

MEDICARE NEXT GENERATION ACO PREFERRED PROVIDER AGREEMENT

THIS AGREEMENT (“Agreement”) is entered into as of the ____ day of _____, 2016 (the “Effective Date”) by and between Trinity Health ACO, Inc., a Delaware nonprofit corporation (“Company”), and the entity or individual identified on the signature page hereof (“Preferred Provider”), on behalf of itself and, if applicable, its Providers (as hereinafter defined). Company and Preferred Provider are the only parties to this Agreement.

RECITALS

WHEREAS, Company is an accountable care organization (“ACO”) and is participating in the Center for Medicare & Medicaid Innovation's Next Generation ACO model (“Next Gen Model”) on January 1, 2016; and

WHEREAS, ACO and Preferred Provider are committed to implementing and following processes and procedures to support accountability for the quality, cost and overall care of Attributed Beneficiaries.

NOW, THEREFORE, the Parties agree as follows:

SECTION 1 – DEFINITIONS

For purposes of this Agreement, the following terms shall have the meanings indicated. These definitions shall apply to the Agreement and to all Attachments, Exhibits and Addendums attached hereto. All terms used herein shall have the same meaning as identified by the Center for Medicare and Medicaid Innovation (“CMMI”) from time to time. Any changes to the definitions by CMMI will also be incorporated herein without the need for a written modification to this Agreement.

- 1.1 “Accountable Care Organization” (“ACO”) means Trinity Health ACO, Inc. and more generally refers to a legal entity that is recognized and authorized under applicable State or Federal law, is identified by a Taxpayer Identification Number (“TIN”), and is formed by one or more providers or suppliers that agree to work together to be accountable for the quality, cost and overall care of Attributed Lives.
- 1.2 “Attributed Life” or “Attributed Lives” means a Medicare Beneficiary who is assigned to ACO and that qualifies to be included in the Shared Savings calculation performed under the Next Gen Model.
- 1.3 “Center for Medicare and Medicaid Innovation” or “CMMI” refers to the federal agency that is responsible for administering the Next Gen Model.

- 1.4 “Clinical Model” means the written ACO guidelines, processes and procedures for quality and cost control founded on three inter-related and mutually supporting elements of: (1) quality performance measure management, (2) case management and (3) clinical data sharing.
- 1.5 “Health Care Services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.
- 1.6 “Medicare Fee-for-Service Beneficiary” or “Medicare Beneficiary” means an individual who is: (1) enrolled in the original Medicare program under both parts A and B; and (2) not enrolled in any of the following: (i) a Medicare Advantage Plan under Part C; (ii) an eligible Health Maintenance Organization or Competitive Medical Plan under section 1876 of the Social Security Act; or (iii) a PACE program under section 1894 of the Social Security Act.
- 1.7 “National Provider Identifier or “NPI” means the unique ten digit identification number required for all licensed health care providers.
- 1.8 “Next Gen Model Agreement” means the Next Gen Model Agreement between ACO and CMMI (the “Next Gen Model Agreement”) under which ACO agrees to be accountable for the quality, cost, and overall care of Medicare Beneficiaries who are enrolled in the traditional Medicare fee-for-service program and who are Attributed Lives in the ACO.
- 1.9 “Next Generation Affiliate” refers to an entity that is not a Next Generation Provider/Supplier and has a written agreement with the ACO regarding a specific model design element. There are two types of Next Generation Affiliates, including capitation affiliates that contract with the ACO in order to participate in a capitation arrangement and SNF affiliates that are skilled nursing facilities to which Next Generation Providers/Suppliers or Preferred Providers may admit Next Gen Model Medicare Beneficiaries according to the SNF 3-day rule benefit enhancement.
- 1.10 “Next Generation Provider/Supplier” means an individual or group of Providers that is identified by a Medicare-enrolled TIN that alone or together with one or more other Preferred Provider(s) comprise(s) an ACO, and that is included on the list of Preferred Providers submitted by ACO to CMMI and updated at the start of each Performance Year and at other times as specified by CMMI.
- 1.11 “Performance Year” shall mean the 12-month period beginning January 1 and ending December 31 of each year during the Agreement period, unless otherwise noted in the Next Gen Model Agreement.
- 1.12 “Physician” shall mean a doctor of medicine or osteopathy.
- 1.13 “Primary Care Physician” shall mean a physician who has a primary specialty designation of internal medicine, general practice, family practice or geriatric medicine, or, for services

furnished in an Federally Qualified Health Centers (“FQHC”) or Rural Health Clinics (“RHC”), a physician providing primary care services included in an attestation by the ACO to CMMI.

