Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation
Patient Care Models Group
2810 Lord Baltimore Drive, Suite 130
Baltimore, MD 21244

BUNDLED PAYMENTS FOR CARE IMPROVEMENT ADVANCED PARTICIPATION AGREEMENT

LAST UPDATED 09/15/2019

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PARTICIPATION AGREEMENT

This Participation Agreement ("**Agreement**") is between (BPID) ("**Participant"**) and the Centers for Medicare & Medicaid Services ("**CMS**") (each a "**Party**" and collectively the "**Parties**").

CMS is the agency within the U.S. Department of Health and Human Services ("**HHS**") that is charged with administering the Medicare and Medicaid programs.

The Participant is either a Non-Convener Participant or a Convener Participant that, by entering into this Agreement, agrees to bear financial risk to CMS for Clinical Episodes under the Bundled Payments for Care Improvement Advanced initiative ("**BPCI Advanced**" or the "**Model**").

To the extent the Participant is a Convener Participant, the Participant also brings together at least one Downstream Episode Initiators to participate in the Model and facilitates coordination among them (if more than one). Although Convener Participants bear full financial risk to CMS under the Model, they may apportion this risk downstream in accordance with the terms of this Agreement and applicable law.

The healthcare providers participating in BPCI Advanced will continue to bill Medicare under the traditional fee-for-service ("**FFS**") system for services furnished to Medicare FFS beneficiaries. However, the Participant may also receive a Net Payment Reconciliation Amount payment from CMS if Medicare FFS expenditures on the Clinical Episodes for which the Participant has elected to be held accountable are less than the applicable Target Price, subject to a quality adjustment described in Appendix A. As BPCI Advanced is a two-sided risk model, the Participant may also be liable to CMS for a portion of the Medicare FFS expenditures for such Clinical Episodes that exceed the applicable Target Price in the form of a Repayment Amount.

Under Section 1115A of the Social Security Act ("**Act**"), the CMS Center for Medicare and Medicaid Innovation ("**Innovation Center**") is authorized to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, or Children's Health Insurance Program ("**CHIP**") expenditures while maintaining or improving the quality of care for Medicare, Medicaid, or CHIP beneficiaries.

Through the BPCI Advanced initiative, the Innovation Center will test whether an episode payment model that involves Care Redesign and financial accountability for quality measure performance results in high quality, coordinated health care for Medicare FFS beneficiaries at a lower cost to the Medicare FFS program.

The Participant wishes to participate in the Model.

The Parties, intending to be legally bound, therefore agree as follows:

Article 1
Agreement Term

1.1 Effective Date. The effective date of this Agreement (the "**Effective Date**") is the date this Agreement is signed by the last Party to sign it (as indicated by the date associated with that Party's signature).

1.2 Agreement Term**.** The term of this Agreement ("**Agreement Term**") begins on the Effective Date and, in accordance with this Article 1.2, expires two years after the last day of the Agreement Performance Period defined in Article 1.3, unless this Agreement or, if applicable, an Amended and Restated Agreement offered pursuant to Article 1.4(a), is sooner terminated by either Party in accordance with Article 21 or in accordance with the terms of such Amended and Restated Agreement.

1.3 Agreement Performance Period. The performance period for this Agreement ("Agreement Performance Period") is the only period of time during the Agreement Term during which a Clinical Episode may initiate. The Agreement Performance Period begins on January 1, 2020 (the "Start Date") and ends on the applicable date specified in Article 1.3(a) or Article 1.3(b), unless this Agreement or, if applicable, an Amended and Restated Agreement offered pursuant to Article 1.4(a), is sooner terminated by either Party in accordance with Article 21 or in accordance with the terms of such Amended and Restated Agreement.

(a) In the event that CMS offers an Amended and Restated Agreement pursuant to Article 1.4(a):

    (i) If the Participant does not sign the Amended and Restated Agreement by November 15, 2020, the Agreement Performance Period expires at 11:59 PM EST on December 31, 2020.

    (ii) If the Participant signs the Amended and Restated Agreement by no later than November 15, 2020 (or other such date as CMS may specify in writing), the Agreement Performance Period will be extended beyond December 31, 2020 until 11:59 PM EST on December 31, 2021 and in accordance with the terms specified in the Amended and Restated Agreement.

(b) In the event that CMS does not offer an Amended and Restated Agreement pursuant to Article 1.4(a), then the Agreement Performance Period will expire at 11:59 PM EST on December 31, 2023.

1.4 Amended and Restated Agreements.

(a) By no later than November 15, 2020 (or other such date that CMS may specify in writing), CMS may offer the Participant the opportunity to extend the Agreement Term beyond December 31, 2022, and to extend the Agreement Performance Period beyond December 31, 2020, by signing an amended and restated version of the Agreement ("**Amended and Restated Agreement**"). To the extent practicable, CMS

will provide notice to the Participant by September 1, 2020 if CMS does not intend to offer an Amended and Restated Agreement pursuant to this Article 1.4(a).

(b) CMS may offer the Participant the opportunity to further extend the Agreement Term and Agreement Performance Period by offering amended and restated agreements in addition to the Amended and Restated Agreement described in Article 1.4(a) for subsequent Model Years. The last of any such amended and restated agreements offered by CMS and signed by the Participant will expire no later than 11:59 PM EST on December 31, 2025, unless stated otherwise in the terms of such amended and restated agreement or unless such amended and restated agreement is sooner terminated by either Party in accordance with the terms of such agreement.

