Beneficiaries and their families or caregivers.

c. Coordination of Beneficiaries' care and care transitions (e.g., sharing of electronic summary records across health care providers, telehealth, remote Beneficiary monitoring, and other enabling technologies).

d. Providing Beneficiaries access to their own medical records and to clinical knowledge so that they may make informed choices about their care.

e. Ensuring individualized care for Beneficiaries, such as through personalized care plans.

f. Routine assessment of Beneficiary and caregiver and/or family experience of care and seek to improve where possible.

g. Providing care that is integrated with the community resources Beneficiaries require.

The Participant Provider or Preferred provider must be included on the DC Participant Provider List or Preferred Provider List as applicable at the start of a Performance Year to participate in the DCE's selected Payment Mechanism(s) for a Performance Year in advance of the Performance Year, as applicable.

In addition, the DCE will prohibit a DC Participant Provider or Preferred Provider that is added to the DC Participant List during a Performance Year from participating in the DCE's selected Payment Mechanism (s) for a Performance Year in advance of the Performance Year, as applicable.

DCE shall institute remedial processes and penalties, as appropriate, if Provider fails to comply with or implement a required process or protocol.

3. Participating or Preferred Status. Only if Provider is certified by CMS as Participating or Preferred by the CMS certification date will be deemed Participating or Preferred for the following Performance Year. If Provider is not so certified will be excluded from the Payment Mechanism for the applicable Performance Year.

4. Beneficiary Inducements. Provider, Practice Providers, and Suppliers are prohibited from:

a. providing gifts or other remuneration to Beneficiaries as inducements for receiving items or services from or remaining in, the DCE or with Provider, Practice Providers, or Suppliers of the DCE or receiving items or services from DCE participants, Practice Providers, or Suppliers; they may, however, provide in-kind items or services to Beneficiaries if: (i) there is a reasonable connection between the items and services and the medical care of the Beneficiary; (ii) the items or services are preventive care items or services or advance a clinical goal for the Beneficiary, including adherence to a treatment regime, adherence to a drug regime, adherence to a follow-up care plan, or management of a chronic disease or condition; and (iii) the in-kind item or service is not a Medicare-covered item or service for the Beneficiary on the date the in-kind item or service is furnished to that Beneficiary. For purposes of this exception, an item or service that could be covered pursuant to a benefit enhancement is considered a Medicare-covered item or service, regardless of whether the DCE selects to participate in such benefit enhancement for a given performance year.

b. Conditioning the participation of Practice Providers or Suppliers on referrals of Federal health care program business that the DCE, Provider, Practice Provider, or Suppliers know or should know is being (or would be) provided to Beneficiaries who are not aligned with the DCE.

c. Except as permitted by the CMS Agreement, requiring that Beneficiaries be referred only to Provider, Practice Providers, or Suppliers within the DCE or to any other provider or Supplier.

5. Compliance. DCE shall have a process for Provider, Practice Providers, and other individuals or entities performing functions or services related to DCE activities to anonymously report suspected problems related to the DCE to the DCE and its compliance officer.

6. Marketing. Provider is prohibited from conducting Marketing Activities, as defined in the CMS Agreement, before the Start Date or such other date specified by CMS. In conducting Marketing Activities, Provider shall not:

a. Conduct Marketing Activities outside the DCE Service Area, as defined in the CMS Agreement;

b. Discriminate or selectively target Beneficiaries based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability, geographic location, or income;

c. Use Marketing Materials or engage in Marketing Activities until such Marketing Materials and Marketing Activities are reviewed and approved by CMS;

d. Engage in activities that could mislead or confuse a Beneficiary regarding the Direct Contracting Model, Medicare benefits, or DCE;

e. Claim DCE is recommended or otherwise endorsed by CMS or that CMS recommends that the Beneficiary select Provider as his or her main doctor, main provider, and/or the main place the Beneficiary receives care;

f. Expressly state or imply that selecting Provider as the Beneficiary's main doctor, main provider, and/or the main place the Beneficiary receives care removes a Beneficiary's freedom to choose to obtain health services from providers and suppliers who are not a DCE Participating Provider or Preferred Provider;

g. Use Marketing Materials or conduct Marketing Activities through the use of door-to-door solicitation, including leaving information such as a leaflet or flyer at a residence, approaching Beneficiaries in common areas, such as parking lots, hallways, lobbies, sidewalks, or using telephonic solicitation, including text messages and leaving voicemail messages. This restriction does not apply to solicitation in common areas of a health care setting, which is subject to the limitations as set forth in the CMS Agreement;

h. Conduct Marketing Activities in restricted areas of a health care setting. Restricted areas of a health care setting include, but are not limited to, exam rooms, hospital patient rooms, treatment areas (where patients interact with a health care provider and his/her clinical team and receive treatment, including dialysis treatment facilities), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications).

Provider shall promptly discontinue the use of any Marketing Materials and Marketing Activities reviewed and disapproved by CMS. Any material changes to CMS-approved Marketing Materials and Marketing Activities must be submitted to CMS and approved by CMS, or deemed approved in accordance with the CMS Agreement before use.

Provider is able to conduct Marketing Activities through unsolicited direct contact with Beneficiaries using conventional mail and other print media or email, provided that the Beneficiaries are given an opportunity to opt-out of subsequent such contacts.

7. Release of Information. Provider agrees it shall obtain prior approval from CMS during the term of the CMS Agreement and for one (1) year thereafter for the publication or release of any press release, external report or statistical/analytical material that materially and substantially references DCE's participation in the Direct Contracting Model. External reports and statistical/analytical material may include, but are not limited to, papers, articles, professional publications, speeches, and testimony. All external reports and statistical/analytical material that are subject to this requirement must include the following statement on the first page: "The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document."

8. Confidentiality of Records and Enrollment Information. Provider shall comply, and shall contractually require each Practice Provider and Supplier to comply, with all Applicable Requirements regarding health care privacy and security and the use and disclosure of any medical records or other information Provider, Practice Providers, or Suppliers maintain with respect to Beneficiaries, including the use of software that is interoperable (as defined in 42 C.F.R. § 411.351) or satisfies 42 C.F.R. § 411.357(w)(2) (related to interoperability) at the time it is provided to the Provider. Nothing herein shall be construed to limit or restrict appropriate sharing of medical record data with providers and suppliers both within and outside the DCE in accordance with Applicable

Requirements.

