DMC Practice Participation Attestation

Provided by: ADVANCED VALUE CARE II
(Direct Contracting Entity)

_____
(Name of Primary Care Practice)

_____
(Street Address, Suite, Building, etc.)

_____, New York _____
(City/Town) (Zip Code)

Congratulations!

You have been selected to participate in an innovative program designed by Centers of Medicaid and Medicare services ("CMS").

The program concerns Direct Contracting.

Note that Direct Contracting is a program for Medicare Beneficiaries only. They must NOT be enrolled into a Medicare Advantage Plan.

Basically, this program rewards you for keeping your patients healthy, reporting positive outcomes, and reducing medical cost.

For these reasons you may receive a portion of these cost savings in the form of financial reimbursement to you.

In order to get you started we will need your authorization at the bottom of this form allowing Advanced Value Care to be your representation for the purposes of this program only. There is no fee associated with this representation.

Under our unique "COVID-19 Plan" those patients whom you have not been able to see under a Fee for Service arrangement will be able to bill under a competitive Capitated Payment system.

Because of your participation in this new CMS directive you will have access, where available to you, of cutting-edge diagnostic tools designed to maximize total patient care and financial renumeration to your practice.

Base software components that you will use is through an approved of Health Care platform which should include such components which are limited to the following:

(i) REPORTS & ANALYTICS: A comprehensive reports dashboard that provides detailed, real time clinical and operational reports. Provides drill down analytics across all patient data including but not limited to claims, demographic, clinical and all other related data.

(ii) SYSTEM INBOX: Direct, secure, reliable and real-time messaging to exchange clinical, operational and patient information with providers.

(iii) BENEFICIARY & NETWORK MANAGEMENT: Efficient, flexible and reliable way to manage health plan member attributions and Customer network participants.

(iv) CARE MANAGEMENT: A care management program that allows for stratification of patient data, care plan creation and a proactive focus on at-risk patients. Personal care plans based on trusted protocols can be created and monitored.

(v) PATIENT HEALTH PROFILE: A comprehensive patient health profile comprised of demographic, clinical, risk score, medical histories, care plans and other clinical documents.

(vi) MONITORING & REPORTING: Track the patient against New York State and Federal standards for care quality, seamless transitions and improved continuity of care.

(vii) MEANINGFUL USE: meet these gold standard measures easily to maximize practice profit potential.

(viii) TELEHEALTH: Chronic Care Management Certified Telehealth application for live, real time audio, video and text-based interactions with patients.

(ix) DATA WAREHOUSE: Comprehensive Patient Data warehouse to help with clinical analysis, population health management, and Value Based Shared Savings Programs.

(x) MRA MANAGER: A Medical Risk Adjustment (MRA) tool for revenue optimization, tracking of suspect, outstanding and accepted codes and utilization management.

(xi) INTERFACES: Health Level 7 (HL7), Continuity of Care Document (CCD), Claims, Lab, Fast Healthcare Interoperability Resources (FHIR), Electronic Data Interchange (EDI) and Digital Imaging and Communication in Medicine (DiCom) interfaces, Electronic Medical Records (EMR) integration services to all practice EMRs.

(xii) HIPAA COMPLIANCE & SECURITY: Full compatibility with HIPAA and other state and federal regulations for patient privacy and data security

The DC Participant hereby shall comply with the following CMS requirements IP2 as defined below:

(i) DC Participant or Preferred Provider agree to participate in the Model during the Implementation Period 2 ("IP2"), to engage in Model-related activities, to comply with the applicable terms of the Model, and to comply with all applicable laws and regulations.

(ii) DC Participant Provider or Preferred Provider shall update their Medicare enrollment information (including the addition and deletion of individuals that have reassigned to the DC Participant or Preferred

Provider their right to Medicare payment on a timely basis in accordance with Medicare program requirements.

(iii) DC Participant Provider or Preferred Provider shall notify the DCE of any changes to its Medicare enrollment information (including the addition and deletion of individuals that have reassigned to the DC Participant Provider or Preferred Provider their right to Medicare payment) within 30 Days after the change

(iv) DC Participant Provider or Preferred Provider must notify the DCE within 7 Days of becoming aware that they are under investigation or have been sanctioned by the government or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of Medicare billing privileges).

(v) DC Participant or preferred Provider hereby acknowledge and agree that CMS requires the DCE to take remedial action against the DC Participant Provider or Preferred Provider (including the imposition of a corrective action plan, denial of any payments, and termination of the DCE's arrangement with the DC Participant Provider or Preferred Provider) to address noncompliance with the terms of the Participation Agreement or program integrity issues identified by CMS.

(vi) DC Participant or preferred Provider hereby acknowledge that for the duration of the IP2 they shall remain active in the program, but permit early termination if CMS requires the DCE to remove the DC Participant or Preferred Provider from their PY2022 DC Participant Provider List or Preferred Provider List, as applicable.

(vii) DC Participant Provider or Preferred Provider shall as required by CMS, complete a closeout process upon termination or expiration of the arrangement that requires the DC Participant or Preferred Provider to furnish all data required by the DCE to participate in the Model and any data required by CMS to monitor or evaluate the Model.

(viii) If DC Participant Provider or Preferred Provider receives from or though the DCE electronic health records software to one or more DC 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.