Article 2
Definitions

In this Agreement, the following definitions apply:

"Accountable Care Organization" or **"ACO"** means a legal entity that is recognized and authorized under applicable law, identified by a TIN, and formed by one or more entities that participates in the ACO. For the purposes of this initiative, an ACO includes a participant in the Medicare Shared Savings Program, Next Generation ACO Model, Comprehensive ESRD Care Model, or any other Medicare-specific ACO-related initiative administered by CMS.

"Acute Care Hospital" or **"ACH"** means a Medicare-enrolled "subsection (d) hospital" as defined in Section 1886(d)(1)(B) of the Act, including ACHs where outpatient procedures are performed in hospital outpatient departments (HOPDs). PPS-exempt cancer hospitals, inpatient psychiatric facilities, critical access hospitals (CAHs), hospitals in Maryland, hospitals participating in the Rural Community Hospital demonstration, and Rural Hospitals participating in the Pennsylvania Rural Health Model, are excluded from the definition of an ACH for purposes of BPCI Advanced.

"**Adjusted Negative Total Reconciliation Amount**" means, if applicable, the Negative Total Reconciliation Amount as adjusted by the CQS Adjustment Amount, which either becomes the Repayment Amount to the extent the Participant is a Non-Convener Participant or, if the Participant is a Convener Participant, is netted against all other Adjusted Negative Total Reconciliation Amounts and all Adjusted Positive Total Reconciliation Amounts for the Convener Participant (if applicable) and the Convener Participant's Downstream Episode Initiators, resulting in either the Repayment Amount or the NPRA.

"**Adjusted Positive Total Reconciliation Amount**" means, if applicable, the Positive Total Reconciliation Amount as adjusted by the CQS Adjustment Amount, which either becomes the NPRA to the extent the Participant is a Non-Convener Participant or, if the Participant is a Convener Participant, is netted against all other Adjusted Positive Total Reconciliation Amounts and all Adjusted Negative Total Reconciliation Amounts for the Convener Participant (if applicable) and the Convener Participant's Downstream Episode Initiators, resulting in either the Repayment Amount or the NPRA.

"**Administrative Services**" means services furnished by a BPCI Advanced Entity pursuant to a BPCI Advanced Entity Agreement described in Article 8.1(f) that are directly related to the administration of the Participant's Financial Arrangements.

"**Aggregate FFS Payment"** or **"AFP**" means the total dollar amount of Medicare FFS expenditures for items and services included in a Clinical Episode as described in Article 5.3(a), excluding all Medicare FFS expenditures for items and services specifically excluded from a Clinical Episode as described in Article 5.3(b), calculated in accordance with Appendix A of this Agreement.

"Anchor Procedure" means a hospital outpatient procedure performed in a hospital outpatient department of an ACH identified by a HCPCS code specified on the Clinical Episode List described in Article 5.1, and maintained on the BPCI Advanced webpage, for which an Episode Initiator submits a claim to Medicare FFS. In accordance with Article 5.2, the first day of an Anchor Procedure initiates a Clinical Episode.

"Anchor Stay" means an inpatient stay at an ACH assigned to an MS-DRG specified on the Clinical Episode List described in Article 5.1, and maintained on the BPCI Advanced webpage, for which an Episode Initiator submits a claim to Medicare FFS. In accordance with Article 5.2, the first day of the Anchor Stay initiates a Clinical Episode.

"Benchmark Price" means a metric used by CMS, together with the CMS Discount, to calculate an Episode Initiator-specific Target Price for each Clinical Episode. The Benchmark Price is calculated in accordance with Appendix A of this Agreement.

"**BPCI Advanced Activities**" means activities related to the overall care of BPCI Advanced Beneficiaries during a Clinical Episode, which include: furnishing direct patient care to BPCI Advanced Beneficiaries in a manner that reduces cost or improves quality; engaging in Care Redesign; reporting on quality measures described in Article 4.3 and Appendix D of this Agreement; using CEHRT in accordance with Article 4.4; performing a minimum of four MIPS Improvement Activities in accordance with Article 4.5; and any other related activities specified by CMS.

"**BPCI Advanced Beneficiary**" means a Medicare beneficiary entitled to benefits under Part A and enrolled under Part B on whose behalf an Episode Initiator submits a claim to Medicare FFS for an Anchor Stay or Anchor Procedure. The term BPCI Advanced Beneficiary specifically excludes: (1) Medicare beneficiaries covered under United Mine Workers or managed care plans (e.g., Medicare Advantage, Health Care Prepayment Plans, or cost-based health maintenance organizations); (2) beneficiaries eligible for Medicare on the basis of an end-stage renal disease (ESRD) diagnosis; (3) Medicare beneficiaries for whom Medicare is not the primary payer; and (4) Medicare beneficiaries who die during the Anchor Stay or Anchor Procedure. A BPCI Advanced Beneficiary must meet this definition for the full duration of the Clinical Episode.

"BPCI Advanced Entity" means an entity other than the Participant that administers the Participant's Financial Arrangements pursuant to a BPCI Advanced Entity Agreement.

"BPCI Advanced Savings Pool" means a collection of funds maintained in the name of the Participant by either the Participant or a BPCI Advanced Entity on the Participant's behalf, that

consists solely of: (1) contributions by NPRA Sharing Partners of the NPRA Sharing Partners' own Internal Cost Savings and Shared Repayment Amounts; (2) contributions by the Participant of NPRA received by the Participant from CMS; and (3) in the case of a Non-Convener Participant, contributions of its own Internal Cost Savings. Funds maintained in the BPCI Advanced Savings Pool may be distributed as either NPRA Shared Payments or as payment for Administrative Services furnished by a BPCI Advanced Entity, except as prohibited under Article 21.5(c).