9. Screening and Related Requirements.

a. Provider shall not employ or contract with, and shall contractually require its Practice Providers and Supplier to not employ or contract with, individuals or entities that are excluded under the U.S. Department of Health and Human Services ("**HHS**") Office of Inspector General's List of Excluded Individuals/Entities (the "**OIG List**"), the U.S. General Services Administration's Excluded Parties List System ("**EPLS**"), or otherwise excluded from participation in Medicare or other Federal Health Care Programs, or are debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency ("**Excluded Individuals**").

b. Provider shall and shall contractually require its Practice Providers and Suppliers to:

i. Review the OIG List and the EPLS prior to the initial hiring of any employee or the engagement of any Practice Provider or Supplier to furnish Covered Services, and monthly thereafter, to ensure compliance with this Section 9;

ii. Provide documentation, upon written request by DCE, of such screening;

iii. Immediately notify DCE upon discovering that it, or any of its employees or a Practice Provider or Supplier (a) has furnished Covered Services to Beneficiaries under this Agreement as or through an Excluded Individual; (b) has been convicted of a criminal felony that could serve as the basis of federal health care program exclusion; or (c) has a history of health care program integrity, including any history of Medicare program exclusions or other sanctions and affiliations with individuals or entities that have a history of program integrity issues; and

iv. Immediately remove an Excluded Individual from any work related, directly or indirectly, to services furnished under this Agreement, and take other appropriate corrective action requested by DCE based on the above notification.

10. Beneficiary Hold Harmless. Neither Provider, Practice Provider, nor Supplier shall, in any event, including, without limitation, insolvency of DCE or breach of this Agreement, bill, charge, collect a deposit from, seek compensation or remuneration or reimbursement from, hold responsible, or otherwise have any recourse against any Beneficiary, or any other person acting on behalf on any Beneficiary, other than for beneficiary costs or non-Covered Services. Provider agrees that neither Provider nor any Practice Provider shall maintain any action at law or equity against a Beneficiary to collect sums owed to Provider or Practice Provider pursuant to this Agreement other than for beneficiary costs or non-Covered Services. This section shall (a) survive the termination or expiration of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Beneficiaries; and (b) supersede any oral or written contrary agreement now existing or hereafter entered into between Provider, Practice Provider, or Supplier and Beneficiary or a person acting on a Beneficiary's behalf.

11. Compliance with Law. Provider and its Practice Providers that bill through the TIN of Provider agree to participate in the Direct Contracting Model through DCE and shall comply with the requirements and conditions of the Direct Contracting Model, including, but not limited to those specified in the CMS Agreement. Without limiting the generality of the foregoing, Provider shall comply and shall contractually require its Practice Providers, Suppliers, and subcontractors providing services hereunder, to comply with any and all applicable federal and state laws, regulations and rules, CMS instructions and guidance, including, without limitations, (a) federal criminal law; (b) the False Claims Act (31 USC 3729 et seq.); (c) the anti-kickback statute (42 USC 1320a-7b(b)); (d) the civil monetary penalties law (42 USC 1320a-7a); (e) the physician self-referral law (42 USC 1395nn); and (f) those requirements specified in the CMS Agreement, including any provisions regarding the following: participant exclusivity, Voluntary Alignment Activities, Marketing Activities, Beneficiary freedom of choice, participation in

evaluation, shared learning, monitoring, and oversight activities, the DCE compliance plan, and audit and record retention requirements (collectively the "**Applicable Requirements**").

12. Maintenance of Records and Audits.

a. Provider shall maintain and shall contractually require its Practice Providers and Suppliers to maintain operational, financial, administrative and medical records, contracts, books, files and other documents as required legally or pursuant to prudent business practices in connection with services performed under this Agreement ("**Records**"). Such Records shall be maintained in a timely and accurate manner and shall, at a minimum, be sufficient to allow DCE to determine whether Provider, Practice Providers, and its Suppliers are performing their obligations under this Agreement consistent with the terms of this Agreement and in accordance with Applicable Requirements and to confirm that the data submitted by Provider, Practice Providers, and its Suppliers for reporting and other purposes is accurate. Such Records shall include records of any payments made or received under this Agreement.

b. Upon request, Provider shall give and shall contractually require its Practice Providers and Suppliers to give DCE, HHS, the Comptroller General of the United States, CMS, and/or their designees, the right to access, audit, evaluate, and inspect any books, contracts, computer or electronic systems and records, including medical records, patient care documentation, encounter data, and other records of the Provider, Practice Provider, or any Supplier or its transferee that pertain to any aspect of this Agreement, including, without limitation, services performed under this Agreement, DCE's, Provider's, and Practice Providers' compliance with the CMS Agreement, the quality of services performed, data related to Medicare utilization and costs; quality performance measures, distributions and other financial arrangements to related to this Agreement, or such other Records as may deemed necessary to enforce the CMS Agreement. Provider, Practice Providers, and Suppliers shall furnish such access, audit, evaluation and inspection rights by providing copies of such Records to DCE at no additional cost and DCE will provide such Records directly to the applicable regulatory agency, unless DCE, in its discretion, directs Provider, Practice Provider, or Supplier to furnish copies directly to the applicable regulatory agency.

c. Provider agrees to permit and shall contractually require Practice Providers and Suppliers to permit DCE, CMS, HHS, the Comptroller General, or their designees to conduct on-site evaluations of Provider, Practice Provider, and Supplier personnel, physical premises, facilities and equipment to assess and audit Provider's, Practice Provider's, and Supplier's performance under this Agreement and with Applicable Requirements.

d. The terms of this section, including with respect to maintenance of Records by Provider, Practice Providers, and Suppliers, shall remain in effect for a period of the longer of (a) ten (10) years from the final date of the CMS Agreement period; or (b) completion of any audit, evaluation, or inspection; unless (i) CMS determines there is a special need to retain a particular Record or group of Records for a longer period and notifies DCE at least thirty (30) days before the normal disposition date; or (ii) there has been a termination, dispute, or allegation of fraud or similar fault against DCE, Provider or its Practice Providers, DCE's other providers and/or suppliers, or other individuals or entities performing functions or services related to DCE's activities under the CMS Agreement, in which case Provider shall and shall contractually require its Practice Providers and Suppliers to retain Records for an additional six (6) years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault.

