

Summary of Arrangements Conducted under the Medicare ACO Participation Waiver

Last Updated: January 1, 2015

1. EHR Subsidy Arrangements (2013-2015).

- Effective August 14, 2013, the John Muir Physician Network (JMPN) dba John Muir Health Medicare Accountable Care Organization (the ACO) approved an arrangement (EHR Subsidy Arrangement) under the ACO Participation Waiver pursuant to which JMPN will provide or arrange for the provision of certain EHR Software and Support Services to various Eligible Practices at discounted rates.
 - The EHR Subsidy Arrangement, as approved by the ACO, includes a form of EHR Software and Support Services Agreement (EHR Subsidy Agreement). The parties to each EHR Subsidy Arrangement will be John Muir Health (JM) and the ACO, on the one hand, and the Eligible Practice, on the other hand.
 - “EHR Software and Support Services” will include an integrated EHR suite (core EHR, patient registration/scheduling functionality, and practice management/billing functionality), as well as related training and support services.
 - “Eligible Practices” include ACO Participants and ACO Affiliated Practices.
 - “ACO Participants” are individuals or entities that have entered into a Participation Agreement to participate in the ACO as “ACO Participants” (as defined under the MSSP).
 - “ACO Affiliated Practices” are individuals or entities that employ or contract with physicians practicing in one of the Select Specialties, and which have entered into a Care Coordination Agreement with the ACO under which they commit to substantially similar care coordination and citizenship requirements as ACO Participants, but without participating as ACO Participants.
 - “Select Specialties” include 13 specialties that the ACO has identified as critical to managing its ACO Beneficiary population, either on the basis of the Specialty’s relative contribution to the ACO’s benchmark Medicare Part A/B fee-for-service claims/encounters, or on the basis of the Specialty’s ability to effectively manage or mitigate the ACO’s Medicare Part A/B fee-for-service claims experience.
- The EHR Subsidy Arrangement is intended to facilitate the widespread adoption of EHR technology by healthcare providers providing medical care and treatment to individuals residing in the communities served by the ACO (Service Area) in order to enhance and improve the efficiency, effectiveness, quality and clinical integration of care provided to such individuals.
- The EHR Subsidy Arrangement otherwise is structured to comply with the exception for donation of EHR software and services at 42 C.F.R. § 411.357(w) (EHR Donation Exception) and the related safe harbor at 42 C.F.R. § 1001.952(y) (EHR Donation Safe Harbor). However, the subsidy levels under the EHR Subsidy

Arrangement are higher than those permitted under the EHR Donation Exception and the EHR Donation Safe Harbor. Accordingly, the EHR Subsidy Arrangement must comply with an applicable MSSP waiver.

- The EHR Subsidy Arrangement has two components – an up-front, one-time implementation component and an ongoing monthly maintenance and support component.
 - For each component, Eligible Practices will pay JMPN a specified amount per “Authorized User” that corresponds to a percentage of JMPN’s actual aggregate cost of providing or arranging for the provision of the EHR Software and Support Services (Practice Payments).
 - “Authorized Users” include physicians and mid-level practitioners (i.e., nurse practitioners and physician assistants). Mid-level practitioners and part-time physicians are eligible for additional discounts off the base Authorized User rate.
 - JMPN may review and adjust Practice Payments on an annual basis to ensure that each Eligible Practice pays a minimum percentage of JMPN’s actual aggregate cost to provide or arrange for the provision of the EHR Software and Support Services.
- If an Eligible Practice undergoes a change in control (as defined in the EHR Subsidy Agreement) within a defined time period following the effective date of its EHR Subsidy Agreement (Effective Date), then, unless agreed in writing by JMPN, for each of the Eligible Practice’s Authorized Users from the Effective Date through the effective date of the change in control, the Eligible Practice will owe JMPN certain default fees.
 - The default fees equal the difference between the subsidized rate the Eligible Practice received for the one-time implementation component and JMPN’s actual costs (i.e., to make JMPN whole for its implementation costs for those Authorized Users).
- If an Eligible Practice wants to add an Authorized User who renders professional services at locations outside of the Service Area, or if an existing Authorized User begins to render professional services at locations outside of the Service Area (Out-of-Area Practitioner), the Eligible Practice will notify JMPN and discuss the request.
 - JMPN has discretion to determine: (a) whether such Out-of-Area Practitioner may become or remain, as applicable, an Authorized User, and (b) the amount of the Practice Payments that the Eligible Practice will pay going forward with respect to the Out-of-Area Practitioner.
 - Modified Practice Payments for Out-of-Area Practitioners may be higher than the Practice Payments for other Authorized Users, and any modified Practice Payments will be set forth in a written amendment to the Eligible Practice’s EHR Subsidy Agreement.
 - JMPN will have the right to audit an Eligible Practice’s books and records to validate potential Out-of-Area Practitioners.
- Each EHR Subsidy Agreement has an initial term that is coterminous with the ACO’s MSSP Participation Agreement with CMS, with specified renewal options upon mutual agreement of the parties.