"**Care Redesign**" means the specific planned interventions and changes to the Participant's, its Downstream Episode Initiators', Participating Practitioners', NPRA Sharing Partners', or NPRA Sharing Group Practice Practitioners' current healthcare delivery system that are described in Article 4.2 and set forth with particularity in the Participant's Care Redesign Plan.

"**Care Redesign Plan**" means the Participant's plan for Care Redesign, as established and updated in accordance with Article 4.2.

"**CCN**" means a CMS Certification Number.

"**Certified Electronic Health Record Technology**" or "**CEHRT**" means CEHRT as defined in 42 C.F.R. § 414.1305, as may be amended from time to time.

"**Change of Control**" means any of the following: (1) the acquisition by any "person" (as such term is used in Sections 13(d) and 14(d) of the Securities Exchange Act of 1934) of beneficial ownership (within the meaning of Rule 13d-3 promulgated under the Securities Exchange Act of 1934), directly or indirectly, of voting securities of an entity representing more than 50 percent of the entity's outstanding voting securities or rights to acquire such securities; (2) the acquisition of an entity by any other individual or entity; (3) any merger, division, or expansion of an entity (including satellite offices); or (4) the sale, lease, exchange or other transfer (in one transaction or a series of transactions) of all or substantially all of the assets of an entity, or an agreement for the sale or liquidation of the entity.

"**Clinical Episode**" means the period of time described in Article 5.2 initiated on the first day of an Anchor Stay or an Anchor Procedure, during which all Medicare FFS expenditures for all non-excluded items and services furnished to a BPCI Advanced Beneficiary are bundled together as a unit for purposes of calculating the Target Price and for purposes of Reconciliation. Clinical Episodes may be initiated only during the Agreement Performance Period defined in Article 1.3.

"CMS Discount" means a set percentage by which CMS reduces the Benchmark Price in order to calculate the Target Price.

"Convener Participant" means an entity that enters into a BPCI Advanced participation agreement with CMS to participate in the BPCI Advanced model and that brings together at least one Downstream Episode Initiator to participate in BPCI Advanced, facilitates coordination among Downstream Episode Initiators (if more than one), and bears full financial risk to CMS under the Model. A Convener Participant may be an entity that is either a Medicare-enrolled provider or supplier or an entity that is not enrolled in Medicare. Entities other than ACHs and PGPs (e.g., PAC Providers) may participate in BPCI Advanced as Convener Participants, but not

as Non-Convener Participants. ACHs and PGPs may participate in BPCI Advanced as either Convener Participants or as Non-Convener Participants.

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

"**CQS**" means Composite Quality Score.

"**CQS Adjustment Amount**" means the adjustment applied during the Reconciliation process to the Positive Total Reconciliation Amount, if any, or the Negative Total Reconciliation Amount, if any, in order to calculate the Adjusted Positive Total Reconciliation Amount or Adjusted Negative Total Reconciliation Amount, as applicable. The CQS Adjustment Amount is calculated in accordance with Appendix A of this Agreement.

"**Days**" means calendar days unless otherwise specified.

"**Descriptive Materials**" means general audience materials, such as brochures, advertisements, outreach events, letters to BPCI Advanced Beneficiaries, web pages published on a web site, mailings, social media, or other activities conducted by or on behalf of the Participant, a Downstream Episode Initiator, BPCI Advanced Entity, NPRA Sharing Partner, NPRA Sharing Group Practice Practitioner, Participating Practitioner or other individuals or entities performing functions or services related to BPCI Advanced Activities used to educate, notify, or contact BPCI Advanced Beneficiaries regarding the Model. Descriptive Materials do not include any of the following: communications that do not reference BPCI Advanced (for example, general information about care coordination would not be considered Descriptive Materials); material that covers Beneficiary-specific billing and claims issues; educational information on specific medical conditions; or any other material that is excepted from the definition of "marketing" under the HIPAA Privacy Rule (45 C.F.R. parts 160 and 164, subparts A & E).

"**Downstream Episode Initiator**" means an ACH or PGP that participates in BPCI Advanced pursuant to an agreement with the Participant, to the extent the Participant is a Convener Participant, under which such Downstream Episode Initiator agrees to participate in BPCI Advanced and which requires the Downstream Episode Initiator to comply with all of the applicable terms and conditions of this Agreement.

"**Eligible Clinician**" means "eligible clinician" as defined in 42 C.F.R. § 414.1305, as may be amended from time to time.

"**Episode Initiator**" means any ACH or a PGP that participates in BPCI Advanced as either: (1) the Participant; or (2) a Downstream Episode Initiator. Any Episode Initiator identified on the Participant Profile can trigger Clinical Episodes under BPCI Advanced.

"**Excess Spending Amount**" means the dollar amount specific to the Post-Episode Spending Calculation by which the Medicare FFS expenditures on items and services furnished to a BPCI Advanced Beneficiary during the Post-Episode Monitoring Period exceeds a benchmark beyond a risk threshold, each calculated in accordance with Appendix A of this Agreement.

"**Federal Government**" means the federal executive, legislative, and judicial branches of the United States of America.

"**Financial Arrangement**" means an NPRA Sharing Arrangement or a Partner Distribution Arrangement, or both.

"**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.

