Bundled Payments for Care Improvement Advanced Participation Agreement
2019-2 Amendment

This amendment is made to the Bundled Payments for Care Improvement Advanced Participation Agreement ("Agreement") between _____ ("**Participant**"), _____ (**BPID**) and the Centers for Medicare & Medicaid Services ("**CMS**"), referred to collectively as the "Parties."

On or before October 1, 2018, the Parties executed the Agreement governing their rights and obligations under the Bundled Payments for Care Improvement (BPCI) Advanced Model ("Model"). The Parties wish to amend the Agreement to add definitions and modify certain definitions; to require the submission of a QPP List rather than a PGP List; to add the QPP List to certain provisions of the Agreement regarding legal name changes and identifier changes; to remove the provision requiring the identification of Wholly-Owned Episode Initiators and remove references to Wholly-Owned Episode Initiators everywhere the term appears in the Agreement; to add the phrase "recoupment or SRS" in various Articles and clarify those processes; to more precisely define SRS and SRS Covered Participant; to modify the Agreement and Appendix B to allow for recovery of amounts owed to CMS by Convener Participants from the reduction of Medicare payments otherwise owed to their Downstream Episode Initiators pursuant to a SRS Reduction Agreement with CMS; to eliminate the 50 percent cap on NPRA Sharing and the 50 percent cap on Partner Distribution Payments; to remove the restriction on reapplying to participate in the Model in order to allow Participants who terminate the Agreement to reapply; to allow Convener Participants with the same TIN and multiple BPIDs to aggregate all of their Standard SRS Amounts together for the purpose of receiving the benefit of the Adjusted Amount calculation at the TIN level as opposed to the individual BPID level; and to waive the originating site requirements (both the geographic limitations and setting limitations) in the Telehealth Payment Policy Waiver.

The Parties therefore agree to amend the Agreement as follows:

1. Effective Date. This amendment shall be effective on the date it is signed by the last Party to sign it (as indicated by the date associated with that Party's signature).

2. Effect of Amendment. All other terms and conditions of the Agreement shall remain in full force and effect. In the event of any inconsistency between the provisions of this amendment and the provisions of the Agreement or any earlier amendment, the provisions of this amendment shall prevail.

3. Article 2 of the Agreement is hereby amended as follows:

    a. The definition of "Eligible Clinician" is hereby inserted in alphabetical order and reads as follows: *"Eligible Clinician" means "eligible clinician" as defined in 42 C.F.R. § 414.1305, as may be amended from time to time.*

    b. The definitions of "Financial Arrangement List" and "Participating Practitioner" are hereby amended to read in their entirety as follows:

        i. "Financial Arrangement List" means the list that, in accordance with Article 8.5, identifies the BPCI Advanced Entity and all individuals and entities that

are parties to a Financial Arrangement with the Participant or with a PGP NPRA Sharing Partner.

ii. "Participating Practitioner" means:

(1) *For the calendar quarter starting October 1, 2018 and ending December 31, 2018, a Medicare-enrolled physician or non-physician practitioner listed at 42 C.F.R. § 410.78(b)(2) who: (a) is identified by an individual NPI; (b) is participating in BPCI Advanced Activities; (c) has a written agreement with the Participant that requires the Participating Practitioner to comply with all applicable terms and conditions of this Agreement; and (d) is identified on the PGP List (if the Participant is a PGP) or the Financial Arrangement List (if the Participant is not a PGP); and*

(2) *Beginning on January 1, 2019, an Eligible Clinician who (a) is identified by an individual NPI; (b) is Medicare enrolled; (c) is participating in BPCI Advanced Activities; (d) has a written agreement with the Participant that requires the individual to comply with all applicable terms and conditions of this Agreement; and (e) is identified on the QPP List.*

c. The definition of "PGP List" is hereby amended to read in its entirety as follows:

"PGP List" *means, for the calendar quarter starting October 1, 2018 and ending December 31, 2018, the list that the Participant must provide to CMS and must update pursuant to Article 6 if the Participant is itself a PGP or if the Participant is a Convener Participant with Downstream Episode Initiators that are PGPs. The PGP List identifies all Participating Practitioners who are physicians and who have reassigned their rights to receive Medicare payment to an Applicable PGP (as such term is defined in Article 6.2). For the calendar quarter starting October 1, 2018 and ending December 31, 2018, CMS will use this PGP List for purposes of the Qualified Alternative Payment Model Participant (QP) determinations and to attribute Clinical Episodes to such Applicable PGPs for purposes of Reconciliation under certain circumstances.*

d. The definition of "Quality Payment Program (QPP) List" is hereby inserted in alphabetical order and reads as follows:

"Quality Payment Program (QPP) List*" means, starting on January 1, 2019, a list as set forth in Article 6 that includes two separate tabs that are used as the Participation List and Affiliated Practitioner List as defined in 42 C.F.R. § 414.1305 for purposes of the Quality Payment Program as set forth in 42 CFR Part 414 Subpart O for the BPCI Advanced Model.*

4. Article 3 of the Agreement is hereby amended as follows:

a. Article 3.1(b)(3) of the Agreement is hereby amended to read in its entirety as follows:

A Financial Arrangement List (if applicable);
Article 3.1(b)(4) of the Agreement is hereby amended to read in its entirety as follows:

A PGP List (if applicable for the calendar quarter starting October 1, 2018 and ending December 31, 2018); and

b. Article 3.1(b)(5) is hereby added to the Agreement as follows:

A QPP List (if applicable starting on January 1, 2019).

c. Article 3.2(a)(2) of the Agreement is hereby amended to read in its entirety as follows:

The Participant shall provide written notice to CMS within 60 Days before any change in the legal name of any Downstream Episode Initiator, NPRA Sharing Partner, or BPCI Advanced Entity. After review of such notice, CMS reserves the right to remove such Downstream Episode Initiator, NPRA Sharing Partner, or BPCI Advanced Entity from the Participant Profile, QPP List, or Financial Arrangement List, as applicable.

d. Article 3.2(c)(2) of the Agreement is hereby amended to read in its entirety as follows:

The Participant shall provide written notice to CMS as soon as practicable, but no later than 30 Days after any change in TIN, CCN, NPI, or other identifier specified by CMS with respect to any Participating Practitioner, Downstream Episode Initiator, NPRA Sharing Partner, NPRA Sharing Group Practice Practitioner, or BPCI Advanced Entity. After review of such notice, CMS reserves the right to conduct a Program Integrity Screening with respect to such Participating Practitioner, Downstream Episode Initiator, NPRA Sharing Partner, NPRA Sharing Group Practice Practitioner, or BPCI Advanced Entity and may remove such Participating Practitioner, Downstream Episode Initiator, NPRA Sharing Partner, NPRA Sharing Group Practice Practitioner, or BPCI Advanced Entity from the Participant Profile, PGP List, QPP List, or Financial Arrangement List, as applicable.

5. Article 5 of the Agreement is hereby amended as follows:

a. Article 5.5(a)(3) of the Agreement is hereby amended to read in its entirety as follows:

i. Downstream Episode Initiators. If the Participant is a Convener Participant, then the Participant shall include at least one Downstream Episode Initiator in its Participant Profile.

b. Article 5.5(c)(4)(iii) of the Agreement is hereby amended to read in its entirety as follows:

i. The Participant shall submit to CMS an updated Participant Profile reflecting the change in ownership status of a Downstream Episode Initiator at least 60 Days prior to the effective date of that change together with the certification that such Participant Profile is true, accurate, and complete,

signed by an executive of the Participant who is authorized to sign such certification on behalf of the Participant.

a. Article 5.5(c)(4)(iv) of the Agreement is hereby amended to read in its entirety as follows:

The Participant shall submit to CMS an updated Participant Profile reflecting the termination of any agreement described in Article 7.6(c) for an Episode Initiator identified on the Participant Profile at least 60 Days prior to the effective date of such termination together with the certification that such Participant Profile is true, accurate, and complete, signed by an executive of the Participant who is authorized to sign such certification on behalf of the Participant.

6. Article 6 of the Agreement is hereby amended to read in its entirety as follows:

Article 6

PGP List and QPP List

6.1 Applicable Period for PGP List. Articles 6.1 through 6.4 apply for the calendar quarter starting October 1, 2018 and ending December 31, 2018.

6.2 PGP List General.

To the extent that the Participant is itself a PGP, or is a Convener Participant with one or more Downstream Episode Initiators that are PGPs, the Participant shall maintain a PGP List in accordance with this Article 6 using the PGP List template provided to the Participant by CMS identifying each Participating Practitioner who:

*a. Is a physician and who has reassigned his or her right to receive Medicare payment either to the Participant, if the Participant is a PGP, or to a Downstream Episode Initiator that is a PGP (an "**Applicable PGP**"); and*

b. Could potentially trigger a Clinical Episode for which the Participant has committed to be held accountable in the Participant's Participant Profile based on the Participating Practitioner's scope of practice.

The Participant shall not identify on the PGP List any non-physician, any physician who is not a Participating Practitioner, or any physician who has not reassigned his or her right to receive Medicare payment to an Applicable PGP. CMS may impose remedial action pursuant to Article 20.2 or terminate this Agreement pursuant to Article 21 for the Participant's failure to include all Participating Practitioners who meet these criteria on the PGP List.