- Each party can terminate for cause and certain other reasons specified in the EHR Subsidy Agreement (e.g., expiration or termination of the ACO’s MSSP Participation Agreement; expiration or termination of an Eligible Practice’s Participation Agreement or Care Coordination Agreement with the ACO).

2. Care Coordination Payments (2015)

2015 Care Coordination Fee. Effective January 1, 2015, the ACO approved a prospective update to the Performance Criteria under the ACO Participation Waiver for the period 01/01/15-12/31/15. See “Care Coordination Payments (2014)” below for descriptions of the most recent set of Performance Criteria and Care Coordination Payments.

- The updated Performance Criteria reduce the total number of measures to better focus Participants’ efforts on activities the ACO believes will further its achievement of the Triple Aim, refine certain measurement thresholds, and extend the measurement period to a full calendar year. Specifically:
 - Criteria #1 (annual Medicare wellness visit) and Criteria #2 (PCP follow-up following hospital discharge) are removed.
 - Criteria #3 (care plan engagement) is updated to increase the relative point value of this measure.
 - Criteria #4 (monthly care coordination team meetings) is retained.
 - New criteria added (ACO Congress attendance), requiring each of an ACO Participant’s PCP Professionals to attend at least two JMH Medicare ACO Congress sessions during the 2015 calendar year, except as otherwise approved in advance by the ACO Co-Chairs and ACO Medical Director. New criteria validated based on attendance sheets at ACO Congress sessions (sign-in and sign-out).
 - The financial penalty for each ACO Professional who fails to attend an ACO Congress session is removed.
 - The measurement period for the Care Coordination Payments is extended to include full calendar year 2015, rather than a 6-month period.
- The ACO’s governing body retained the certification, validation, and payment process outlined below for the 2014 Care Coordination Payments. As with the 2014 Care Coordination Payments, the ACO’s governing body reviewed and approved distribution of a form of notice containing the relevant details of the restructuring, to be distributed to each Participant before November 30, 2014.
- The parties covered under the Care Coordination Payment arrangements summarized above include Participants who were Participants in the ACO as of the end of the applicable twelve-month performance period.

3. Care Coordination Payments (2014)

Second-Half 2014 Care Coordination Fee. Effective July 1, 2014, the ACO approved a prospective update to the Performance Criteria under the ACO Participation Waiver for the period 07/01/14-12/31/14. See “First-Half

2014 Care Coordination Fee” below for descriptions of the most recent set of Performance Criteria and Care Coordination Payments.