"**Internal Cost Savings**" means, for each NPRA Sharing Partner and Non-Convener Participant, the measurable, actual, and verifiable cost savings realized by the NPRA Sharing Partner or the Non-Convener Participant, as applicable, resulting from Care Redesign undertaken by the NPRA Sharing Partner (or by either the NPRA Sharing Partner or the Non-Convener Participant, in the case of Internal Cost Savings contributions made by a Participant) in connection with furnishing items and services to BPCI Advanced Beneficiaries within the Clinical Episodes for which the Participant has committed to be held accountable in the Participant Profile. Internal Cost Savings do not include savings realized by a Convener Participant or any individual or entity that is not an NPRA Sharing Partner.

"**Medically Necessary**" means reasonable and necessary as determined in accordance with Section 1862(a) of the Act.

"**Medicare Fee-for-Service"** or **"Medicare FFS"** means Medicare Part A and Part B. The term Medicare FFS does not include Medicare Part C (Medicare Advantage) or Medicare Part D.

"**MIPS Improvement Activity**" means an activity to improve clinical practice or care delivery and is included on the MIPS Improvement Activities list on the Quality Payment Program website at: https://Quality Payment Program.cms.gov/mips/improvement-activities.

"**Model Year**" means a full or partial calendar year during which Clinical Episodes may initiate. Notwithstanding the duration of the Agreement Performance Period defined in Article 1.3, BPCI Advanced includes the following six (6) Model Years:

Model Year 1: October 1, 2018 through December 31, 2018
Model Year 2: January 1, 2019 through December 31, 2019
Model Year 3: January 1, 2020 through December 31, 2020
Model Year 4: January 1, 2021 through December 31, 2021
Model Year 5: January 1, 2022 through December 31, 2022
Model Year 6: January 1, 2023 through December 31, 2023

The BPCI Advanced initiative will extend for an additional two calendar years after the end of Model Year 6 and will conclude at 11:59 PM EST on December 31, 2025.

"**NPI**" means National Provider Identifier.
"**Negative Reconciliation Amount**" means, if applicable, the amount by which the AFP for a Clinical Episode exceeds the final Target Price for that Clinical Episode. This amount is summed across all Clinical Episodes attributed to an Episode Initiator, together with all Positive

Reconciliation Amounts for such Clinical Episodes, to determine either the Positive Total Reconciliation Amount or Negative Total Reconciliation Amount, as applicable, for that Episode Initiator.

"**Negative Total Reconciliation Amount**" means, if applicable, the negative sum of all Negative Reconciliation Amounts and all Positive Reconciliation Amounts for all Clinical Episodes attributed to an Episode Initiator. CMS adjusts the Negative Total Reconciliation Amount by the CQS Adjustment Amount to calculate the Adjusted Negative Total Reconciliation Amount.

"**Net Payment Reconciliation Amount"** or **"NPRA**" means, if applicable, the amount paid to the Participant by CMS if the sum of all Adjusted Negative Total Reconciliation Amounts and all Adjusted Positive Total Reconciliation Amounts for the Participant (if the Participant is an Episode Initiator) and/or for all of the Participant's Downstream Episode Initiators (if the Participant is a Convener Participant) is positive, as specified in the Reconciliation Report deemed to be final pursuant to Article 7.3(a)(3), Article 7.3(b)(3), Article 7.3(b)(4), or Article 7.3(c)(4).

"Non-Convener Participant" means either an ACH or a PGP that enters into a BPCI Advanced Participation Agreement with CMS to participate in the BPCI Advanced initiative but is not a Convener Participant because it does not bear financial risk on behalf of Downstream Episode Initiators.

"**NPRA Shared Payment**" means any payment made by the Participant, or the BPCI Advanced Entity on the Participant's behalf, from the BPCI Advanced Savings Pool to an NPRA Sharing Partner pursuant to an NPRA Sharing Arrangement.

"NPRA Sharing Arrangement" means an arrangement between the Participant and an NPRA Sharing Partner pursuant to which: (1) the NPRA Sharing Partner may contribute Internal Cost Savings and Shared Repayment Amounts to the BPCI Advanced Savings Pool; and (2) the Participant may: (a) make contributions to, as applicable, and payments to the NPRA Sharing Partner from the BPCI Advanced Savings Pool and (b) apportion some or all of a Repayment Amount owed to CMS by the Participant to such NPRA Sharing Partner.

"**NPRA Sharing Group Practice Practitioner**" means a Medicare-enrolled physician or non-physician practitioner who is: (1) identified by an individual NPI; (2) has reassigned his or her right to receive Medicare payment to the TIN of a PGP NPRA Sharing Partner; (3) is participating in BPCI Advanced Activities; (4) is identified as an NPRA Sharing Group Practice Practitioner on the Financial Arrangement List; and (5) has entered into a Partner Distribution Arrangement.

"**NPRA Sharing Partner**" means a Participating Practitioner, a PGP, an ACH, an ACO, or a PAC Provider that is not the Participant and is: (1) participating in BPCI Advanced Activities; (2) identified as an NPRA Sharing Partner on the Financial Arrangement List; and (3) has entered into a written NPRA Sharing Arrangement.

"**Participant Profile**" means the document submitted, accepted, and updated in accordance with Article 5.5, which includes: (1) a list indicating the Clinical Episodes for which the Participant commits to be held accountable under BPCI Advanced; (2) to the extent the Participant is a

Convener Participant, a list of the Participant's Downstream Episode Initiators and whether or not each Downstream Episode Initiator has entered into an SRS Reduction Agreement (as defined in Article 7.6 of this Agreement) with CMS; (3) the Participant's intention to: (i) engage in Financial Arrangements permitted under Article 8; (ii) offer beneficiary incentives permitted under Article 10; or (iii) furnish services to BPCI Advanced Beneficiaries pursuant to one or more of the Payment Policy Waivers described in Article 11 and Appendices E, F, and G of this Agreement; and (5) the four MIPS Improvement Activities in which the Participant will participate as required by Article 4.5.