13. Monitoring. Provider acknowledges and understands that DCE has a contractual obligation to CMS to comply with the Applicable Requirements relating to the Direct Contracting Model and that DCE is ultimately responsible and accountable to CMS for compliance with all terms and conditions of the CMS Agreement. In view of the foregoing, accordingly, Provider agrees that all services performed by Provider, Practice Providers, or its

Suppliers will be consistent with and comply with the CMS Agreement. Provider shall permit, and shall contractually require its Practice Providers and Suppliers to permit, DCE, directly or through their respective representatives, to monitor the services furnished under this Agreement on an on-going basis, in any reasonable manner that DCE or CMS deems appropriate for compliance with DCE's obligations to CMS.

14. Reporting and Disclosure; Submission of Encounter and Other Data.

a. As applicable, Provider shall submit (and require Practice Providers and Suppliers to submit) encounter data with respect to Provider's and Practice Provider's participation under this Agreement, medical records, and such other information and data as DCE may reasonably request, including, without limitation and as applicable, as may be required in connection with DCE's reporting and other obligations under the CMS Agreement, including, but not limited to (a) actual or suspected fraud, waste and abuse or non-compliance with Applicable Requirements by Provider, Practice Provider, a Supplier or others; or (b) responses to CMS requests for information and/or surveys. Such information shall be submitted by Provider and its Practice Providers and Suppliers in compliance with Applicable Requirements.

b. Provider shall cooperate and assist with, DCE's requests for information and shall promptly submit encounter data, medical records and such other information as requested by DCE to allow DCE to respond in a timely manner to any data validation audits or requests for information by CMS, and to monitor and audit the obligation of Provider, Practice Providers, and Suppliers to provide accurate, complete and truthful data and other information in accordance with Applicable Requirements.

c. Provider shall fully cooperate with DCE and CMS efforts to evaluate the Direct Contracting Model, which may include, but is not limited to: participation in surveys, interviews, and site visits; participation and cooperation in any independent evaluation activities conducted by or on behalf of CMS, as well as monitoring and oversight requests and activities; and other activities that CMS or DCE determines necessary to conduct a comprehensive, formative, and summative evaluation.

d. This section shall survive termination of this Agreement, regardless of the cause giving rise to termination.

15. Compliance Program and Anti-Fraud Initiatives. Provider shall, and shall contractually require its Practice Providers and Suppliers to, institute, operate, and maintain an effective compliance program to detect, correct and prevent the incidence of non-compliance with Applicable Requirements and the incidence of fraud, waste and abuse relating to the Direct Contracting Model and the federal healthcare program generally. Such compliance program shall be appropriate to Provider's, Practice Providers', or Supplier's organization, and operations and shall include:

a. Written policies, procedures and standards of conduct articulating the entity's commitment to comply with federal and state laws; and

b. Provision of and required participation of all officers, directors, and employees in effective compliance and anti-fraud training and education that is consistent with guidance from CMS.

16. Certifications/Attestation. Upon request, Provider, Practice Providers, and Suppliers shall certify and attest that:

a. Provider, Practice Provider, and Supplier (a) has agreed to become accountable for the quality, cost, and overall care of the Medicare fee-for-service Beneficiaries aligned with DCE under the Direct Contracting Model; (b) will comply with and implement DCE's processes required by the CMS

Agreement; and (c) is held accountable for meeting DCE's performance standards for each required process;

b. Provider, Practice Providers, and other individuals or entities performing functions or services related to DCE activities, are, to the best of Provider's and Practice Provider's knowledge, information, and belief, in compliance with CMS requirements and compatible with the DCE Mission;

c. All data and information that is generated or submitted by Provider, or other individuals or entities performing functions or services related to DCE activities, including any quality data or other information or data relied upon by CMS in determining the DCE's eligibility for, and the amount of a shared savings payment or the amount of shared losses or other monies owed to CMS, is to the best of Provider's knowledge, information, and belief, accurate, complete, and truthful.

17. Conformity with CMS Requirements. This Agreement shall be supplemented automatically to conform to Applicable Requirements.

18. Standards. Provider shall provide all covered services to Beneficiaries without regard to the amount, type, or extent of care required and in accordance with locally accepted medical, surgical, and scientific practices. Provider shall not discriminate with respect to quality of care or otherwise between Beneficiaries and Provider's other patients. Neither DCE, nor Provider, shall take any action to limit the ability of Provider or Practice Provider to make decisions that are in the best interests of a Beneficiary, including the selection of devices, supplies and treatments used in the care of the Beneficiary.

19. Non-Discrimination; Closing of Practice. Provider shall accept Beneficiaries for services without regard to race, color, religion, gender, gender identity, sexual orientation, national origin, age, marital status, health status, disability, source of payment for services, or any other basis prohibited by state or federal law or the CMS Agreement. Practice Providers may close his/her practice to new Beneficiaries only if such Practice Provider closes his/her practice to all new patients.

20. Clinician-Patient Relationship. Provider shall maintain an independent clinician-patient relationship with all individuals who are Provider's patients and exercise its independent professional judgment consistent with accepted standards of health care in rendering treatment to such patients. Provider also acknowledges that Provider is solely responsible to such patients for all treatment they render and that actions by DCE pursuant to the its policies, utilization management, referral management or other programs do not absolve Provider of the responsibility to provide appropriate health care to patients.

21. Provision of Interoperable Software. The parties agree that in the event that the Agreement involves the provision of electronic health records software to one or more DCE Participant Providers or Preferred Providers, such software shall be interoperable (as defined in 42 C.F.R. § 411.351) or satisfy 42 C.F.R § 411.357(w)(2) (related to interoperability) at the time it is provided to the recipient.

22. Prior Authorization. DCE shall not require prior authorization for services furnished to Beneficiaries.

23. Interpretation. In the event of any conflict or inconsistency between this **Exhibit B** and this Agreement, the terms of this **Exhibit B** shall control.

EXHIBIT C
BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT ("**Agreement**"), is made and entered into on the effective date of the Direct Contracting Entity Participant Provider Agreement to which it is appended (the "**Effective Date**"), by and between Provider ("**Covered Entity**") and DCE ("**Business Associate**") (collectively the "**Parties**") in order to comply with the Health Insurance Portability and Accountability Act of 196, Public Law 104-191, as amended, and its implementing privacy, security and breach notification regulations (collectively "**HIPAA**"), and any other applicable state and federal confidentiality laws, as they may be amended from time to time.

RECITALS

WHEREAS, pursuant to the Direct Contracting Entity Participant Provider Agreement, Business Associate provides services, including but not limited to, legal, actuarial, accounting consulting, data aggregation, management, administrative, accreditation or financial services, to or on behalf of Covered Entity;

WHEREAS, in connection with these services, Covered Entity discloses to Business Associate certain Protected Health Information ("**PHI**"), as that term is defined under HIPAA; and

WHEREAS, Covered Entity desires to receive adequate assurances that Business Associate will comply with certain obligations with respect to the PHI in the course of providing services to or on behalf of Covered Entity.