- 1.14 “Primary Care Service” means the set of services identified by the following CPT codes: (1) 99201 through 99215; (2) 99304 through 99340, and 99341 through 99350, G0402 (the code for the Welcome to Medicare visit), G0438 and G0439 (codes for annual wellness visits); (3) Revenue center codes 0521, 0522, 0524, 0525 submitted by FQHCs (for services furnished prior to January 1, 2011), or by RHCs.
- 1.15 “Primary Care Provider” means a Provider who is either of the following: (1) a Primary Care Physician legally authorized to practice medicine by the state in which s/he performs such function or action related to Primary Care Services; or (2) a practitioner who both provides Primary Care Services and is one of the following: (i) a physician assistant; (ii) a nurse practitioner; or (iii) a clinical nurse specialist.
- 1.16 “Preferred Provider” refers to an ACO selected Medicare provider with whom the ACO has a relationship based upon high quality care and care coordination for Medicare Beneficiaries associated with the ACO. The ACO may allow certain benefit enhancements that are available to aligned beneficiaries when receiving care from Preferred Providers to also be available through Preferred Providers; provided that the ACO has a written agreement with the Preferred Provider and has supplied CMMI with the Preferred Provider list according to CMMI instructions.
- 1.17 “Provider” refers to an individual or entity that: (1) is a Medicare enrolled provider or supplier other than a DMEPOS supplier; (2) is identified by a National Provider Identifier (NPI) or CMS Certification Number; (3) bills for items and services it or he/she furnishes to Medicare Beneficiaries under a Medicare billing number assigned to the TIN of an Preferred Provider and (4) is included on the list of Preferred Providers submitted by ACO to CMMI.
- 1.18 “Quality Measures” means the measures defined by CMMI and applicable to the Next Gen Model.
- 1.19 “Shared Savings” means a specified percentage of total savings achieved, as determined by CMMI. Shared Savings are determined by CMMI through reconciling expenditures against the benchmark.
- 1.20 “Taxpayer Identification Number” (“TIN”) means a Federal taxpayer identification number or employer identification number.

SECTION 2 - OBLIGATIONS OF PREFERRED PROVIDERS, AND PROVIDERS

- 2.1 Accountability. Next Generation Providers/Suppliers, Next Generation Affiliates, Preferred Providers and Providers agree to become and remain accountable for the quality, cost and

overall care of Attributed Lives. Toward that end, Next Generation Providers/Suppliers, Next Generation Affiliates, Preferred Providers and Providers will comply with and implement the Clinical Model to: (1) promote evidence based medicine; (2) promote patient engagement; (3) develop and implement infrastructure and reporting on quality and cost metrics to enable monitoring and feedback of performance in order to evaluate performance and improve care over time; and (4) coordinate care.

2.2 Authority to Bind Preferred Provider and Providers. Preferred Provider hereby represents and warrants that it has binding authority on behalf of its Providers identified on **Exhibit 1** to enter into this Agreement on their behalf. Those Providers will be bound by the terms and conditions of this Agreement and materials it incorporates by reference, including but not limited to, all applicable terms and conditions of the Next Gen Model Agreement, duly adopted policies and procedures and all applicable program requirements. By way of example, the Next Gen Model Agreement requires Preferred Providers to participant exclusivity, quality measure reporting, continuous care improvement objectives, voluntary alignment, beneficiary freedom of choice, benefit enhancements, coordinated care reward, participation in evaluation, shared learning, monitoring and oversight activities, the ACO compliance plan and the audit and record requirements. Preferred Providers will be responsible for, cause and make best efforts to ensure each of their Provider's compliance with the terms of this Agreement and each Provider's performance hereunder.

2.2.1 Each Provider, identified by NPI, whose services are billed to Medicare through the TIN of a Preferred Provider and who are identified on the exhibit attached hereto, will participate in ACO as a Provider.

2.2.2 Preferred Provider will notify ACO as soon as reasonably possible, but no later than one week from the event, if any Provider becomes disassociated with the Preferred Provider's TIN for any reason. Preferred Provider shall notify ACO of any Providers being added to its TIN no less than thirty (30) days before the addition. Preferred Provider understands that ACO has a reporting obligation to CMMI to advise of any changes in NPIs included in Preferred Provider's TIN(s) within thirty (30) days and that Preferred Provider's timely notification is essential to ACO's compliance.