6.3 Initial PGP List.

To the extent the Participant is itself a PGP, or is a Convener Participant with one or more Downstream Episode Initiators that are PGPs, the Parties acknowledge that the Participant submitted to CMS an initial PGP List, together with the certification stating that the PGP List is true, accurate, and complete, signed by an executive of the Participant who is authorized to sign such certification on behalf of the Participant. Such Initial PGP List is effective on the Start Date. The Participant shall update the PGP List in accordance with Article

6.4 Updates to the PGP List.

a. *In a form and manner specified by CMS, the Participant shall submit to CMS on a quarterly basis an updated PGP List that contains the certification stating that such list is true, accurate, and complete, and such certification must be signed by an executive of the Participant who is authorized to sign such certification on behalf of the Participant.*

b. *If the Participant updates its Participant Profile pursuant to Article 5.5(c)(1), then the Participant shall also submit to CMS an updated PGP List, in a form, manner, and by a date specified by CMS, removing all physicians who have reassigned his or her rights to receive Medicare payment to a Downstream Episode Initiator that is a PGP that was removed from the initial Participant Profile pursuant to such Article 5.5(c)(1). The Participant may not add any physicians to the Participant's PGP List pursuant to this Article 6.4(b).*

c. *The addition of a Participating Practitioner to the PGP List will be effective as of the effective date of the individual's change in reassignment of his or her right to receive Medicare payment to the Applicable PGP.*

d. *Except as provided in Article 6.4(b), the removal of an individual from the PGP List will be effective as of the earlier of the date on which the individual ceased to be a Participating Practitioner or the effective date of the individual's termination of his or her reassignment to the Applicable PGP of his or her right to receive Medicare payment. For purposes of this Article 6.4(d), an individual ceases to be a Participating Practitioner when he or she is no longer a Medicare-enrolled physician; is no longer identified by an individual NPI; is no longer participating in BPCI Advanced Activities; or no longer has a written agreement with the Participant that requires the Participating Practitioner to comply with all applicable terms and conditions of this Agreement.*

e. *CMS will update the PGP List to reflect a change in identifier reported by the Participant pursuant to Article 3.2(c)(2) and may remove a Participating Practitioner from the PGP List as a result of such notification.*

6.5 Applicable Period for QPP List. Articles 6.5 through 6.10 apply starting on January 1, 2019.

6.6 QPP List General.

a. The Participation List tab of the Quality Payment Program (QPP) List is the Participation List as defined in 42 C.F.R. § 414.1305, as may be amended from time to time. The Affiliated Practitioner List tab of the QPP List is the Affiliated Practitioner List as defined in 42 C.F.R. § 414.1305, as may be amended from time to time. CMS will use the QPP List for purposes outlined in 42 C.F.R. Part 414 Subpart O, as may be amended from time to time.

b. If the Participant is a PGP, ACH, or a Convener Participant with one or more Downstream Episode Initiators that are PGPs or ACHs, then the Participant shall maintain a QPP List in accordance with this Article 6 and in a form and manner specified by CMS. The QPP List shall have a Participation List tab and an Affiliated Practitioner List tab as set forth below.

6.7 Participation List Tab. In order for the Participant to include an individual on the Participation List tab of the QPP List, the individual must:

a. be a Participating Practitioner; and

b. have reassigned his or her right to receive Medicare payment to the TIN of the Participant or to a Downstream Episode Initiator.

The Participant shall not identify on the Participation List tab of the QPP List any individual who does not meet these requirements.

6.8 Affiliated Practitioner List Tab. In order for the Participant to include an individual on the Affiliated Practitioner List tab of the QPP List, the individual must:

a. be a Participating Practitioner; and

b. meet the definition of Affiliated Practitioner at 42 C.F.R. § 414.1305, as may be amended from time to time.

CMS may impose remedial action pursuant to Article 20.2 or terminate this Agreement pursuant to Article 21 if the Participant fails to submit a QPP List or to include all Participating Practitioners who meet the criteria included in Articles 6.7 and 6.8 on the QPP List, for the applicable period.

6.9 Initial QPP List. If the Participant is a PGP, ACH, or a Convener Participant with one or more Downstream Episode Initiators that are PGPs or ACHs, then the Participant shall submit to CMS an initial QPP List on or before June 1, 2019, and the Participant certifies that the initial QPP List is true, accurate, and complete. The initial QPP List includes a Participation List tab and Affiliated Practitioner List tab

for January 1, 2019 through March 31, 2019. The Participant shall update the initial QPP List in accordance with Article 6.10.