The DC Participant shall further comply with the following CMS requirements for Performance Year ("PY2022"):

(i) DC Participant or Preferred Provider agree to participate in the Model during the Model Performance Period, to engage in Model-related activities (e.g., promoting accountability for the quality, cost, and overall care for the DCE's aligned beneficiaries), to comply with the applicable terms of the Model, and to comply with all applicable laws and regulations.

(ii) DC Participant or Preferred Provider agree to CMS requirements related to participant exclusivity; quality measure reporting, and continuous care improvement objectives; 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 compliance plan; and audit and record retention requirements.

(iii) DC Participant Provider or Preferred Provider hereby agree to update their Medicare enrollment information (including the addition and deletion of individuals that have reassigned to the DC Participant or Preferred Provider their right to Medicare payment) on a timely basis in accordance with Medicare program requirements.

(iv) DC Participant Provider or Preferred Provider shall notify the DCE of any changes to its Medicare enrollment information (including the addition and deletion of individuals that have reassigned to the DC Participant Provider or Preferred Provider their right to Medicare payment) within 30 Days after the change.

(v) DC Participant or Preferred Provider shall 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.

(vi) DC Participant Provider or Preferred Provider hereby acknowledge that they are prohibited when they are added to the DC Participant Provider List during a Performance Year from participating in the DCE's selected Payment Mechanism(s) for the Performance Year in which the DC Participant Provider or Preferred Provider is so added, as applicable.

(vii) DC Participant Provider or Preferred Provider shall notify the DCE within 7 Days of becoming aware that they are under investigation or have been sanctioned by the government or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of Medicare billing privileges).

(viii) DC Participant Provider or Preferred Provider shall permit the DCE to take remedial action against the DC Participant Provider or Preferred Provider (including the imposition of a corrective action plan, denial of any payments, and termination of the DCE's arrangement with the DC Participant Provider or Preferred Provider) to address noncompliance with the terms of the Participation Agreement or program integrity issues identified by CMS.

(ix) Remain effective for a term of at least one Performance Year, but permit early termination if CMS requires the DCE to remove the DC Participant or Preferred Provider from their PY2022 DC Participant Provider List or Preferred Provider List, as applicable.

(ix) DC Participant Provider or Preferred Provider shall complete a closeout process upon termination or expiration of the arrangement that requires the DC Participant or Preferred Provider to furnish all data required by the DCE to participate in the Model and any data required by CMS to monitor or evaluate the Model.

(x) If DC Participant Provider or Preferred Provider receives from or though the DCE electronic health records software to one or more DC 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.

Notwithstanding the foregoing, the key additional benchmarks for your practice to be mindful are you must comply with all applicable laws and regulations related to disclosure of personally identifiable information and other confidential information including but not limited to reporting required by CMS.

You hereby understand that your practice hereby acknowledges that AVC may deny or terminate services if they find your practice to be in receipt of more than one impermissible federal funding source, such as the Medicare Advantage Plan for Medicare activities during the same time frame. Your practice understands that AVC may deny or terminate services if they find your practice to be non-compliant with CMS requirements, or may specify corrective action requirements in order for your practice to continue participating in DCME services.

You further should be aware that CMS shall disseminate specific quality measures focused on reducing hospitalization of patients from time to that you must adhere to in order to be legally compliant.

If the AVC organization determines that your practice has committed illegal or inappropriate activity, or any issues that may not be in the best interest of the APC model, they may terminate services and report their findings to the New York State Department of Health as required under applicable law.

The DC Participant hereby agrees to the forgoing by executing the Direct Contracting Model: Fee Agreement attached hereto and made a part hereof.

TIN NUMBER: _____

NPI NUMBER: _____

Physician or Authorized Representative:

_____

Name

_____

Title

_____

Signature

_____

Date

DIRECT CONTRACTING MODEL: FEE AGREEMENT

GENERAL INFORMATION

From January 1, 2022 – December 31, 2022, 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).1 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.

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 January 1, 2022 – December 31, 2022 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.

Legal Business Name (as Reported to Tax Identification Number: the Internal Revenue Service):

First Name **Middle Initial** **Last Name** **Jr., Sr., M.D., D.O**.

Authorized or Delegated Official's Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.) **Date Signed (mm/dd/yyyy)**

Individual NPI NUMBER:

Organization NPI NUMBER: _____

APPENDIX – LIST OF INDIVIDUAL AND ORGANIZATIONAL IDENTIFIERS

From January 1, 2022 – December 31, 2022, as part of the Center for Medicare & Medicaid Services (CMS) Direct Contracting Model, Advanced

Value Care II [DCE] has elected to participate in Alternative Payment Arrangements (APA) as described in the Direct Contracting Model Participation Agreement.3 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_____.

4 Note: When completing this Agreement, please ensure that your DCE retains a copy of the Beneficiary Engagement (BE) and Payment Mechanism (PM) Report ("Benefit Enhancement Report") for providers aligned to your TIN. The Benefit Enhancement Report will contain the complete list of provider's aligned to a DCE, their associated identifiers, along with their effective start and termination date of their enrollment in each BE and PM. The DCE may download the Benefit Enhancement Report via the 4i Application under Reports once the DCE's BEs and PMs have been submitted and finalized. Please store the signed Agreement with the Benefit Enhancement Report once signed for auditing purposes. As a reminder, this Agreement will not be submitted to CMS, however, it may be audited during PY2022. The Agreement must be completed by January 1, 2022.