2.2.3 To the extent that any Provider identified by an NPI linked to Preferred Provider's TIN may be excluded from ACO for any reason, disciplinary or otherwise, Preferred Provider will cooperate in de-linking or disassociating that Provider's NPI from the Preferred Provider TIN for purposes of billing Medicare and/or other payors as required by CMMI.

2.3 Provision of Services. Preferred Provider will provide Attributed Lives with professional and/or facility services, as appropriate, in accordance with Medicare program statutes, regulations and policies as well as the policies and procedures set forth by CMMI and policies created by ACO that are made available from time to time.

- 2.4 Attributed Life Medicare Benefit. As directed by CMMI, Attributed Lives will remain free to use their Medicare benefits as they choose and, to the extent permitted by Medicare, to self-refer to any provider, regardless of Preferred Provider status. Without limiting this freedom, and in accordance with regulatory authorities, Preferred Provider will cooperate with ACO's policies and procedures with regard to clinical coordination of care.
- 2.5 Verification of Professional Qualifications of Preferred Providers and Providers. Preferred Provider and Providers shall be a participating provider in Medicare, in good standing to provide services to Medicare Beneficiaries and licensed and in good standing to practice their professions in each state in which they practice and provide services to Attributed Lives. Nothing in this Agreement supersedes any of the terms and conditions of Preferred Provider's enrollment in the Medicare program. ACO, may, in its discretion, require additional reasonable verification of professional qualifications, such as, by way of example and not limitation, validation of licensure in good standing, hospital privileges, and ACO may delegate such functions to a qualified entity.
- 2.6 Nondiscrimination. Preferred Provider, and Providers shall not discriminate or differentiate in treatment or access to health care on the basis of race, age, gender, gender identity medical history, religion, marital status, sexual orientation, color, national origin, place of residence, health status, creed, ancestry, disability, veteran status, type of illness or condition, or source of payment for services. Preferred Provider and Providers shall not avoid or discriminate against Attributed Lives that may be generally characterized as "at-risk" in any manner.
- 2.7 Cooperation with Case Management. Preferred Provider shall make best efforts to cooperate with ACO's case management protocols, which may include placing in-office case managers at Preferred Provider's practice and/or requiring Preferred Provider to coordinate with hospital or other facility case managers regarding the care of Attributed Lives.
- 2.8 Implementation of Protocols. Preferred Provider shall make best efforts to implement such cost and quality control protocols or other interventions as may be adopted by ACO regarding the care of Attributed Lives.
- 2.9 Exercise of Professional Judgment. Nothing in the Clinical Model shall be interpreted to interfere in any manner with the exercise of Provider's professional judgment.
- 2.10 Compliance. Preferred Provider and Providers shall comply with all applicable laws and regulations governing participation with the ACO which includes, but is not limited to, Next Generation Program Participation Agreement requirements, Next Gen Model rules and regulations, federal laws such as the False Claims Act, Anti-Kickback Laws, Civil Monetary Penalties Laws, HIPAA and Stark.

Preferred Provider, and Providers shall comply with the provisions set forth in the Business Associate Agreement attached hereto as **Exhibit 2**, implementing the Health

Insurance Portability and Accountability Act of 1996 (“HIPAA”) and shall observe all relevant statutory and regulatory provisions regarding the appropriate use of data and confidentiality and privacy of individual health information as they apply to Preferred Provider, and Providers, and which may be modified from time to time. Preferred Provider, and Providers will implement all necessary requirements of HIPAA in the manner and time frame required by HIPAA.

2.11 Required Disclosures to ACO. In addition to such disclosures as may be required elsewhere in this Agreement, Preferred Provider shall notify ACO as soon as reasonably possible (but no later than seven days) in writing of the occurrence of, and shall upon request provide ACO with additional documentation or information regarding, any of the events indicated below:

2.11.1 The voluntary surrender or termination of any of Preferred Provider’s, or a Provider’s licenses, certifications, accreditations; or

2.11.2 The investigation into ACO related conduct, meaning conduct substantially related to the performance of this Agreement, by any law enforcement entity, conviction of Preferred Provider, or a Provider of a fraud or felony, or the suspension, debarment or exclusion from participation in a federal health care program (as defined in 42 U.S.C. § 1320a-7b(f)) of Preferred Provider, or any Provider; or

2.11.3 The occurrence of an act of nature or any event beyond Preferred Provider’s, or a Provider’s reasonable control which substantially interrupts all or a portion of Preferred Provider’s, or a Provider’s business or practice, or that has a materially adverse effect on Preferred Provider’s, or a Provider’s ability to perform its or his/her obligations hereunder; or

2.11.4 Preferred Provider’s, and/or, as applicable, a Provider’s, failure to maintain the insurance coverage required by this Agreement.