NOW THEREFORE, in consideration of the mutual promises and covenants herein, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties agree as follows:

ARTICLE 1

DEFINITIONS

Terms used herein, but not otherwise defined, shall have meaning ascribed by Title 45, Parts 160 and 164, of the United States Code of Federal Regulations, as amended from time to time. Should any term set forth in 45 CFR Parts 160 or 164 conflict with any defined term herein, the definition found in 45 CFR Parts 160 or 164 shall prevail.

1.1 1.1 "**Breach**" means the acquisition, access, use, or disclosure of PHI in a manner not permitted which compromises the security or privacy of such information as defined and subject to the exceptions set forth in 45 CFR § 164.402.

1.2 "**Breach Notification Rule**" means the HIPAA Regulations pertaining to breaches of unsecured PHI as codified in 45 CFR Parts 160 and 164.

1.3 "**Designated Record Set**" means a group of records maintained by or for a covered entity, as defined under HIPAA, that is: (i) the medical records and billing records about Individuals maintained by or for a covered health care provider; (ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (iii) used, in whole or in part, by or for the covered entity to make decisions about Individuals. For purposes of this definition, the term "record" means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

1.4 "**Electronic PHI**" or "**EPHI**" means PHI that is transmitted by or maintained in electronic media as defined by the Security Rule.

1.5 "**Individual**" means the same as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502 (g).

1.6 "**Law**" means all applicable federal and state statutes and all relevant regulations.

1.7 "**Privacy Rule**" means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR parts 160 and 164, subparts A and E.

1.8 "**Protected Health Information**" or "**PHI**" has the same meaning as the term "Protected Health Information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

1.9 "**Secretary**" means the Secretary of the U.S. Department of Health and Human Services ("HHS") or his or her designee.

1.10 "**Security Incident**" shall have the meaning set out in the Security Rule. Generally, a "Security Incident" shall mean any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or systems operations in an electronic information system.

1.11 "**Security Rule**" means the Security Standards and Implementation Specifications at 45 CFR parts 160 and 164, subparts A and C, as they may be amended from time to time.

1.12 "**Unsecured PHI**" means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of either the encryption method or the destruction method, as defined in HHS guidance published on April 27, 2009 (74 FR 19006) and modified by guidance published on August 24, 2009 (74 FR 42740), as amended. Unsecured PHI can include information in any form or medium, including electronic, paper or oral.

ARTICLE 2

PURPOSES FOR DISCLOSURE

In connection with the services provided by Business Associate to or on behalf of Covered Entity described in this Agreement, Covered Entity may disclose PHI to Business Associate for the purposes of treatment, payment or healthcare operations as described in 45 CFR part 164.506(a)(b)(c) for standard uses and in 45 CFR part 164.508 for uses and disclosures for which an authorization is required.

ARTICLE 3

BUSINESS ASSOCIATE OBLIGATIONS

Business Associate agrees to comply with applicable federal and state confidentiality and security laws, specifically the provisions of HIPAA applicable to business associates, including:

3.1 Use and Disclosure of PHI. Except as otherwise permitted by this Agreement or applicable law, Business Associate shall not use, maintain, transmit or disclose PHI except as necessary to provide services to or on behalf of Covered Entity and except as required by Law. Provided, however, Business Associate may use and disclose PHI as necessary for the proper management and administration of Business Associate, or to carry out its legal responsibilities. Business Associate shall in such cases:

3.1.1 provide information to members of its workforce using or disclosing PHI regarding the confidentiality requirements in HIPAA and this Agreement;

3.1.2 obtain reasonable assurances from the person or entity to whom the PHI is disclosed that: (i) the PHI will be held confidential and further used and disclosed only as required by Law or for the purpose for which it was disclosed to the person or entity; and (ii) the person or entity will notify Business Associate of any instances of which it is aware in which confidentiality of the PHI has been breached;

3.1.3 agree to notify the Privacy Officer of Covered Entity of any instances of which it is aware in which the PHI is used or disclosed for a purpose that is not otherwise provided for in this Agreement or for a purpose not expressly permitted by HIPAA.

3.2 Disclosure to Agents and Subcontractors. If Business Associate discloses PHI to agents, including a subcontractor, Business Associate shall require the agent or subcontractor to agree to the same restrictions and conditions as apply to Business Associate under this Agreement and to comply with the applicable requirements of the Privacy Rule, Security Rule, Breach Notification Rule and other Law with respect to such information. Business Associate shall ensure that any agent, including a subcontractor, agrees to implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of the EPHI that it creates, receives, maintains, stores, uses or transmits on behalf of the Covered Entity in accordance with Law. Business Associate shall be liable to Covered Entity for any acts, failures or omissions of the agent or subcontractor in providing the services as if they were Business Associate's own acts, failures or omissions, to the extent permitted by law. Business Associate further expressly warrants that its agents or subcontractors will be specifically advised of, and will comply in all respects with, the terms of this Agreement.

3.3 Data Aggregation. In the event that Business Associate works for more than one covered entity, Business Associate is permitted to use and disclose PHI for data aggregation purpose only to the extent that such use is permitted under HIPAA.

3.4 Withdrawal of Authorization. If the use or disclosure of PHI in this Agreement is based upon an Individual's specific authorization for the use or disclosure of his or her PHI, and the Individual revokes such authorization, the effective date of such authorization has expired, or such authorization is found to be defective in any manner that renders it invalid, Business Associate shall, if it has notice of such revocation, expiration or invalidity, cease the use and disclosure of the Individual's PHI except to the extent it has relied on such use or disclosure, or if an exception under HIPAA expressly applies.

3.5 Safeguards. Business Associate agrees to maintain appropriate safeguards as required by Law, including without limitation, a written security program that contains the necessary administrative, physical and technical safeguards to ensure that PHI or EPHI is not used, maintained, transmitted or disclosed other than as provided by this Agreement or as required by Law. Business Associate shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any EPHI it creates, receives, maintains, stores, uses, transmits or discloses on behalf of Covered Entity in accordance with Law.