"**Participating Practitioner**" means an Eligible Clinician who (1) is identified by an individual NPI; (2) is Medicare enrolled; (3) is participating in BPCI Advanced Activities; (4) has a written agreement with the Participant that requires the individual to comply with all applicable terms and conditions of this Agreement; and (5) is identified on the QPP List.

"**Partner Distribution Arrangement**" means an arrangement between a PGP NPRA Sharing Partner and an NPRA Sharing Group Practice Practitioner pursuant to which the PGP NPRA Sharing Partner may: (1) share a Partner Distribution Payment with the NPRA Sharing Group Practice Practitioner; and (2) apportion some or all of a Shared Repayment Amount owed by the PGP NPRA Sharing Partner to the Participant to such NPRA Sharing Group Practice Practitioner.

"**Partner Distribution Payment**" means the portion of an NPRA Shared Payment paid by a PGP NPRA Sharing Partner to an NPRA Sharing Group Practice Practitioner pursuant to a Partner Distribution Arrangement.

"**Payment Policy Waiver**" means the following additional benefits the Participant chooses to make available to BPCI Advanced Beneficiaries in order to support high-value services and allow the Participant to more effectively manage the care of BPCI Advanced Beneficiaries: (1) 3-Day SNF Rule Payment Policy Waiver (as described in Article 11.2 and Appendix E of this Agreement); (2) Post-Discharge Home Visits Payment Policy Waiver (as described in Article 11.3 and Appendix F of this Agreement); and (3) Telehealth Payment Policy Waiver (as described in Article 11.4 and Appendix G of this Agreement).

"**Performance Period**" means the defined period of time during the Agreement Performance Period defined in Article 1.3 during which Clinical Episodes may initiate. Notwithstanding the duration of the Agreement Performance Period defined in Article 1.3, the BPCI Advanced initiative includes the following ten (10) Performance Periods:

Performance Period 1: October 1, 2018 through June 30, 2019
Performance Period 2: July 1, 2019 through December 31, 2019
Performance Period 3: January 1, 2020 through June 30, 2020
Performance Period 4: July 1, 2020 through December 31, 2020
Performance Period 5: January 1, 2021 through June 30, 2021
Performance Period 6: July 1, 2021 through December 31, 2021
Performance Period 7: January 1, 2022 through June 30, 2022
Performance Period 8: July 1, 2022 through December 31, 2022
Performance Period 9: January 1, 2023 through June 30, 2023

Performance Period 10: July 1, 2023 through December 31, 2023
"**PGP**" means a Medicare-enrolled physician group practice.
"**PGP NPRA Sharing Partner**" means an NPRA Sharing Partner that is a PGP.

"**Positive Reconciliation Amount**" means, if applicable, the amount by which the AFP for a Clinical Episode is less than the final Target Price for that Clinical Episode. This amount is summed across all Clinical Episodes attributed to the Episode Initiator, together with all Negative Reconciliation Amounts for such Clinical Episodes, to determine either the Positive Total Reconciliation Amount or the Negative Total Reconciliation Amount, as applicable, for that Episode Initiator.

"**Positive Total Reconciliation Amount**" means, if applicable, the positive sum of all Negative Reconciliation Amounts and all Positive Reconciliation Amounts for all Clinical Episodes attributed to an Episode Initiator. CMS adjusts the Positive Total Reconciliation Amount by the CQS Adjustment Amount to calculate the Adjusted Positive Total Reconciliation Amount.

"**Post-Acute Care Provider**" or "**PAC Provider**" means a Medicare-certified Skilled Nursing Facility (SNF), Long-term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), or Home Health Agency (HHA).

"**Post-Episode Spending Calculation**" means the financial analysis performed by CMS after each Performance Period to determine whether aggregate Medicare FFS spending on items and services furnished to BPCI Advanced Beneficiaries during the Post-Episode Spending Monitoring Period exceeds a baseline of trended historical aggregate Medicare FFS payment beyond an empirically titrated risk threshold due to cost shifting or other reasons.

"Post-Episode Spending Calculation Report" means the report issued by CMS to the Participant following each Performance Period, which specifies whether the Participant will owe an Excess Spending Amount to CMS, as described in Article 7 and Appendix A of this Agreement.

"**Post-Episode Spending Monitoring Period**" means the period of 30 Days after the end of a Clinical Episode during which Medicare FFS spending for items and services furnished to BPCI Advanced Beneficiaries is monitored by CMS for purposes of conducting the Post-Episode Spending Calculation.

"**Program Integrity Screening**" means a review of an individual's or entity's program integrity history, which may include a review of Medicare or Medicaid, or any combination of the two, program exclusions or other sanctions, current or prior law enforcement investigations or administrative actions, affiliations with individuals or entities that have a history of program integrity issues, or other information pertaining to the trustworthiness of the individual or entity.

"**Quality Payment Program (QPP) List**" means a list as set forth in Article 6 that includes two separate tabs that are used to develop the Participation List and Affiliated Practitioner List as defined in 42 C.F.R. § 414.1305, as may be amended from time to time, for purposes of the Quality Payment Program, as set forth in 42 C.F.R. Part 414 Subpart O for the BPCI Advanced Model.

"**Reconciliation**" means the semi-annual process of comparing the aggregate Medicare FFS expenditures for all items and services included in a Clinical Episode attributed to the Participant against the final Target Price for that Clinical Episode to determine whether the Participant is eligible to receive an NPRA payment from CMS, or is required to pay a Repayment Amount to CMS.