2.12 Reports to ACO. Preferred Provider shall make available, upon request, encounter data and other information specific to Medicare covered services rendered to Attributed Lives as necessary for the administration of this Agreement as required by regulation, ACO or as reasonably requested by ACO.

2.13 Data Reporting. Preferred Provider shall provide and report such data from its Electronic Health Records (“EHR”) system or medical records as ACO may reasonably require to monitor the cost and quality of services, including care management services, provided to Attributed Lives. Preferred Provider will cooperate in connecting its information systems to ACO, or ACO’s designee, in order to facilitate the exchange of clinical and cost related data in furtherance of the requirements of the Next Gen Model. If requested by ACO, Preferred Provider agrees to enter into an agreement with a designed health information exchange provider (“HIE”), to forward clinical information from Preferred Provider’s EHR to a data repository, analytics, or case management system provider

designated by ACO (“Data Repository”). Preferred Provider authorizes ACO to direct HIE to forward clinical information to the Data Repository and authorizes Data Repository to de-identify protected health information sent by Preferred Provider aggregate that de-identified data with other de-identified data and use the aggregated, de-identified data for Data Repository’s data reporting, analytics purposes, and other data purposes. Preferred Provider authorizes ACO to seek individually identifiable health information (“IIHE”) regarding Attributed Lives from any sources to be directed through the Data Repository for ACO purposes.

- 2.14 Delegation Prohibited. Preferred Provider shall not delegate or subcontract any of its duties under this Agreement to a Provider or entity who is not a Preferred Provider without the approval of ACO which approval shall not be unreasonably withheld.
- 2.15 Marketing. CMMI requires all marketing materials to be submitted to it for approval and ACO will make all such requests. Preferred Provider may not create or distribute any marketing or other materials that reference ACO, Preferred Provider’s participation in Next Gen Model. If Preferred Provider wishes to create, use or modify such marketing materials, it must submit first to ACO for approval by CMMI and shall not use any materials that do not have CMMI approval as obtained by ACO.
- 2.16 No ACO Liability for Claims. Preferred Provider and Provider(s) agree and acknowledges that CMS, and not ACO, has the full and final responsibility and/or liability for payment of claims for services provided to Attributed Lives.
- 2.17 Billing. Notwithstanding anything to the contrary, nothing in this Agreement shall modify or otherwise limit the ability of Preferred Provider to directly bill CMS for services provided and Preferred Provider shall continue to bill CMS in accordance with all applicable laws, rules and regulations.
- 2.18 Authority. The undersigned has full power and authority to bind the participant to the terms and conditions of this Agreement and further represents he/she has the authority to bind providers who bill pursuant to a Medicare billing number assigned to the Preferred Provider to the terms and conditions of this Agreement.
- 2.19 Current Medicare Enrollment Information. Preferred Provider acknowledges it is required to and hereby agrees to timely update its Medicare enrollment information, including the addition and deletion of ACO professionals and ACO providers/suppliers billing through Preferred Provider's TIN, on a timely basis and in accordance with Medicare program requirements and to notify the Company of any such changes within thirty (30) days after the change.

SECTION 3 - ACO OBLIGATIONS

- 3.1 Compliance with ACO Program Rules. ACO will comply with all applicable rules and regulations governing the administration of an ACO program qualified to participate in the Next Gen Model. If, for any reason, ACO ceases to qualify as an eligible participant in the Next Gen Model, ACO shall, as soon as reasonably possible, notify all Preferred Providers.
- 3.2 No Inducement to Forego Medically Necessary Services. Nothing in this Agreement shall be construed to offer an inducement to Preferred Provider or a Provider to forego providing medically necessary services to Attributed Lives.
- 3.3 Compliance. ACO shall comply with and abide by all applicable federal, state and local rules and regulations, as applicable, including but not limited to, federal laws such as the False Claims Act, Anti-Kickback Laws, Civil Monetary Penalties, and Stark.
- 3.4 Privacy and Security of Shared Information. ACO shall manage all data received from Preferred Provider which includes protected health information, in a manner that is compliant with state and federal privacy and security laws, rules and regulations, as they are applicable and as they may change from time to time. ACO will develop policies and procedures that will require ACO to protect the privacy and security of health information shared with ACO by Preferred Provider consistent with the Business Associate and Qualified Service Organization Addendum attached hereto as **Exhibit 2** and ACO shall comply with that Addendum. ACO also agrees to manage data supplied to Preferred Provider in accordance with the ACO Data Use Policy(ies) and/or contract amendment as may be implemented at a later date.