6.10 Updates to the QPP List.

a. In a form and manner specified by CMS, the Participant shall submit to CMS for the dates set forth in 42 C.F.R. § 414.1425(b) for a QP Performance Period as defined in 42 C.F.R. § 414.1305 (both as may be amended from time to time) on dates and times specified by CMS an updated QPP List that the Participant certifies is true, accurate, and complete using the template provided by CMS.

b. If the Participant updated its Participant Profile pursuant to Article 5.5(c)(1), then the Participant shall also submit to CMS an updated QPP List, in a form, manner, and by a date specified by CMS, removing all Participating Practitioners associated with a Downstream Episode Initiator that is a PGP or an ACH that was removed from the initial Participant Profile pursuant to such Article 5.5(c)(1). The Participant may not add any Participating Practitioner to the Participant's QPP List pursuant to this Article 6.10(b).

c. The addition of a Participating Practitioner to the QPP List will be effective as of the effective date of the individual's change in reassignment of his or her right to receive Medicare payment to the applicable ACH or PGP.

d. Except as provided in Article 6.10(b), the removal of an individual from the QPP List will be effective as of the earlier of the date on which the individual ceased to be a Participating Practitioner or the effective date of the individual's termination of his or her reassignment to the applicable ACH or PGP of his or her right to receive Medicare payment. For purposes of this Article 6.10(d), an individual ceases to be a Participating Practitioner when he or she no longer meets the definition thereof.

e. CMS will update the information in the QPP List to reflect a change in identifier reported by the Participant pursuant to Article 3.2(c)(2) and may remove a Participating Practitioner from the QPP List as a result of such notification

7.Article 7 of the Agreement is hereby amended as follows:

a. Article 7.3(d)(2)(iii) of the Agreement is hereby amended to read in its entirety as follows:

If the Participant fails to pay CMS the Repayment Amount owed by the date indicated in the demand letter, then CMS will either recoup owed monies pursuant to Article 7.6, or invoke CMS's rights under the Secondary Repayment Source provided pursuant to Article 7.7, to collect all monies due to CMS.

b. Article 7.3(d)(2)(iv) of the Agreement is hereby amended to read in its entirety as follows:

The Participant shall be solely liable for the payment of the Repayment Amount to CMS. Where CMS seeks payment through recoupment or the Secondary Repayment Source, and the funds are unavailable or do not fully cover the Repayment Amount owed, CMS will invoke all legal means to collect the debt, including referral of the remaining debt to the United States Department of the Treasury, pursuant to 31 U.S.C. § 3711(g).

c. Article 7.4(d)(3) of the Agreement is hereby amended to read in its entirety as follows:

If the Participant fails to pay CMS the amount owed by the date indicated in the demand letter, then CMS will either recoup owed monies pursuant to Article 7.6, or invoke CMS's rights under the Secondary Repayment Source provided pursuant to Article 7.7 to collect all monies due to CMS.

d. Article 7.4(d)(4) of the Agreement is hereby amended to read in its entirety as follows:

The Participant shall be solely liable for the payment of the Excess Spending Amount to CMS. Where CMS seeks payment through recoupment or the Secondary Repayment Source and the funds are unavailable or do not fully cover the Excess Spending Amount owed, CMS will use all legal means to collect the debt, including referral of the remaining debt to the United States Department of the Treasury, pursuant to 31 U.S.C. § 3711(g).

e. Article 7.6 of the Agreement is hereby amended to read in its entirety as follows with new subsections added and reordered as below:

7.6 <u>Recoupment and Secondary Repayment Source.</u>

a. <u>Definitions.</u>

*1) "**SRS Reduction Agreement**" means a written agreement pursuant to which a Downstream Episode Initiator has agreed to permit CMS to collect amounts owed by the Participant under this Agreement by reducing Medicare payments otherwise owed to such Downstream Episode Initiator.*

*2) "**SRS**" stands for Secondary Repayment Source and means a financial mechanism that guarantees the Participant's ability to pay on demand a portion of amounts owed to CMS under this Agreement.*

*3) "**SRS Covered Participant**" means a Convener Participant that must obtain an SRS because it has at least one Downstream Episode Initiator that is not a party to an SRS Reduction Agreement.*

(b) Recoupment.

(1) Recoupment from Participant. If the Participant is not a SRS Covered Participant, then CMS will recoup any monies owed by the Participant to CMS under this Agreement from Medicare payments otherwise due and owing to the Participant and, in accordance with Articles 7.6(b)(2) and (3), to the Participant's Downstream Episode Initiators that triggered the Clinical Episode(s) that, in the aggregate, resulted in funds being owed to CMS, if any.

(2) Recovery from Downstream Episode Initiator. If the Participant fails to timely repay any monies owed to CMS under this Agreement, then CMS shall, for each Downstream Episode Initiator:

(i) identify the portion of the net Repayment Amount or Excess Spending Amount owed to CMS as a result of the Clinical Episode(s) triggered by such Episode Initiator; and

(ii) reduce the amounts specified in Article 7.6(b)(2)(i) from present and future Medicare payments otherwise owed to any Downstream Episode Initiator that is a party to a SRS Reduction Agreement with CMS.