Business Associate shall ensure, at a minimum, that:

3.5.1 PHI or EPHI will be maintained in locked and secured areas when PHI or EPHI is not in use;

3.5.2 Facsimile machines receiving EPHI shall not be located in a public area;

3.5.3 EPHI stored electronically shall be password protected; and

3.5.5 PHI and EPHI will be used internally on a need to know basis only.

3.6 Individual Rights.

3.6.1 Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI as required by and in accordance with 45 CFR § 164.528. Business Associate, in accordance with 45 CFR § 164.528, does not need to document disclosures of PHI that are for treatment, payment or healthcare operations or disclosures that are incidental to another permissible disclosure. If Business Associate or its agents or subcontractors uses or maintains PHI in an electronic record of health-related information created, gathered or maintained or consulted by authorized health care clinicians and staff (an "**EHR**"), then Business Associate and its agents and subcontractors shall document and make available to Covered Entity the information required to provide an accounting of disclosures to enable Covered Entity to fulfill its obligations under the HIPAA, including disclosures and uses relating to treatment, payment and health care operations.

3.6.2 Business Associate agrees to provide to Covered Entity, within thirty (30) days of the request, in a mutually agreed upon form, information collected in accordance with Section 3.6.1 above to the extent required to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. Covered Entity shall provide to Business Associate within thirty (30) days of the effective date of this Agreement, a written explanation of Covered Entity's requirements under this Section 3.6.2 in sufficient detail to enable Covered Entity to comply with such requirements. Covered Entity agrees to respond promptly to requests from Business Associate for clarification of such requirements, and Business Associate may rely on such responses. The Parties agree to work together in good faith to resolve any disagreement over the requirements of 45 CFR § 164.528. Covered Entity will be responsible for the reasonable costs incurred by Business Associate to respond to a request for an accounting of disclosures. Covered Entity, rather than Business Associate, will directly handle all requests for accounting from an Individual. Business Associate shall promptly forward all requests for accounting it receives from Individuals to Covered Entity.

3.6.3 Business Associate shall, at the request of Covered Entity, provide PHI maintained in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements of an Individual's right of access and requests for access to his or her PHI. An Individual's right of access to PHI includes the right to access EPHI contained in an EHR. Covered Entity will be responsible for the reasonable costs incurred by Business Associate to respond to a request for access. The provision of access to the Individual's PHI or EPHI and any denials of access to PHI or EPHI shall be the sole responsibility of the Covered Entity. If Business Associate or its agents or subcontractors maintains or uses PHI in an EHR, then promptly after receipt of a request from Covered Entity, Business Associate shall make a copy of such PHI available to Covered Entity in an electronic format in order to enable Covered Entity to fulfill its obligations under the Privacy Rule.

3.6.4 Business Associate shall make any amendment(s) to PHI maintained in a Designated Record Set that Covered Entity directs or agrees to at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity. Covered Entity will be responsible for the reasonable costs incurred by Business Associate to respond to a request to amend an Individual's PHI in a Designated Record Set. All decisions regarding the amendment of PHI shall be the responsibility of the Covered Entity.

3.7 Internal Practices, Policies, and Procedures. Except as otherwise specified herein, Business Associate shall make available its internal practices, books, records, policies and procedures relating to the use and disclosure of PHI or EPHI, documentation required by the Security Rule relating to safeguards, and documentation required by the Breach Notification Rule available to the Secretary or to the Covered Entity for the purpose of determining Covered Entity's compliance with the Privacy Rule, Security Rule and Breach Notification Rule. Records requested that are not protected by an applicable legal privilege will be made available in the time and manner specified by Covered Entity or the Secretary.

3.8 De-identified Information. Business Associate may use and disclose de-identified health information if (i) the de-identification is in compliance with 45 CFR §164.502(d); and (ii) the de-identified health information meets the standard and implementation specifications for de-identification under 45 CFR §164.514(a) and (b).

3.9 Minimum Necessary. Business Associate shall attempt to ensure that all uses and disclosures of PHI are subject to the principle of "minimum necessary use and disclosure," i.e., that only PHI that is the minimum necessary to accomplish the intended purpose of the use, disclosure or request is used or disclosed.

3.10 Notice of Privacy Practices. Business Associate shall abide by the limitations of Covered Entity's notice of privacy practices ("Notice of Privacy Practices") of which it has knowledge. Any use or disclosure permitted by this Agreement may be amended by changes to Covered Entity's Notice of Privacy Practices; provided, however, that the amended Notice of Privacy Practices shall not affect permitted uses and disclosures on which Business Associate relied prior to receiving notice of such amended Notice of Privacy Practices.

3.11 Security Incident / Unauthorized Disclosure of PHI.

(a) Business Associate shall report to Covered Entity any instances, including Security Incidents, of which it is aware in which PHI or EPHI is used or disclosed for a purpose that is not otherwise provided for in this Agreement. In the event that Business Associate knows of: (i) any suspected Breach of any individual PHI or EPHI; (ii) a Security Incident (i.e. PHI was inappropriately used, disclosed, released or obtained) or (iii) a Breach of Unsecured PHI, Business Associate shall notify Covered Entity in writing within five (5) calendar days of such Breach. Notification shall include detailed information about the Breach, including, but not limited to, the nature and circumstances of such Breach, the means by which PHI or EPHI was or may have been breached (e.g. stolen laptop; breach of security protocols; unauthorized access to computer systems, etc.), the names and contact information of all individuals affected or reasonably believed by the Business Associate to be affected, and such other information as Covered Entity may reasonably request. Any delay in notification must include evidence demonstrating the necessity of the delay. The notice shall also set forth the remedial action taken or proposed to be taken with respect to such prohibited use or disclosure. Business Associate and Covered Entity agree to act together in good faith to take reasonable steps to investigate and mitigate any harm caused by such unauthorized use or successful Security Incident. The party responsible for the breach shall bear the cost of any required notifications and corrective actions (e.g. credit monitoring services). The Business Associate will provide the Covered Entity with any reasonable information known by Business Associate that the Covered Entity needs for the required notifications under the Breach Notification Rule. The Covered Entity shall have responsibility for determining that an incident is a Breach, including the requirement to perform a risk assessment. However, the Business Associate is expected to perform a risk assessment and provide such assessment to the Covered Entity. Further, Business Associate shall provide and pay for required notifications to Individuals, HHS and/or the media, as requested by the Covered Entity.

(b) Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI or EPHI by Business Associate in violation of the requirements of this Agreement.