- The updated Performance Criteria make two sets of modifications to better focus Participants’ efforts on activities the ACO believes will further its achievement of the Triple Aim. Specifically:
 - Criteria #4 (monthly meetings with Care Coordinators) is updated to: (1) provide that the Care Coordination Team will measure and report the results based upon the methodology approved by the ACO Executive Committee; and (2) change the measurement threshold from a sliding scale that required 5 meetings to achieve full credit, to an all-or-nothing scale that requires at least 3 meetings to achieve full credit.
 - The Care Coordination Fee payable to a Participant for the second half of 2014 will have a set amount withheld for each of that Participant’s PCP Professionals who do not attend at least one JMH Medicare ACO education session before 12/31/2014.
- The ACO’s governing body retained the certification, validation, and payment process outlined below for the 2013 Care Coordination Payments. As with the 2013 Care Coordination Payments, the ACO’s governing body reviewed and approved distribution of a form of notice containing the relevant details of the restructuring, to be distributed to each Participant before May 31, 2014.
- The parties covered under the Care Coordination Payment arrangements summarized above include Participants who were Participants in the ACO as of the end of the applicable six-month performance period.

First-Half 2014 Care Coordination Fee. Effective January 1, 2014, the ACO approved a prospective update to the Performance Criteria under the ACO Participation Waiver for the period 01/01/14-06/30/14. See “Care Coordination Payments (2012-2013)” below for descriptions of the most recent set of Performance Criteria and Care Coordination Payments.

- The updated Performance Criteria reduce the total number of measures to better focus Participants’ efforts on activities the ACO believes will further its achievement of the Triple Aim, and refine certain measurement thresholds. Specifically:
 - Criteria #1 (annual wellness visits) is updated to increase the relative point value of this measure (from 20 to 30 points), eliminate the ability for Participants to self-report billing data, and increase the measurement threshold that Participants must meet to receive credit for this measure.
 - Criteria #2 (post-discharge PCP appointment) is updated to increase the relative point value of this measure (from 20 to 30 points), extend the appointment window to 14 days of discharge from a John Muir Health hospital (from 7 days), eliminate the reference to discharges from “affiliate hospitals,” and eliminate the reference to discharges where the patient’s assigned PCP is also the discharging physician.
 - Criteria #3 (PCP follow-up visit after ED or urgent care encounter) is eliminated.
 - Criteria #4 (ACO Congress/training attendance by PCPs) is eliminated.

- Criteria #5 (PCP engagement in development of care plan) is updated to reflect PCP participation in development of the care plan for ACO Beneficiaries assigned to the ACO's care management team (per the ACO's care management guidelines). Renumbered to Criteria #3.
 - Criteria #6 (PCP responsiveness to care managers) is updated to reflect PCP participation in either in-person or telephonic monthly meetings with a member of the Care Coordination Team to review at-risk ACO Beneficiaries and discuss plans of care. Point value increased (from 10 to 30 points). Renumbered to Criteria #4.
 - Criteria #7 (ACO training/education session attendance by office managers) is eliminated.
 - The Care Coordination Fee payable to a Participant for the first half of 2014 will have a set amount withheld for each of that Participant's PCP Professionals who do not attend at least one JM Health Medicare ACO education session before June 30, 2014.
- The ACO's governing body retained the certification, validation, and payment process outlined below for the 2013 Care Coordination Payments. As with the 2013 Care Coordination Payments, the ACO's governing body reviewed and approved distribution of a form of notice containing the relevant details of the restructuring, to be distributed to each Participant before November 30, 2013.
 - The parties covered under the Care Coordination Payment arrangements summarized above include Participants who were Participants in the ACO as of the end of the applicable six-month performance period.

4. Care Coordination Payments (2012-2013).

Effective January 24, 2013, the John Muir Physician Network dba John Muir Health Medicare Accountable Care Organization (the ACO) approved two related arrangements under the ACO Participation Waiver that restructure certain care coordination incentive payments (Care Coordination Payments) payable by the ACO to its ACO Participants (collectively, Participants). The first arrangement restructures Care Coordination Payments for the period 07/01/12-12/31/12. The second arrangement restructures Care Coordination Payments for the period 01/01/13-06/30/13. Neither arrangement changes the maximum amounts potentially payable in Care Coordination Payments. Rather, these arrangements (a) adjust the performance criteria Participants must meet to qualify for the Care Coordination Payments (the Performance Criteria), and (b) refine the calculation and payment methodology for the Care Coordination Payments to more appropriately reflect the parties' original intent.