(3) The amount reduced by CMS pursuant to Article 7.6(b)(2) shall not exceed the portion of the net Repayment Amount or Excess Spending Amount owed to CMS as a result of the Clinical Episode(s) triggered by such Downstream Episode Initiator.

(c) SRS Reduction Agreements.

1) The Participant shall identify in a form and manner and by a deadline specified by CMS each Downstream Episode Initiator that is a party to a SRS Reduction Agreement with CMS.

2) SRS Reduction Agreements executed on or after June 15, 2019 must be in the form of the "SRS Reduction Agreement" template that will be provided by CMS.

3) If the Participant is a Convener Participant that is not an SRS Covered Participant, then the Participant represents that each and every Downstream Episode Initiator is a party to a SRS Reduction Agreement.

f. Article 7.7 of the Agreement "Secondary Repayment Source" is hereby amended to read in its entirety as follows:

7.7 Secondary Repayment Source.

a. A Convener Participant must obtain a Secondary Repayment Source if it has at least one Downstream Episode Initiator that is not a party to a SRS Reduction Agreement. The Participant shall maintain the Secondary

Repayment Source in accordance with the requirements of this Article 7.7 and Appendix B.

i. The amount guaranteed by the Participant's Secondary Repayment Source must be for the applicable amount calculated by CMS in accordance with the methodology described in Appendix B and specified in the Secondary Repayment Source File described in Appendix B.

ii. The Secondary Repayment Source must become effective by a date specified by CMS or prior to the date on which the Participant becomes an SRS Covered Participant (if the Participant was not an SRS Covered Participant on the Start Date). The SRS must remain in effect until at least 24 months after the conclusion of the Agreement Term or until all of the Participant's financial obligations to CMS pursuant to this Agreement have been fulfilled, whichever is later. The Participant shall remain liable for any amount owed to CMS in excess of the amount specified in the Secondary Repayment Source File.

iii. The Participant shall scan and submit to CMS by email, prior to the Start Date (or, if the Participant is not an SRS Covered Participant on the Start Date, prior to the date on which the Participant becomes an SRS Covered Participant), executed documents establishing a Secondary Repayment Source that complies with the criteria set forth in this Article 7.7 and Appendix B.

(b) CMS may reject any Secondary Repayment Source that does not comply with the terms of this Article 7.7 and Appendix B of this Agreement.

(c) Any changes in the Secondary Repayment Source must be approved in advance by CMS.

(d) If CMS rejects the Secondary Repayment Source obtained by the Participant pursuant to Appendix B of this Agreement or does not approve changes to such Secondary Repayment Source, then CMS may terminate the Agreement pursuant to Article 21.

8. Article 8.2 (c)(2)(iii) is hereby stricken in its entirety.

9. Article 21.1 of the Agreement is hereby amended to read in its entirety as follows:

21.1 <u>Termination by the Participant</u>. The Participant may terminate this Agreement at any time for any reason upon 90 Days advance written notice to CMS.

a. If the Participant submits an updated Participant Profile indicating that all Clinical Episodes and Downstream Episode Initiators are being removed, then the Participant shall also provide 90 Days advance written notice of termination to CMS in accordance with this Article 21.1.

b. The effective date of termination of this Agreement by the Participant is also the effective date of termination of the Agreement Performance Period described in Article 1. No Clinical Episodes may be initiated under this Agreement after the effective date of such termination.

10. Appendix B of the Agreement ("Secondary Repayment Source") is hereby amended in its entirety and replaced with the version of Appendix B included as an attachment to this amendment following the signature page.

11. Section II "Waiver and Terms" of Appendix G is hereby amended in its entirety as follows:

> *CMS waives the originating site requirements in Sections 1834(m)(4)(C)(i) (geographic limitations) and (ii) (setting limitations) of the Act, as those sections may be amended from time to time during the Agreement Term, and the corresponding regulations at section 410.78(b)(3) and (4). This waiver allows Medicare payment for telehealth services regardless of whether the service is furnished to a BPCI Advanced beneficiary located in a telehealth originating site, provided that the telehealth service is furnished to a BPCI Advanced Beneficiary in a BPCI Advanced Beneficiary's home or place of residence during a BPCI Advanced Clinical Episode by an Eligible Telehealth Provider (as defined in Section III of this Appendix G) in accordance with all other Medicare coverage and payment criteria, including the remaining provisions of Section 1834(m) of the Act and regulations at 42 CFR 410.78.*

[SIGNATURE PAGE FOLLOWS]

The signatory for the Participant certifies that he or she is authorized to execute this amendment and to legally bind the Participant. Each party is signing this amendment on the date stated below that party's signature. If a party signs but fails to date a signature, then the date that the other party receives the signing party's signature will be deemed to be the date that the signing party signed this amendment.