ARTICLE 4

COVERED ENTITY OBLIGATIONS

4.1 Covered Entity shall:

4.1.1 provide Business Associate a copy of its Notice of Privacy Practices produced by Covered Entity in accordance with 45 CFR 164.520 as well as any changes to such notice;

4.1.2 provide Business Associate with any changes in, or revocation of, authorizations by Individuals relating to the use and/or disclosure of PHI, if such changes affect Business Associate's permitted or required uses and/or disclosures;

4.1.3 notify Business Associate of any restriction to the use and/or disclosure of PHI to which Covered Entity has agreed in accordance with 45 CFR 164.522;

4.1.4 notify Business Associate of any amendment to PHI to which Covered Entity has agreed that affects a Designated Record Set maintained by Business Associate; and

4.1.5 if Business Associate maintains a Designated Record Set, provide Business Associate with a copy of its policies and procedures related to an Individual's right to: access PHI; request an amendment to PHI; request confidential communications of PHI; or request an accounting of disclosures of PHI.

ARTICLE 5

TERM AND TERMINATION

6.1 Term. The term of this Agreement shall begin on the Effective Date and shall terminate when all of the PHI is destroyed or returned to Covered Entity, or, if it is not feasible to return or destroy PHI, protections are extended to such PHI, in accordance with the provisions in Section 6.3.

6.2 Termination for Breach. If Business Associate breaches any provision in this Agreement, Business Associate may timely (but no more than thirty (30) days) cure the breach to reasonable satisfaction of Primary Business Association and this Agreement shall remain in full force and effect. Upon breach, Covered Entity may, at its option, access and audit the records of Business Associate related to its use and disclosure of PHI, require Business Associate to submit to monitoring and reporting, and such other conditions as Covered Entity may determine is necessary to ensure compliance with this Agreement, or Covered Entity may terminate this Agreement on a date specified by Covered Entity.

6.3 Effect of Termination. Upon termination of this Agreement for any reason, Business Associate agrees to return or destroy all PHI maintained by Business Associate in any form. If Business Associate determines that the return or destruction of PHI is not feasible, Business Associate shall inform Covered Entity in writing of the reason thereof, and shall agree to extend the protections of this Agreement to such PHI and limit further uses and disclosures of the PHI to those purposes that make the return or destruction of the PHI not feasible for so long as Business Associate retains the PHI.

ARTICLE 6
MISCELLANEOUS

7.1 Survival. The respective rights and obligations of Business Associate with regard to the return of records to Covered Entity shall survive the termination of the Agreement.

7.2 Regulatory References. A citation in this Agreement to the Code of Federal Regulations means the cited section as that section may be amended from time to time.

7.3 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with HIPAA. The provisions of this Agreement shall prevail over the provisions of any other agreement that exists between the Parties that may conflict with, or appear inconsistent with, any provision of this Agreement or HIPAA.

EXHIBIT D
PROVIDER PERFORMANCE STANDARDS

1. Performance and Engagement. Provider shall meet all performance and engagement goals within the first six (6) months of the [**Effective Date / January 1, 2022**] and annually thereafter on or before [June 30] of each year. Performance and Engagement goals are as follows:

    a. Complete DCE required Annual Compliance Training by date specified from DCE or CMS.

    b. Use best efforts to engage Beneficiaries by participating with DCE's Annual Wellness Visit ("**AWV**") outreach initiative and annually complete AWVs for at least seventy percent (70%) of Provider's attributed Beneficiaries. Half of the aforementioned goal (i.e., 35%) is to be completed on or before June 30 each year.

    c. Complete and submit to DCE's management company, CHS, all program quality measures during each AWV. Proper documentation of quality measures shall also be included in the Beneficiaries medical record maintained by Provider.

    d. Comply with CMS quality reporting and implement policies and processes to achieve optimal performance. Provider will assign staff to enter data into the online application within the timeframe assigned by DCE.

    e. Collaborate with DCE's care coordination team as necessary to for care coordination of Beneficiaries, including:

        i. Instituting transition of care plans for Beneficiaries;

        ii. Actively managing Beneficiaries with chronic conditions (e.g., COPD/Asthma, CHF, ESRD, DM, HTN);

        iii. Identifying and remediating, to the extent possible, Beneficiaries who frequently utilize emergency room services;

        iv. Actively managing Beneficiaries that are identified as high risk or high utilizers of services;

        v. Providing or referring Beneficiaries to community resources, as appropriate (e.g., for education, nutrition, or non-urgent transportation).

    f. Provide after-hours and weekend service access to Beneficiaries;

    g. Support and participate in all DCE quality assurance and quality improvement initiatives; and

    h. Utilize the population health platform, established for DCE by CHS.

2. Performance and Engagement Expectation. In the event performance noted above is not met in full, or in part, by Provider, DCE reserves the right to terminate the Agreement upon ninety (90) days' prior written notice to Provider.

3. Performance Tracking. CHS, on behalf of DCE, will provide an approximation of performance tracking based on information and data received from Provider. Provider acknowledges that performance tracking will be assessed separately for the periods prior to [January 1, 202_], versus the period starting

[January 1, 202_]. Due to the bifurcated tracking of performance tracking, Provider acknowledges that performance of Provider versus performance of all other providers in the DCE will be based on CHS' best approximation.

4. Shared Savings. Provider acknowledges and agrees that Shared Savings, if any, received from CMS will be based on the performance of the DCE as a whole and not on individual providers. In the event Shared Savings are achieved or shared losses incurred, such Shared Savings or Shared Losses will be distributed pursuant to an objective methodology adopted by the DCE's Governing Body

EXHIBIT E
COMPENSATION

Compensation for Primary Care Services from DCE

DCE has elected to participate in the Primary Care Capitation Payment Mechanism under the Direct Contracting Model. In connection with DCE's participation therein, and in accordance with the form of Direct Contracting Model: Fee Reduction Agreement attached hereto as Exhibit F, Provider shall, and shall require its Practice Providers to, accept as payment in full for its provision of health care services and laboratory services customarily furnished by or through a Primary Care Specialist and specifically those CPT/HCPC codes specified by CMS in advance of January 1, 2022 ("**Primary Care Services**"), payments from DCE in accordance with the rates set forth in Table 1 below. For purposes of this section, a Primary Care Specialist is defined to mean a physician or non-physician practitioner ("**NPP**") who has a primary specialty in primary care, such as general practice (CMS Specialty Code: 1), family medicine (CMS Specialty Code: 8), internal medicine (CMS Specialty Code: 11), pediatric medicine (CMS Specialty Code: 37), geriatric medicine (CMS Specialty Code: 38), nurse practitioner (CMS Specialty Code: 50), clinical nurse specialist (CMS Specialty Code: 89), or physician assistant (CMS Specialty Code: 97). CMS will specify a list of CMS specialty codes for Primary Care Specialists prior to the start of the relevant Performance Year. Therefore, this list may be subject to change.