"**Reconciliation Report***"* means the report issued by CMS to the Participant following each Performance Period that specifies whether the Participant is eligible to receive an NPRA payment from CMS, or is required to pay a Repayment Amount to CMS, as described in Article 7 and Appendix A of this Agreement. For purposes of this Agreement, the Reconciliation Report also includes the Post-Episode Spending Calculations, as applicable.

"**Repayment Amount**" means, if applicable, the amount that must be paid to CMS by the Participant if the sum of all Adjusted Negative Total Reconciliation Amounts and all Adjusted Positive Total Reconciliation Amounts for the Participant (in the case of a Non-Convener Participant) or for the Participant and all of the Participant's Downstream Episode Initiators (in the case of a Convener Participant) is negative, as specified in the Reconciliation Report deemed to be final pursuant to Article 7.3(a)(3), Article 7.3(b)(3), Article 7.3(b)(4), or Article 7.3(c)(4). The Repayment Amount must be paid by the Participant to CMS in accordance with Article 7.

"**Shared Repayment Amount**" means the portion of the Repayment Amount owed by the Participant to CMS that is paid by an NPRA Sharing Partner to the Participant pursuant to an NPRA Sharing Arrangement. Such Shared Repayment Amount may be apportioned by a PGP NPRA Sharing Partner among NPRA Sharing Group Practice Practitioners pursuant to a Partner Distribution Arrangement.

"**Target Price**" means the Benchmark Price multiplied by one minus the applicable CMS Discount. The Target Price is prospectively provided as the preliminary Target Price, updated in accordance with Appendix A of this Agreement, and is subject to adjustments for actual patient case-mix used to calculate the final Target Price.

"**TIN**" means a federal taxpayer identification number, which in some cases may be a Social Security Number.

"**Winsorization**" means a statistical method that limits the effects of extreme values or outliers by using the national distribution of Medicare FFS expenditures on non-excluded items and services furnished to a BPCI Advanced Beneficiary during a Clinical Episode.

Article 3
Participant Requirements

3.1 General.

(a) During the Agreement Term, the Participant shall comply with the terms and conditions of this Agreement, as well as any limitations on the Participant's simultaneous participation in BPCI Advanced and another CMS initiative as specified in Appendix A of this Agreement. The Participant shall notify CMS in writing of any changes or deficiencies related to these requirements within 15 Days of discovery.

(b) During the Agreement Term, the following documents will be used to define the scope of the Participant's participation in BPCI Advanced and to identify all individuals and entities participating in the Model pursuant to arrangements, either directly or indirectly, with the Participant:

(1) A Participant Profile;

(2) A Care Redesign Plan;

(3) A Financial Arrangement List (if applicable); and

(4) A QPP List.

(c) During the Agreement Term, the Participant shall ensure compliance with the applicable terms and conditions of this Agreement by all Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, BPCI Advanced Entities, and other entities and individuals performing functions or services related to BPCI Advanced Activities, and shall ensure that the Participant has sufficient access to all necessary records, data, and information of and pertaining to the Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, BPCI Advanced Entities, and other entities and individuals performing functions or services related to BPCI Advanced Activities, as applicable, to enable the Participant to carry out this responsibility.

3.2 Participant Changes.

(a) Legal Name Change.

(1) The Participant shall provide written notice to CMS within 60 Days before any change in the Participant's legal name. The notice of legal name change must include a copy of any legal document effecting the name change, authenticated by the appropriate state official (if applicable) and the Parties shall execute an agreement reflecting the change of the Participant's legal name.

(2) 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.

(b) Change of Control.

(1) The Participant shall provide written notice to CMS at least 90 Days before the effective date of any Change of Control of the Participant. This obligation remains in effect throughout the Agreement Term and until final payment by or to the Participant has been made in accordance with Article 7.

(2) After review of such notice, CMS may terminate this Agreement, demand immediate payment of any Repayment Amount or Excess Spending Amount owed by the Participant to CMS under this Model, or a combination thereof, or may take any other actions consistent with the terms of this Agreement, to include Article 23.6.

(c) Notice of Identifier Change.

(1) 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 the Participant. After review of such notice, CMS may terminate this Agreement, demand immediate payment of Repayment Amounts or Excess Spending Amounts, or a combination thereof, or may take any other actions consistent with the terms of this Agreement, to include Article 23.6.

(2) 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, QPP List, or Financial Arrangement List, as applicable.

3.3 Information on Organizational Readiness. The Participant shall provide CMS with the following information within 10 Days of the date of a request by CMS:

(a) Information confirming the organizational readiness of the Participant, and the systems to be used, for the measurement of clinical quality and cost effectiveness across all Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities;

(b) Information confirming the organizational readiness of the Participant, and accounting systems to be used, to measure and track NPRA payments received from CMS, Repayment Amounts and Excess Spending Amounts owed to CMS, Internal Cost Savings, and Administrative Services, and to provide feedback to all Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities;

(c) Other information, as requested by CMS, to verify and confirm the Participant's and all Downstream Episode Initiators', Participating Practitioners', NPRA Sharing Partners', and NPRA Sharing Group Practice Practitioners' readiness for implementation of the Care Redesign Plan approved by CMS pursuant to Article 4.2;

(d) Other information as requested by CMS to verify, confirm, monitor, or evaluate performance of this Agreement as carried out by the Participant and all Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities;

(e) Information, as requested by CMS, for determining and verifying the eligibility to participate in Medicare of the Participant (if the Participant is itself a provider or supplier), and all Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners (for those NPRA Sharing Partners that are providers or suppliers), and NPRA Sharing Group Practice Practitioners; and

(f) Information regarding the Participant's plan for implementing and tracking the implementation of all BPCI Advanced Beneficiary protections, including those set forth in Article 9, as well as all items and services furnished to BPCI Advanced Beneficiaries during the Clinical Episodes to which the Participant has committed to be held accountable.