PARTICIPANT

By: _____

Name: _____

Title: _____

Date: _____

CENTERS FOR MEDICARE & MEDICAID SERVICES

By: _____

Name: _____

Title: Deputy Director, Center for Medicare and Medicaid Innovation (CMMI)

Date: _____

Attachment

APPENDIX B *Secondary Repayment Source*

1. *Requirement to Obtain Secondary Repayment Source. In accordance with Article 7.7 of the Agreement, if the Participant is an SRS Covered Participant, the Participant must obtain an SRS in accordance with the criteria set forth in Article 7.7 and this Appendix B that guarantees the SRS Covered Participant's ability to pay on demand amounts owed to CMS up to the applicable amount calculated in accordance with this Appendix B and specified in the file provided by CMS to the SRS Covered Participant (the "**Secondary Repayment Source File**").*

    a) If the Participant is an SRS Covered Participant on the Start Date, then CMS will provide an initial Secondary Repayment Source File to the Participant on a date specified by CMS indicating the Standard Amount calculated in accordance with paragraph 4 of this Appendix B and the Adjusted Amount calculated in accordance with paragraph 5 of this Appendix B. The amount guaranteed by the Participant's Secondary Repayment Source for Model Year 1 and Model Year 2 must be the Standard Amount specified in such Secondary Repayment Source File, unless the Standard Amount exceeds $2 million, in which case the Participant may elect to provide the Adjusted Amount specified in such Secondary Repayment Source File.

    b) In the event that the Participant becomes an SRS Covered Participant at any point after the Start Date, CMS will provide an initial Secondary Repayment Source File to the Participant prior to the date on which the Participant becomes an SRS Covered Participant or as soon as practicable following the updates to the Participant Profile described in Article 5.5(c)(4)(iii) and Article 5.5(c)(4)(iv) that resulted in the Participant becoming an SRS Covered Participant. Such Secondary Repayment Source File will indicate the Standard Amount calculated in accordance with paragraph 4 of this Appendix B and the Adjusted Amount calculated in accordance with paragraph 5 of this Appendix B. The amount guaranteed by the Participant's Secondary Repayment Source must be the Standard Amount specified in such Secondary Repayment Source File, unless the Standard Amount exceeds $2 million, in which case the Participant may elect to provide the Adjusted Amount specified in such Secondary Repayment Source File.

    c) (c) CMS will provide an updated Secondary Repayment Source File to the Participant for each subsequent year, indicating the New Standard Amount calculated in accordance with paragraph 6 of this Appendix B and the New Adjusted Amount calculated in accordance with paragraph 7 of this Appendix B. The amount guaranteed by the Participant's Secondary Repayment Source for each such year must be updated to reflect the New Standard Amount specified in such Secondary Repayment Source File, unless the New Standard Amount exceeds $2 million, in which case the Participant may elect to provide the New Adjusted Amount specified in such Secondary Repayment Source File. CMS reserves the right to provide an updated Secondary Repayment Source File at times other than the start of a Model Year or other year.

        a) The SRS Covered Participant must provide the Secondary Repayment Source on its own behalf. Entities such as parent corporations or related or unrelated entities may not provide an SRS on behalf of the SRS Covered Participant. The SRS must include

the Participant's legal name, as well as its "doing business as" name, if applicable. The legal name must match the Participant's name on the Agreement.

2. *Form of Secondary Repayment Source. The Secondary Repayment Source must be in the form of a letter of credit or escrowed funds for the amount calculated by CMS in accordance with this Appendix B and specified in the Secondary Repayment Source File.*

   (a) ***Letter of Credit***

      (i) CMS will generally accept a Letter of Credit under the following conditions:

         (1) the letter of credit is irrevocable;

         (2) CMS is designated as the sole beneficiary;

         (3) the appropriate credit amount is specified;

         (4) the terms allow an authorized official of CMS to draw on the letter of credit upon submission to the issuing bank of the following items: (a) a certification that "The amount of the drawing under this credit represents funds due to CMS from [Participant Legal Name] under the BPCI Advanced Participation Agreement and which have remained unpaid for at least 30 days"; and (b) a copy of the appropriate written notice to the Participant of the amount owed; and

         (5) the letter must show that CMS will receive advance notice if there is any change in the amount of credit.

      (ii) Auto renewal clauses. The Participant must not use clauses providing for the automatic renewal of an irrevocable standby letter of credit to establish the required term specified in Article 7.7(a)(2) of the Agreement. The Participant may, however, use these clauses to automatically renew the letter of credit for a period of time beyond the required term. If the Participant uses an auto renewal clause, then it should state that the lender will notify CMS and the Participant at least 90 Days in advance if electing not to renew.