SECTION 4 - RECORDS

- 4.1 Covered Person Records. Preferred Provider and Provider shall prepare and maintain, and protect the confidentiality, security, accuracy, completeness and integrity of, all appropriate medical and other records related to the provision of Medicare covered services to Attributed Lives (including, but not limited to, medical, encounter, financial, accounting, administrative and billing records) in accordance with: (i) applicable state and federal laws and regulations including, but not limited to, applicable confidentiality requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”); and (ii) ACO and CMS billing, reimbursement, and administrative requirements. Such records shall include such documentation as may be necessary to monitor and evaluate the quality of care and to conduct medical or other health care evaluations and audits to determine, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to Attributed Lives.

Subject to applicable laws regarding confidentiality, Preferred Provider and Providers hereby authorize ACO to release any and all information, records, summaries of records and statistical reports specific to Preferred Provider, or Providers, including but not limited

to utilization profiles, encounter data, treatment plans, outcome data and other information pertinent to Preferred Provider's, or Providers' performance of services and professional qualifications to federal or state governmental authority(ies) with jurisdiction, or any of their authorized agents, and accreditation agencies, without receiving Preferred Provider's, or Providers' prior consent.

- 4.2 Inspection and Access. Subject to applicable confidentiality laws and within ten (10) business days following a request by ACO, Preferred Provider, and Providers shall provide ACO or its designees and, if required by law or contract, authorized state and/or federal agencies, or CMMI, access during regular business hours for: (i) inspection and copying of all records maintained by Preferred Provider, and Providers related to Preferred Provider, or Providers' provision of Medicare covered services to Attributed Lives (including, but not limited to, medical, financial, accounting, administrative and billing records); (ii) assessing the quality of care or investigating grievances and complaints of Medicare Fee-for-Services Beneficiaries that are Attributed Lives; and (iii) inspection of Preferred Provider, and Providers' facilities for quality assurance, utilization review, verification of professional qualifications, claims payment verification, fraud and abuse investigation and other activities reasonably necessary for the efficient administration of the ACO, and as necessary for compliance with federal and state law or CMMI requirements.
- 4.3 Sharing With Other Providers. Subject to all applicable state and federal laws and regulations regarding privacy and confidentiality, Preferred Provider and Providers shall also cooperate with ACO in permitting maximum sharing of medical records specific to Medicare covered services with Providers providing services to Attributed Lives. Preferred Provider, and Providers shall make the records available to and communicate as appropriate with each provider treating the Attributed Life, as needed, for the purpose of facilitating the delivery of appropriate Health Care Services to each Attributed Life and carrying out the purposes and provisions of this Agreement.
- 4.4 Survival. The provisions of this Section 4 shall survive termination of the Agreement.

SECTION 5 - INSURANCE

- 5.1 Professional Insurance. Preferred Provider who is not a hospital or ambulatory service center or an FQHC enjoying the privileges of Federal Tort Claim Act immunity, at its sole cost and expense, shall procure and maintain such professional liability insurance as is necessary to insure Preferred Provider, and each of its respective Providers, employees, agents and representatives. Upon request, Preferred Provider, or Provider, as appropriate, agree to submit to ACO a certificate of insurance as evidence of such coverage. In the event any such professional liability policy is a "claims made" policy, Preferred Provider will purchase a "tail" policy, effective upon the termination of the primary policy, or obtain replacement coverage which insures for prior acts, insuring for losses arising from occurrences during the term of this Agreement, which tail policy or prior acts coverage shall have the same policy limits as the primary policy and shall extend the claims reporting period for the longest period for which coverage is available. Preferred Provider

agrees to provide ACO with immediate, and in no event less than thirty (30) days' prior, written notice of any cancellation, non-renewal or change to such policy.