The original participation agreements between the ACO and its Participants provided for a Care Coordination Payment, calculated on a per member per month (PMPM) basis, payable once every 6 months to each Participant based on the number of Medicare fee-for-service (FFS) beneficiaries assigned to the Participant's primary care physicians (PCPs). The Care Coordination Payments were to be paid based on the number of Medicare FFS beneficiaries assigned to the Participant's PCPs as of the end of the 6-month performance period. Payment of the Care Coordination Payment was contingent on the Participant (and each of such Participant's PCPs) meeting certain Performance Criteria, as defined in the participation agreement.

The initial Performance Criteria required, among other things, that Participants (and each PCP under such Participant's TIN) implement or agree to implement an approved electronic health record system by December 31, 2012; agree to participate in data integration initiatives; collaborate and fully engage in ACO care

management programs; electronically submit data by June 30, 2013 for all applicable Quality Standards metrics and Meaningful Use data, and share all clinical data for care management and quality purposes, as requested by both CMS and the ACO; participate in at least 75% of ACO educational sessions annually; perform and document annual office visits with at least 80% of CMS beneficiaries assigned to physician's practice; and demonstrate engaged use of the McKesson MedVentive software.

Various issues with the Performance Criteria led to the need for restructuring:

- Among other issues, the Performance Criteria were originally and inadvertently drafted in an "all or nothing" fashion. i.e., if the terms and conditions of the participation agreements were interpreted and enforced literally, then if one PCP of one Participant failed to meet any of the numerous Performance Criteria, the Participant would receive \$0 in Care Coordination Payments. This outcome would have been inconsistent with the parties' original intent to provide a scaled Care Coordination Payment based on a Participant's PCPs' performance relative to the Performance Criteria.
- The Performance Criteria were developed months before the ACO realized there would be significant delays in obtaining beneficiary data from CMS, which materially limited what activities the ACO would be able to measure. In addition, since the initial criteria were developed, the ACO identified different activities that were also important to its goals but which were not reflected in the original Performance Criteria. As a result, if the participation agreements were strictly enforced as written, no Care Coordination Payments would have been made for 2012 or for the first month of 2013. This outcome would have frustrated the intent of the ACO's original agreement with its Participants, all of whom had dedicated time, personnel, and resources to carrying out various activities at the request of the ACO in furtherance of the ACO's care coordination goals.

In light of these circumstances, the ACO restructured the Care Coordination Payments for 2012 and the first half of 2013 as follows:

- For the period 07/01/12-12/31/12, the ACO's governing body reviewed and approved a revised set of Performance Criteria that more accurately reflected the nature of the care coordination activities the ACO had requested its Participants to perform.
 - The revised Performance Criteria for 2012 were substantially similar to the original Performance Criteria, but in place of some of the original criteria, substituted requirements related to logging in to the email account to which communications from the ACO would be sent; implementing the standardized ACO template materials at applicable practice locations; and revising the office visit percentage threshold to more appropriately reflect a partial year performance period.
 - The Performance Criteria were restructured on a sliding scale basis to provide partial credit if Participant's PCPs met some, but not all, of the Performance Criteria. Each of the Performance Criteria was assigned an equal weight (i.e., 7 points total possible for each PCP).
 - For Participants with multiple PCPs under one TIN (e.g., PCPs participating in a group practice), the sliding scale would be applied first to each PCP practicing under the applicable TIN, and then aggregated to determine the total percentage of the Care Coordination Payment for which the Participant would be eligible. That total percentage would be applied to the PMPM Care Coordination Payment, and then multiplied by the total number of Medicare FFS beneficiaries

assigned to that Participant's PCPs to determine the total Care Coordination Payment payable to such Participant. For Participants participating on an individual basis, the sliding scale would be calculated with respect to each such individual PCP.