TABLE 1		
CPT/HCPC	**Code Description**	**Rate (Percentage of CMS Medicare physician fee schedule)**
96160-96161	Administration of HRA	110%
99201-99205	Outpatient Visit New	110%
99211-99215	Outpatient Visit Established	110%
99339-99340	Home Care Plan Oversight Services	110%
99354-99355	Prolonged Care	110%
99495-99496	Transitional Care Mgmt.	110%
99324-99328, 99334-99337, 99339-99345, 99347-99350	Home Care E&M	110%
99421-99423, 99441-99443	Telephone Visits (Audio Only)	110%
99497-99498	Advanced Care Planning	110%
G0402, G0438, G0439	Welcome to Medicare & AWV	110%

99487, 99489, 99490, G0506	Chronic Care Mgmt.	110%
G2010-G2012	Virtual Check-ins	110%
99484, 99492, 99493, 99494	Behavioral Health Integration Services	110%
G0442-G0444	Depression & Alcohol Misuse	110%
G0463	Professional Services Provided in Electing Teaching Amendment Hospitals	110%
99304-99318	Professional Services Provided in a Non-Skilled Nursing Facility	110%

In the event DCE determines Provider has failed to (i) adhere to the Provider Performance Standards set forth in Exhibit D; (ii) perform the quality improvement activities set forth in Exhibit G; or (iii) meet the care coordination criteria set forth in Exhibit H, DCE may reduce the compensation that it pays to Provider for Primary Care Services from 110 percent of the applicable Medicare Physician Fee Schedule rate to 100 percent of the applicable Medicare Physician Fee Schedule rate; provided, however, that DCE will provide Provider with 30 calendar days prior notice, at which time Provider will have 30 calendar days to propose and begin to engage in a corrective action plan.

Compensation for Non-Primary Care Services from CMS

For all Covered Services that do not meet the definition of Primary Care Services ("**Non-Primary Care Services**"), Provider shall look to CMS for payment pursuant to Provider's standard Medicare fee for service billing processes. DCE shall not compensate Provider or its Practice Providers for Non-Primary Care Services.

Shared Savings

At the sole discretion of the DCE, and as set forth by the Governing Body, Provider may be eligible to receive up to twenty percent (20%) of the per capita Shared Savings achieved by the DCE. Participant eligibility requirements and calculation of Shared Savings payments to Provider will be set forth by the Governing Body. DCE will bare responsibilities for downside losses. At no time is the provider required to pay any sums related to payment made by the DCE to CMS for healthcare expenditures above the Performance Year benchmark, otherwise known as "downside risk" or shared losses.

Timing

DCE shall pay Provider for Primary Care Services within thirty (30) days of receiving notice of the processed claim of any applicable Primary Care Service, as indicated in claims data sent by CMS to DCE, unless a different time period is specified by CMS pursuant to the Primary Care Capitation Payment Mechanism.

Payment of any compensation by DCE shall be subject to coordination of benefits and subrogation activities and adjustments.

EXHIBIT F
FORM OF DIRECT CONTRACTING MODEL:
FEE REDUCTION AGREEMENT[1]

FORM OF DIRECT CONTRACTING MODEL:
FEE REDUCTION AGREEMENT

GENERAL INFORMATION

From [April 1, 2021 – December 31, 2021], as part of the Center for Medicare & Medicaid Services (CMS) Direct Contracting Model, _____, herein referred to as the Direct Contracting Entity (DCE), has elected to participate in one or more of three Alternative Payment Arrangements (APA): Total Care Capitation (TCC), Primary Care Capitation (PCC), and/or Advanced Payment Option (APO) as described in the Direct Contracting Model Participation Agreement (PA). The APA Payments will result in a lump sum monthly payment to the DCE that reflect a percentage of total expected Medicare Fee-For-Service (FFS) payments to selected providers and suppliers participating in the Direct Contracting Model ("Direct Contracting (DC) Participant Providers" and/or "Preferred Providers") for items and services furnished to Medicare beneficiaries who are aligned to the DCE ("Direct Contracting Beneficiaries"). The expected Medicare FFS payments are calculated based on historical claims billed by the selected DC Participant and/or Preferred Providers under the Medicare billing number assigned to the Taxpayer Identification Number (TIN) of each selected DC Participant Provider and/or Preferred Provider.

The DCE has indicated that one or more providers in your organization (as identified below) has agreed to receive FFS Reductions. Under this arrangement, your organization will not be reimbursed by CMS for the applicable Medicare FFS amount for each Medicare Part A and/or Part B claim that is submitted for covered items and services furnished to Direct Contracting Beneficiaries by a selected DC Participant Provider or Preferred Provider. Instead, reimbursement for the applicable Medicare FFS amount related to claims for covered items and services furnished to Direct Contracting Beneficiaries will be paid by the DCE, based upon the agreement between the provider (or organization) and the DCE. Not all DC Participant and/or Preferred Providers assigned to your TIN are required to receive FFS Reductions and those that do are not necessarily required to receive the same percentage reductions, subject to the participation rules of the Direct Contracting Model. You (or your organization) and the DCE have identified and agreed upon which DC Participant and/or Preferred Providers billing for items and services furnished to Direct Contracting Beneficiaries through your TIN will receive FFS Reductions and the percentage reduction for each provider based on the DCE's DC Participant and Preferred Provider List in the Appendix to this form.

Please note that you as a provider or your affiliated organization may only attest to APAs that your DCE elects. For example, if your DCE elects TCC, all DC Participant Providers must elect TCC, and all Preferred Providers may elect TCC if they so choose. However, if your DCE elects PCC, DC Participant Providers may elect PCC with or without APO, and all Preferred Providers may elect PCC with or without APO if they so choose. Finally, due to their unique billing requirements and the populations they serve, Critical Access Hospital Method-2 facilities only eligible for APO, and providers working in a Rural Health Clinics (RHCs) or Federally Qualified Health Centers (FQHCs) are only eligible for PCC.

[1] This agreement is for those DCEs who elect to participate in FFS Reductions for Performance Year (PY) 1 (April 1, 2021 – December 31, 2021) and is for informational purposes only. Provider agrees to execute the most up to date version of the Fee Reduction Agreement that has been released by CMS at such time as execution is required. Such Fee Reduction Agreement shall specify that Provider agrees to a 100 percent reduction of payment from CMS for Primary Care Services.