      (iii) Sanctioned entity clauses. The bank issuing the letter of credit must omit these clauses entirely, or, if included, exclude entities sanctioned by a federal healthcare program or by any federal agency.

   (b) ***Funds Placed in Escrow.*** *CMS and U.S. Bank National Association ("**U.S. Bank**") have a standard escrow account agreement available for use between U.S. Bank, CMS, and third parties, where CMS is the recipient of funds held in escrow if payment is due to CMS. The Participant should contact the BPCI Advanced model team to open a U.S. Bank escrow account. If the Participant wants to establish an escrow account at a different institution, CMS must approve the escrow agreement and the instructions for disbursement of the assets. Generally, CMS will accept an escrow agreement with a different institution under the following conditions:*

      (i) the escrow agreement contains all of the terms and provisions in the Standard Secondary Repayment Source Escrow Agreement Template provided in Appendix C of the Agreement;

(ii) the funds are invested in Treasury-backed securities or a money market fund;

(iii) the instructions for disbursement of the assets are consistent with CMS' standard escrow instructions (see "Instructions of Depositor" in Schedule II of Appendix C of the Agreement);

(iv) the costs, fees, and expenses associated with the escrow account, including any legal expenses incurred by the escrow agent or the Participant, are not borne by CMS and such costs are not charged to the principal;

(v) the principal cannot be encumbered for any purpose other than repaying Repayment Amounts or Excess Spending Amounts owed by the Participant to CMS under the Agreement;

(vi) CMS is not required to indemnify any person or entity against any loss, claim, damages, liabilities, or expenses, including the costs of litigation arising from the escrow agreement or the subject of the escrow agreement; and

(vii) CMS will receive advance notice of early termination of the escrow account and any change in the amount of funds held in escrow as well as any changes in the terms of the escrow agreement and the instructions for disbursement of the assets.

3. *Other Requirements.*

(a) ***SRS Beneficiary****: The Participant shall designate CMS as the sole beneficiary of the Secondary Repayment Source. CMS's address is 7500 Security Boulevard, Baltimore, MD, 21244.*

(b) ***Condition for calling funds****: The Secondary Repayment Source should indicate that the Participant is obligated to repay money it owes to CMS as a result of participation in BPCI Advanced, citing the Bundled Payment for Care Improvement Advanced Participation Agreement.*

Example:
The Participant is obligated to repay money it owes to CMS under BPCI Advanced, as required by the Bundled Payment for Care Improvement Advanced Participation Agreement. The amount of Repayment Amounts and/or Excess Payment Amounts will be noted in a demand letter to the Participant from CMS.

(c) ***Demand letter****: The Secondary Repayment Source must allow for payment to CMS in response to a demand letter from CMS.*

(d) ***Account fees and Encumbrances****: Account fees or other fees associated with establishing, maintaining, or cancelling a Secondary Repayment Source are the responsibility of the Participant and must not be paid out of the principal for the Secondary Repayment Source. The Secondary Repayment Source amount cannot be encumbered for any purpose other than repaying amounts owed by the SRS Covered Participant to CMS.*

4. *Standard Amount Calculation Methodology*.

(a) ***Attributed Baseline Clinical Episodes:*** *CMS calculates the Secondary Repayment Source amount for each SRS Covered Participant based on the Clinical Episodes to which the Participant has committed to be held accountable that are attributable to the Participant (if applicable) and, for Convener Participants, to each of the Participant's applicable Downstream Episode Initiators during the applicable baseline period ("**Attributed Baseline Clinical Episodes**"). The baseline period for Model Years 1 and 2 is calendar year 2013 through calendar year 2016. The baseline period for subsequent years will roll forward on an annual basis.*

Standard Amount*: The standard Secondary Repayment Source amount ("**Standard Amount**") is calculated as follows:*

*(i) Calculate the discount amount for each Attributed Baseline Clinical Episode described in paragraph 4(a) of this Appendix B ("**BPCI Advanced Discount Amount**"). The BPCI Advanced Discount Amount will be the CMS Discount multiplied by the Benchmark Price for that Attributed Baseline Clinical Episode.*

*(ii) Sum the BPCI Advanced Discount Amount for all of the Participant's Attributed Baseline Clinical Episodes and, to the extent that the Participant is a Convener Participant, sum the BPCI Advanced Discount Amount for all of the Attributed Baseline Clinical Episode for each of the Participant's Downstream Episode Initiators ("**Total BPCI Advanced Discount Amount**").*

*(iii) Divide the Total BPCI Advanced Discount Amount for the Participant and, if applicable, each Downstream Episode Initiator by the number of quarters of the baseline period described in paragraph 4(a) of this Appendix B for which the Participant and, if applicable, each Downstream Episode Initiator is attributed Clinical Episodes [1] ("**Average Quarterly Total BPCI Advanced Discount Amount**").*

(iv) The product of this final step of multiplying the Average Quarterly Total BPCI Advanced Discount Amount by three, subject to any adjustments or caps imposed by CMS is the Standard Amount. This Standard Amount is intended to cover the 6-month length of a Performance Period and the true-up calculations from previously reconciled Performance Periods.