Article 4
BPCI Advanced Activities

4.1 General. The Participant shall engage in BPCI Advanced Activities throughout the Agreement Performance Period and shall require all Participating Practitioners, Downstream Episode Initiators, NPRA Sharing Partners, and NPRA Sharing Group Practice Practitioners to do the same.

4.2 Care Redesign Plan.

(a) Initial Care Redesign Plan. The Participant shall submit to CMS, by a date and in a manner specified by CMS, an initial Care Redesign Plan using the Care Redesign Plan template provided to the Participant by CMS, subject to CMS's review and acceptance, together with the certification stating that the Care Redesign Plan is true, accurate, and complete, signed by an executive of the Participant authorized to sign such certification on behalf of the Participant.

(1) CMS will review the Participant's initial Care Redesign Plan and will make reasonable efforts to accept the initial Care Redesign Plan, reject the initial Care

Redesign Plan, or provide notice to the Participant of an extension of the review period of the initial Care Redesign Plan, within 60 Days of CMS' receipt thereof.

(2) CMS may require the Participant to make changes to the initial Care Redesign Plan before acceptance and may reject the initial Care Redesign Plan if the Participant does not make satisfactory changes. If CMS does not approve the changes made to the Participant's initial Care Redesign Plan, CMS may require the Participant to submit a Corrective Action Plan in accordance with Article 20.3 and to implement that Corrective Action Plan once approved by CMS.

(b) Updated Care Redesign Plan. The Participant shall update its Care Redesign Plan on an annual basis by a date specified by CMS, and at such other times as may be specified by CMS, subject to CMS's review and acceptance.

(1) CMS will review any updates to the Care Redesign Plan submitted by the Participant and will make reasonable efforts to accept the updated Care Redesign Plan, reject the updated Care Redesign Plan, or provide notice to the Participant of an extension of the review period of the updated Care Redesign Plan, within 60 Days of CMS's receipt thereof.

(2) CMS may require the Participant to make changes to the updated Care Redesign Plan before acceptance and may reject the updated Care Redesign Plan if the Participant does not make satisfactory changes. If CMS does not approve the changes made to the Participant's Care Redesign Plan, CMS may require the Participant to submit a Corrective Action Plan in accordance with Article 20.3 and to implement that Corrective Action Plan once approved by CMS.

(c) Implementation of the Care Redesign Plan.

(1) The Participant shall ensure that copies of the CMS-accepted Care Redesign Plan are provided to all Participating Practitioners, Downstream Episode Initiators, NPRA Sharing Partners, and NPRA Sharing Group Practice Practitioners.

(2) The Participant shall implement the CMS-accepted Care Redesign Plan and shall require implementation of the CMS-accepted Care Redesign Plan by all Participating Practitioners, Downstream Episode Initiators, NPRA Sharing Partners, and NPRA Sharing Group Practice Practitioners.

(3) CMS' acceptance of the Participant's initial Care Redesign Plan or any updated Care Redesign Plan does not imply or constitute a determination that the Participant's Care Redesign Plan complies with federal statutes or regulations or relieve the Participant, Participating Practitioners, Downstream Episode Initiators, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, or any other individuals or entities performing BPCI Advanced Activities of the obligation to comply with the terms of this Agreement or all applicable laws, rules, and regulations. Such acceptance does not preclude CMS or any other Federal Government authority from enforcing any and all applicable laws, rules, and regulations.

4.3 Quality Measures. CMS will use performance on the quality measures listed in the Quality Measures List and Reporting Requirements (Appendix D) to assess and monitor quality performance. Performance on these measures for each Clinical Episode by the Participant, if the Participant is a provider or supplier, as well as by Downstream Episode Initiators and Participating Practitioners, will be used to calculate the CQS and CQS Adjustment Amount for the Participant and, if the Participant is a Convener Participant, for each of the Participant's Downstream Episode Initiators in the manner specified in Appendix A of this Agreement. The Participant must report data on each quality measure listed in the Required Quality Measures Set (Appendix D) to CMS on behalf of itself (if the Participant is a provider or supplier) and on behalf of all Downstream Episode Initiators and Participating Practitioners, as applicable.

4.4 Use of CEHRT**.** As of the Start Date, the Participant shall use CEHRT, and shall require its Participating Practitioners to use CEHRT, in a manner sufficient to meet the applicable requirements of the Advanced Alternative Payment Model criterion under 42 C.F.R. § 414.1415(a)(1)(i), including any amendments thereto. Prior to the start of each Model Year during the Agreement Performance Period, the Participant is required to certify, as part of the Participant's Care Redesign Plan, its intent to use CEHRT throughout such Model Year in a manner sufficient to meet the requirements as set forth in 42 C.F.R. § 414.1415(a)(1)(i).

4.5 Improvement Activities. The Participant and/or its Downstream Episode Initiators and Participating Practitioners shall participate in a minimum of four MIPS Improvement Activities. The Participant shall provide information to CMS, by a time and in a manner specified by CMS, regarding the Participant's participation in these MIPS Improvement Activities, upon request by CMS.