- 5.2 Hospital Insurance. Preferred Provider who is a hospital or ambulatory service center, at its sole cost and expense, shall procure and maintain such policies of insurance as are necessary to insure Preferred Provider and its Providers, employees, agents and representatives with coverage limits of not less than one million dollars (\$1,000,000) per occurrence, three million dollars (\$3,000,000) in annual aggregate, and five million dollars (\$5,000,000) excess coverage in the performance of any act relating to this Agreement. Upon request, Preferred Provider agrees to submit to ACO a certificate of insurance as evidence of such coverage. In the event any such liability policy is a "claims made" policy, Preferred Provider will purchase a "tail" policy, effective upon the termination of the primary policy, or obtain replacement coverage which insures for prior acts, insuring for losses arising from occurrences during the term of this Agreement, which tail policy or prior acts coverage shall have the same policy limits as the primary policy and shall extend the claims reporting period for the longest period for which coverage is available. Preferred Provider agrees to provide ACO with immediate, and in no event less than thirty (30) days' prior, written notice of any cancellation, non-renewal or change to such policy.

SECTION 6 - TERM & TERMINATION

- 6.1 Term. The term of this Agreement shall commence on the Effective Date and shall continue in effect for an Initial Term ending on December 31, 2018 after which it shall continue for any additional periods in which ACO participates in the Next Gen Model. This Agreement shall terminate immediately with cause on the date of notice from the ACO, should CMMI terminate the Next Gen Model Agreement.
- 6.2 Termination without Cause. This Agreement may be terminated without cause by the mutual written agreement of the Parties. This Agreement may be terminated by either Party by providing notice not less than ninety (90) days to the other Party.
- 6.3 Termination with Cause. Either Party may terminate this Agreement upon a material breach by the other Party, by providing sixty (60) days' prior written notice to the Party alleged to be in breach identifying, with specificity, such breach, but only in the event that the alleged breaching Party fails to cure same within the sixty (60) day notice period.
- 6.4 Immediate Termination.
- 6.4.1 Notwithstanding the foregoing, ACO may terminate this Agreement, or an individual Provider's participation hereunder, immediately upon written notice to the Preferred Provider or in the event that Preferred Provider, or an individual Provider performing

services hereunder who bills under the Preferred Provider's TIN number, is convicted of a fraud or felony or is suspended, debarred or excluded from participation in a federal health care program (as defined in 42 U.S.C. § 1320a-7b(f)) or if Preferred Provider's or any Provider's license is suspended or revoked; and

6.4.2 ACO may terminate or suspend any Preferred Provider's status as a Preferred Provider, or individual provider's participation hereunder, upon written notice to Preferred Provider, or Provider in the event that: (i) the Preferred Provider does not timely de-link or disassociate a terminated Provider's NPI from their TIN; (ii) a final disciplinary action by a state licensing board or other governmental agency that impairs the Preferred Provider, or Provider's ability to practice; or (iii) ACO reasonably determines that the Preferred Provider or Provider's continued participation would jeopardize ACO's fulfillment of its contractual or program obligations; or (iv) CMS notifies ACO that ACO is required to remove the Preferred Provider from the Model. Preferred Provider further acknowledges ACO may require Preferred Provider to take action against a professional within Preferred Provider related to non-compliance with the requirements of the Next Gen Model.

6.5.1 Effect of Termination. Following the effective date of termination of this Agreement, the provisions of this Agreement shall be of no further force or effect, except as otherwise provided in this Agreement, and except that each Party to this Agreement shall remain liable for any obligations or liabilities arising from the activities carried out by such Party prior to the effective date of termination.

SECTION 7 - GENERAL PROVISIONS

7.1 Entire Agreement. This Agreement, including the any Exhibits or other attachments as well as any documents incorporated by reference herein, constitutes the entire agreement of the Parties regarding the subject matter hereof and supersedes any oral or written understandings or agreements prior to the execution of this Agreement.

7.2 Confidentiality. The Parties each acknowledge that each may disclose confidential and proprietary information (by way of example and not limitation, policies and procedures, records, formulas) to the other in the course of performance of this Agreement. All information so disclosed by one Party to the other which is not otherwise publicly available shall be deemed confidential and shall not be disclosed by the receiving Party to any third party without the prior written consent of the Party who disclosed the information to such receiving Party. Upon termination of this Agreement for any reason, each party shall return to the other all electronic and printed materials containing confidential or proprietary information received from the other, that it is not required to retain pursuant to this Agreement or law or certify to the other that those materials have been destroyed. The obligations of this Section shall survive termination of this Agreement for any reason.

7.3 Successors and Assigns. This Agreement shall not be assigned by either Party without the written consent of the other Party, which consent shall not be unreasonably withheld, provided that ACO may assign its rights and obligations under the Agreement to an entity

that it controls or is controlled by or is under common control with ACO.