By signing this form, you certify that you have read the contents of this agreement and that you are authorized to legally bind yourself (or your organization) identified below and the DC Participant and/or Preferred Providers identified in the Appendix to this form that bill through the TIN of that organization. You further certify that you (or your organization) and the selected DC Participant and/or Preferred Providers that bill under the organization's TIN consent to receive a reduced FFS reimbursement of the applicable Medicare FFS amount for all covered Medicare items and services that are furnished to Direct Contracting Beneficiaries during the period of April 1, 2021 – December 31, 2021 from CMS, and that instead, the DCE will pay these claims as agreed upon with the DCE, and, that your TIN has verified which DC Participant Provider and/or Preferred Providers, based upon the applicable individual NPI, organizational NPI, CCN, or TIN, billing for items and services furnished to Direct Contracting Beneficiaries as assigned to your TIN will receive FFS Reductions.

AUTHORIZATION OF FFS REDUCTION

I understand that the knowing and willful omission, misrepresentation, or falsification of any information contained in this document or in any communication supplying information to Medicare may be punished by criminal, civil, or administrative penalties, including fines, civil damages, and/or imprisonment.

PROVIDER

Authorized Signature: _____

Printed Name: _____

Title: _____

Date: _____

Specialty: _____

County: _____

Phone: _____ (as shown in PECOS)

DBA (if applicable): _____

Address for Notices:

_____

_____

Attn: _____

Participant TIN/SSN: _____

APPENDIX – LIST OF INDIVIDUAL AND ORGANIZATIONAL IDENTIFIERS

From [April 1, 2021 – December 31, 2021], as part of the Center for Medicare & Medicaid Services (CMS) Direct Contracting Model, [DCE] has elected to participate in Alternative Payment Arrangements (APA) as described in the Direct Contracting Model Participation Agreement. This DCE has identified the following Individual Providers/Suppliers, Organizational Providers, Federally Qualified Health Centers (FQHCs)/Rural Health Centers/Critical Access Hospital Method 2 (CAH-2), Facility or Institutional Providers that are participating in APAs under:

TIN_____, Legal Business Name _____.[2]

EXHIBIT G
QUALITY INCENTIVE PROGRAM

1. Platform. DCE will provide Provider with access to its technology platform, and will assist Provider in interfacing with DCE's Population Health Platform on a regular basis.

2. Assistance. DCE will provide Provider with Population Health Platform training within sixty (60) days of the Effective Date of the Agreement. DCE will continue to provide ongoing support and training for Provider as needed.

3. Representations. Provider and its Practice Providers agree to:

    a. Use DCE's proprietary technology.

    b. Exchange patient encounter data with Population Health Platform through successful electronic medical record integration or through file transfer no less than at weekly intervals.

    c. Participate in additional trainings and meetings offered by DCE.

    d. Use Population Health Platform as directed by DCE at the time of the patient encounter for any primary care services (including, but not limited to, evaluation and management visits and annual wellness visits) provided to a Beneficiary.

    e. Identify and note each Beneficiary who may benefit from DCE's care coordination / management programs.

4. Quality Incentive Payments. Beginning on the Effective Date, DCE shall pay Provider, if Provider is in good standing, thirty dollars ($30) annually for each unique Beneficiary that completes an in person or telehealth Health Status and Risk Assessment Data Collection Form. The Encounter data must be submitted through DCEs Population Health Platform for the annual performance year.

5. Status. DCE will review Provider status, encounter data, and completion of quality measures and pay Providers within fifteen (15) days of submission.

6. Review. The DCE Governing Body may review, amend, or terminate quality measures or the Quality Incentive program at any time, but will use reasonable efforts to provide notice at least thirty (30) days prior to the effective date of such amendment or termination.

EXHIBIT H
CARE COORDINATION COMPENSATION FOR MEDICARE FFS

1. DCE will pay Provider a care coordination fee of $5.00 per Beneficiary per month in consideration of Provider's reasonable efforts to perform all the following quality improvement activities as described below, as appropriate for Beneficiaries, and Provider's cooperation with DCE's efforts to perform such activities for beneficiaries.

a. Quality Improvement: Provider shall be in good standing, and complete Quality Improvement Incentive Program outlined in Exhibit G, including but not limited to integrating EMR with DCE's population health platform, and completing quality measures for Beneficiaries.

b. Health Outcomes: Provider shall work to improve health outcomes of Beneficiaries implementing and maintaining activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives. Utilizing HEDIS (Healthcare Effectiveness Data and Information Set), Star Ratings, and other CMS quality measures set.

c. Hospitalizations/ Discharge Planning: Provider shall work to prevent hospital readmissions of aligned Beneficiaries by implementing a comprehensive program for hospital discharge that includes Beneficiary centered education, counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional. Critical elements of the program must include hospital discharge planning and follow up in accordance with CMS guidelines.

d. Health Care Data: Provider shall work to enhance the use of health care data for aligned Beneficiaries in order to improve quality, transparency, and outcomes through the meaningful use of health information technology designed to accomplish activities that improve quality of care, electronic creation, maintenance, access, or exchange of health information, or provide the technological infrastructure to enhance current quality improvement activities or make new quality improvement initiatives.

e. Beneficiary Experience: Provider and its Practice Providers are committed to provide a best-in-class beneficiary experience. Providers should determine ways to improve Beneficiary experience by listening to the voice of the Beneficiary, making it easier for the Beneficiary to access care and other healthcare services, making care convenient, and supporting cultural competency and health literacy. DCE uses CMS-required CAHPS (Consumer Assessment of Health Plan Survey) data, which measure a member's experience with their health plan and healthcare services (including their providers). DCE also uses data from the HOS (Health Outcome Survey), which measures a Beneficiary's perception of the improvement/decline of their health and if certain PCP conversations occurred two years after an initial assessment.

2. DCE may monitor the adequacy of Provider's quality improvement activities, including through review of urgent or emergent care utilization, availability of after-hours phone coverage, Beneficiaries' access to care, Beneficiaries' PCP disenrollment requests, and other performance measures. DCE may choose to evaluate access to care and quality of care. In the event DCE determines Provider has failed to provide quality improvement activities, DCE may reduce or terminate Care Coordination Compensation upon thirty (30) days prior notice to Provider. Provider will have thirty (30) days to provide corrective action plan to remedy quality improvement efforts.

3. DCE may audit Provider's performance of the quality improvement activities in accordance with the access and audit provisions set forth in this agreement.