- In order for a Participant to qualify for the restructured Care Coordination Payment, ACO management would distribute a form of certification. Each Participant would be responsible for verifying the performance of its PCPs against the revised Performance Criteria and returning the certification to the ACO Chief Executive or her designee within 30 days of the date of mailing.
 - Once the period for receiving certifications has closed, the ACO Chief Executive or designee would validate the responses and calculate and pay the Care Coordination Payment, if any, owed to each Participant within 30 days.
 - The restructured Care Coordination Payment would be subject to a withhold by the ACO, to reserve against potential reductions in Medicare FFS beneficiaries assigned to the Participant's PCPs as of the end of the applicable performance year (here, 12/31/13). At the end of the performance year, the total Care Coordination Payments paid to each Participant would be reconciled against the Medicare FFS beneficiaries assigned to such Participant as of the end of the performance year, with any resulting difference being paid by or to the ACO, as applicable.
- For the period 01/01/13-06/30/13, the ACO's governing body reviewed and approved a further revised set of Performance Criteria that more accurately reflected the nature of the care coordination activities the ACO had requested its Participants to perform.
 - The further revised Performance Criteria cover seven categories worth a total of 100 points: (1) PCP's practice performs and documents an annual Medicare wellness visit with his/her assigned ACO Beneficiary (20 points); (2) ACO Beneficiary receives an appointment to see his/her assigned PCP's practice within 7 days of discharge from a John Muir Health hospital or affiliate hospital, or within 14 days of discharge where his/her assigned PCP is also the discharging physician (20 points); (3) Following an ED or Urgent Care encounter, follow-up visit appointment with the ACO Beneficiary's assigned PCP's office is available within the timeframe requested by the Care Coordinator (15 points); (4) each of Participant's PCPs attends at least one ACO training session before 06/30/13 (15 points); (5) PCP reviews and signs off on ACO Beneficiary's Care Plan (10 points); (6) PCP returns phone call/email from Care Coordinator within 2 business days (10 points); and (7) each of Participant's PCPs attends at least one Risk Adjustment Form training session before 06/30/13 (10 points).
 - The ACO's governing body retained the certification, validation, and payment process outlined above under the restructured 2012 Care Coordination Payments. To implement the restructured Care Coordination Payments for the first half of 2013, the ACO's governing body reviewed and approved distribution of a form of notice containing the relevant details of the restructuring, to be distributed to each Participant before January 31, 2013.

In addition to the Care Coordination Fee restructuring outlined above, effective July 1, 2013, the ACO approved a prospective update to the Performance Criteria under the ACO Participation Waiver for the period 07/01/13-12/31/13.

- The updated Performance Criteria: (a) expand the universe of CPT codes that qualify for Performance Criteria #1 (annual wellness visits) to include new transitional care management visit codes; (b) resets Performance Criteria #4 to apply to the second half of 2013; and (c) modifies Performance Criteria #7 to provide that each of Participant's office managers attends at least one Medicare ACO training/education session before 12/31/13.
- In addition, for Performance Criteria #1, the ACO will accept self-reported billing data from Participants to make the initial payment calculation, with subsequent validation of those self-reported data against claims data CMS provides the ACO for ACO Beneficiaries.
 - This change addresses the roughly 120-day delay between the end of a calendar quarter and the ACO's ability to validate CMS claims data (i.e., a 90-day delay for CMS to provide the quarterly claims data, and an additional 30 days for the ACO to analyze the data for validation purposes).
 - This update enables the ACO to make Care Coordination Payments within a reasonable time following the close of the six-month performance period. However, the ACO will validate self-reported data against the CMS claims data and will conduct any necessary reconciliation against the withhold amount outlined above.
- The ACO's governing body retained the certification, validation, and payment process outlined above for the first-half 2013 Care Coordination Payments. As with the first-half 2013 Care Coordination Payment, the ACO's governing body reviewed and approved distribution of a form of notice containing the relevant details of the restructuring, to be distributed to each Participant before May 31, 2013.
- The parties covered under the Care Coordination Payment arrangements summarized above include Participants who were Participants in the ACO as of the end of the applicable six-month performance period.

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With respect to each of the arrangements above, the ACO's governing body has made and duly authorized a bona fide determination, consistent with the governing body members' duty under 42 C.F.R. § 425.106(b)(3), that the arrangement is reasonably related to the purposes of the Medicare Shared Savings Program.