- 7.4 Amendments. This Agreement may be amended or modified in writing as mutually agreed upon by the Parties, or as provided in this Agreement. In addition, ACO may unilaterally modify any provision of this Agreement and its Exhibits, Attachments and Riders upon thirty (30) days prior written notice to Preferred Provider or immediately upon receipt by Preferred Provider if such modification is made to comply with federal or state laws or other regulatory bodies.
- 7.5 Independent Contractor Relationship. None of the provisions of this Agreement between or among ACO, Preferred Provider, Providers, or CMMI create a relationship other than that of independent entities contracting solely for the purposes of effecting the provisions of this Agreement. Except as explicitly provided otherwise in this Agreement, neither the Parties, nor CMMI, shall be construed to be the agent, partner, employee, or representative of any of the other Parties or of CMMI. Preferred Provider, and Providers hereby agree that while compliance with applicable CMMI and ACO standards, policies and procedures is a condition of participation in the ACO, Preferred Provider, and Providers shall at all times render independent medical judgment.
- 7.6 No Third-Party Beneficiaries. Except as specifically provided herein by express language, no person or entity shall have any rights, claims, benefits, or powers under this Agreement, and this Agreement shall not be construed or interpreted to confer any rights, claims, benefits or powers upon any third party.
- 7.7 Section Headings. All Section headings contained herein are for convenience or reference only and are not intended to limit, define or extend the scope of any provisions of this Agreement.
- 7.8 Severability. In the event any part of this Agreement shall be determined to be invalid, illegal or unenforceable under any federal or state law or regulation, or declared null and void by any court of competent jurisdiction, then such part shall be reformed, if possible, to conform with the law and, in any event, the remaining parts of this Agreement shall be fully effective and operative so far as reasonably possible to carry out the contractual purposes and terms set forth herein.
- 7.9 Waiver of Breach. The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach or violation of this Agreement.
- 7.10 Notices. Notices and other communications required by this Agreement shall be deemed to have been properly given if mailed by first-class mail, postage prepaid, or hand delivered to the following address:
- 7.11 Counterparts, Signatures: This Agreement may be executed in multiple counterparts, each of which shall be deemed an original, but all of which shall constitute one and the

same instrument and shall be effective when ACO has executed its counterpart. Any signature delivered by facsimile machine, or by .pdf, .tif, .gif, .peg or other similar attachment shall be treated in all manner and respects as an original executed counterpart and shall be considered to have the same binding legal effect as if it were the original signed version thereof delivered in person.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by the duly authorized officers to be effective as of the Effective Date indicated above.

TRINITY HEALTH ACO, INC.

By: _____
Its: _____
Effective Date: _____

PREFERRED PROVIDER

By: _____
Authorized Signature

Print Name: _____

TIN: _____

Date:

TABLE OF EXHIBITS

EXHIBIT 1: List of NPI Numbers

EXHIBIT 2: Business Associate and Qualified Service Organization Addendum

EXHIBIT 1

Provider Name	NPI	TIN

EXHIBIT 2

BUSINESS ASSOCIATE AGREEMENT ADDENDUM

This Business Associate Agreement Addendum ("BAA") is attached to and supplements that certain Medicare Next Generation ACO Provider/Supplier Participation Agreement (the "Agreement") and documents the business associate obligations of Trinity Health ACO, Inc. ("Business Associate") and the obligations of Next Generation Provider/Supplier in its capacity as the "Covered Entity."

- A. HIPAA and HITECH Dominance.** In the event of a conflict or inconsistency between the terms of any other agreement between the parties and this language, this BAA language controls. This language is intended to comply with the Health Insurance Portability and Accountability Act of 1996 as well as the Health Information Technology for Economic and Clinical Health Act (found in Title XIII of the American Recovery and Reinvestment Act of 2009), as amended, and all final regulations issued pursuant to such Acts ("HIPAA" and "HITECH").
- B. Business Associate.** Furthermore, Business Associate acknowledges that to the extent that it is a "Business Associate", it will comply with the business associate provisions of HITECH in the performance of such services as of the date that compliance is required under HITECH.
- C. Protected Health Information.** This BAA applies to all PHI in the Business Associate's possession and/or under its control that was collected, created, received, maintained by or transmitted to or from the Covered Entity.
- D. Agents and Subcontractors.** Business Associate will require that its agent(s) and subcontractor(s) agree to the same restrictions and obligations as Business Associate. Business Associate also will require its agent(s) and subcontractor(s) to agree to implement reasonable administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of all the Covered Entity's PHI.
- E. Permissible Uses of PHI.**
 - 1. Using and Disclosing PHI.** Business Associate may use or disclose PHI as permitted by this BAA or as required by law. Business Associate may use PHI to directly perform services pursuant to this BAA, including data aggregation services.