[1] For example, this number would be 16 if the Episode Initiator had Clinical Episodes in every quarter of the baseline period.

5. *Adjusted Amount Option.*

*(a) Should the Standard Amount calculated in accordance with paragraph 4 of this Appendix B exceed $2 million, the SRS Covered Participant may elect to provide an adjusted Secondary Repayment Source amount ("**Adjusted Amount**").*

(b) The Adjusted Amount under this option shall be equal to the greater of $2 million or one-half of the Standard Amount.

(c) The Adjusted Amount will also apply at the TIN level for Convener Participants that have a common TIN across multiple BPIDs such that all of their Standard Amounts will be added together for the purpose of receiving the benefit of the Adjusted Amount calculation at the TIN level as opposed to the individual BPID Level.

6. *New Standard Amount Calculation Methodology.*

*(a) CMS will adjust the Standard Amount annually, beginning for Model Year 3, or at such other times determined by CMS, in accordance with the calculation described in paragraph 4 of this Appendix B if there are additions or removals of Downstream Episode Initiators or Clinical Episodes in the Participant Profile, or changes in any other factors that may affect amounts owed to CMS by the SRS Covered Participant (e.g. the addition of a new Downstream Episode Initiator who does not choose to enter into a SRS Reduction Agreement with CMS thus resulting in the Participant becoming an SRS Covered Participant for the first time or owing an additional Standard Amount for this new Downstream Episode Initiator if the Participant was already an SRS Covered Participant) ("**New Standard Amount**").*

7.*In adjusting the Standard Amount pursuant to paragraph 6(a) of this Appendix B, CMS will not adjust the Standard Amount to account for Downstream Episode Initiators or Clinical Episodes that have been removed from the Participant Profile until the final true-up Reconciliation for the last full or partial Performance Period for which those Downstream Episode Initiators or Clinical Episodes were included in the Participant Profile.*

New Adjusted Amount Option.

*(a) Should the New Standard Amount calculated in accordance with paragraph 6 of this Appendix B exceed $2 million, the SRS Covered Participant may elect to provide a new adjusted Secondary Repayment Source amount ("**New Adjusted Amount**").*

(b) The New Adjusted Amount under this option shall be equal to the greater of $2 million or one-half of the New Standard Amount.

8. *Updates to the Secondary Repayment Source Amount.*

a) CMS will provide the SRS Covered Participant with a Secondary Repayment Source File identifying the New Standard Amount calculated in accordance with paragraph 6 of this Appendix B and the New Adjusted Amount calculated in accordance with paragraph 7 of this Appendix B at least 60 Days prior to the start of the Model Year or other time in which such amounts are to take effect.

b) The Participant shall update the amount of funds available through the Secondary Repayment Source to the New Standard Amount described in paragraph 6 of this Appendix B, or to the New Adjusted Amount described in paragraph 7 of this Appendix B, as applicable, prior to the start of the Model Year or such other time in which such amount is to take effect.

c) The SRS Covered Participant shall notify CMS by email no later than the first day of the Model Year or such other time in which the New Standard Amount is to take effect whether the Secondary Repayment Source has been adjusted to reflect the New Standard Amount or New Adjusted Amount, as applicable.

9. *Restoration of Secondary Repayment Source Amount.*

a. Should the amount of funds available through the Secondary Repayment Source be reduced due to a draw on the letter of credit, withdrawal of escrowed funds, or for any other reason, the SRS Covered Participant must increase the amount of funds available through the Secondary Repayment Source to the applicable required amount.

b. Such funding increase must occur concurrent with the reduction in the amount of funds available through the Secondary Repayment Source, as described in paragraph 6(a) of this Appendix B or as soon as possible thereafter.

c. The SRS Covered Participant shall notify CMS by email no later than the Day after the reduction in the amount of funds described in paragraph 9(a) of this Appendix B has occurred, and shall indicate whether the funding increase required under such paragraph has occurred.

10. *Duration of the Secondary Repayment Source. The Participant's Secondary Repayment Source, as periodically updated to reflect the New Standard Amount or New Adjusted Amount, as applicable, calculated by CMS in accordance with this Appendix B and specified in the Secondary Repayment Source File, must remain in effect until at least 24 months after the conclusion of the Agreement Term or until all of the Participant's financial obligations to CMS pursuant to this Agreement have been fulfilled, whichever is later.*