Furthermore, the Business Associate may only use or disclose PHI to the extent that the Covered Entity is permitted to use and disclose PHI and, only if, the Covered Entity has delegated that use or disclosure to the Business Associate.

2. **Minimum Necessary.** The Covered Entity will provide Business Associate with the minimum amount of PHI required by Business Associate to perform services pursuant to this BAA
3. **Business Associate Management Uses of PHI.** Business Associate may use or disclose PHI as necessary for its proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

F. Security and Reporting

1. **Safeguards.** Business Associate agrees to implement reasonable administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of all PHI.
2. **Reports.** Business Associate will (i) report to Covered Entity any use or disclosure of PHI not permitted by this BAA; (ii) any successful security incident of which Business Associate becomes aware; and (iii) in summary form, upon request of Covered Entity, any unsuccessful security incident of which Business Associate becomes aware. If the definition of "Security Incident" in the HIPAA regulation is modified to remove the requirement for reporting "unsuccessful" security incidents, section (iii) above will no longer apply as of the effective date of such regulation modification.

G. HITECH. Each party will comply with each obligation applicable to such party under HITECH as of the date that compliance with such obligation is required under the same. In furtherance thereof:

1. Each provision that is required to be included in business associate agreements pursuant to HIPAA and HITECH and is not already set forth in this BAA is hereby incorporated into this BAA by reference;
2. Business Associate agrees to notify the Covered Entity promptly if it discovers a breach involving PHI and to comply with the applicable provisions of HITECH with respect to that breach.
3. Business Associate will document certain disclosures of PHI and information related to such disclosures and provide an accounting of such disclosures in accordance with HIPAA and HITECH.

H. Patient Rights With Respect To PHI. To the extent that Business Associate maintains a Designated Record Set on behalf of the Covered Entity, Business Associate acknowledges that under HIPAA patients have the right to access and review their PHI; amend their health records; and request restrictions on the use and disclosure of PHI.

- I. Notification of Restrictions to Use or Disclosure of PHI.** Covered Entity will notify Business Associate of any restrictions to the use or disclosure of PHI that Covered Entity has agreed to in accordance HIPAA and HITECH to the extent that such restrictions or confidential communication may affect Business Associate's use or disclosure of such PHI.
- J. Notice of Patient Contact.** Business Associate will notify the privacy officer of Covered Entity if a patient contacts Business Associate in connection with the patient's PHI.
- K. Amendment.** Upon enactment of any law, regulation, court decision or relevant government publication and/or interpretive policy affecting the use or disclosure of PHI, the parties agree to amend this BAA to comply with the same.
- L. Access for Audit.** Business Associate will make its internal practices, books and records relating to the use and disclosure of any PHI available to any authorized government investigators for purposes of determining the Covered Entity's compliance with HIPAA.
- M. Termination of Relationship**
 - 1. Covered Entity - Termination and Cure.** In the event of Business Associate's material failure to comply with this BAA, the Covered Entity may terminate its relationship with Business Associate upon 30-days advanced written notice to Business Associate; provided, however, that Business Associate has not cured the material failure to comply within 30-days after receiving written notice from the Covered Entity.
 - 2. Business Associate - Termination and Cure.** In the event of Covered Entity's material failure to comply with this BAA, the Business Associate may terminate its relationship with Covered Entity upon 30-days advanced written notice to Covered Entity; provided, however, that Covered Entity has not cured the material failure to comply within 30-days after receiving written notice from Business Associate.
 - 3. PHI Obligations upon Termination or Expiration.** Unless Business Associate is required by law to maintain PHI, Business Associate will return (and not retain any copies of) all PHI in its possession or under its control within 30 days after the termination/expiration of this BAA. If Business Associate is unable to return PHI, then Business Associate will notify the Covered Entity of the reasons for being unable to return PHI in writing and must, at a minimum, maintain PHI as required by this BAA and HIPAA for so long as the Covered Entity's PHI exists.
- N. Survival.** The respective rights and obligations of the parties under this BAA, including without limitation the obligations of the Business Associate under Section Termination of Relationship, shall survive termination of the BAA to the extent necessary to fulfill their purposes.

EXHIBIT 2