Article 5
Clinical Episodes and Participant Profile

5.1 Clinical Episode List. The Participant acknowledges that the Participant has access to the list of Clinical Episodes offered under BPCI Advanced ("Clinical Episode List"), which will be kept and maintained by CMS on the BPCI Advanced webpage: https://innovation.cms.gov/initiatives/bpci-advanced . Pursuant to Article 5.5(a)(2) below, the Participant will be held accountable only for those Clinical Episodes identified on the Participant's CMS-accepted Participant Profile.

5.2 Clinical Episode Duration.

(a) Clinical Episodes Initiated by an Anchor Stay. For those Clinical Episodes initiated by an Anchor Stay, the Clinical Episode will begin on the first day of the BPCI Advanced Beneficiary's Anchor Stay, and end after an additional 90 Days beginning on the date that the BPCI Advanced Beneficiary is discharged from the Anchor Stay. Clinical Episodes may be initiated only during the Agreement Performance Period.

(1) For purposes of Reconciliation, a Clinical Episode initiated by an Anchor Stay will be included in the Reconciliation calculations for the Performance Period that

is ongoing at the end of the 90-Day period that begins on the date of discharge from the Anchor Stay ("**Post-Anchor Period**").

(2) The date of discharge from the Anchor Stay will be used to determine the applicable preliminary Target Price, the prospective Target Price provided to Participants, and calculated in accordance with Appendix A for a Clinical Episode initiated by an Anchor Stay.

(3) When the duration of an Anchor Stay (excluding the date of discharge) extends for a period of 60 Days or more, such that total duration of the Clinical Episode extends for a period of 150 Days or more (60 Days for the Anchor Stay (excluding the date of discharge), plus a 90-Day Post-Anchor Period), the Clinical Episode will be excluded from Reconciliation conducted pursuant to Article 7.3 and from the Post-Episode Monitoring Spending Calculation conducted pursuant to Article 7.4.

(4) In the event this Agreement is early terminated by either Party pursuant to Article 21, if the date of discharge from the Anchor Stay occurs prior to the effective date of termination, the Participant will be held accountable for the Clinical Episode for purposes of Reconciliation and the Post-Episode Monitoring Spending Calculation, regardless of whether the Clinical Episode ends after the final Performance Period. If the date of discharge from the Anchor Stay occurs on or after the effective date of termination, the Participant will not be held accountable for the Clinical Episode for purposes of Reconciliation or the Post-Episode Monitoring Spending Calculation.

(b) Clinical Episodes Initiated by an Anchor Procedure. For those Clinical Episodes initiated by an Anchor Procedure, the Clinical Episode will begin on the first day of the BPCI Advanced Beneficiary's Anchor Procedure and end 90 Days after completion of the Anchor Procedure. Clinical Episodes may only be initiated during the Agreement Performance Period.

(1) For purposes of Reconciliation, a Clinical Episode initiated by an Anchor Procedure will be included in the Reconciliation calculations for the Performance Period that is ongoing at the end of the 90-Day period after completion of the Anchor Procedure.

(2) The date the Anchor Procedure is completed will be used to determine the applicable preliminary Target Price calculated in accordance with Appendix A for a Clinical Episode initiated by an Anchor Procedure.

(3) In the event this Agreement is terminated by either Party pursuant to Article 21, if the date of completion for the Anchor Procedure occurs prior to the effective date of termination, the Participant will be held accountable for the Clinical Episode for purposes of Reconciliation and the Post-Episode Monitoring Spending Calculation, regardless of whether the Clinical Episode ends after the final Performance Period. If the date of completion for the Anchor Procedure occurs on

or after the effective date of termination, the Participant will not be held accountable for the Clinical Episode for purposes of Reconciliation or the Post-Episode Monitoring Spending Calculation.

Additional information regarding Clinical Episode construction specifications can be found on the CMS website: https://innovation.cms.gov/initiatives/bpci-advanced ("**Clinical Episode Construction Specifications**"). CMS reserves the right to modify this document at any time.

5.3 Clinical Episode Items and Services.

(a) Inclusions. Each Clinical Episode will include the following items and services, unless excluded pursuant to Article 5.3(b):

(1) All Medicare Part A and Part B items and services that are furnished to the BPCI Advanced Beneficiary during the Anchor Stay or Anchor Procedure, as applicable;

(2) All Medicare Part A and Part B items and services furnished to the BPCI Advanced Beneficiary during the 90-Day period beginning on the date of discharge from the Anchor Stay or the 90-Day period following completion of the Anchor Procedure, as applicable, including hospice services; and

(3) With respect to only those Clinical Episodes initiated by an Anchor Stay:

(i) All hospital diagnostic testing and certain therapeutic services furnished to the BPCI Advanced Beneficiary by the admitting hospital or by an entity wholly owned or wholly operated by the admitting hospital in the three Days prior to the first day of the Anchor Stay, as applicable (according to the 3-Day Payment Window Rule Policy, see Medicare Claims Processing Manual (Pub. 100-4), Ch. 3, section 40.3); and

(ii) Charges from a BPCI Advanced Beneficiary's emergency department (ED) visit, if the Beneficiary was transferred from the ED at another facility to the ACH Episode Initiator that furnished the Anchor Stay, either the day of or the day before admission for the Anchor Stay.

(b) Exclusions. The following are examples of what will be excluded from each Clinical Episode:

(1) All Medicare Part A and Part B services furnished to a BPCI Advanced Beneficiary during certain specified ACH admissions and readmissions (i.e., ACH admissions assigned at discharge to an MS-DRG for an organ transplant, trauma, cancer-related care, or ventricular shunts);

(2) Contralateral procedures with the same MS-DRG (e.g., Major Joint Replacement of the Lower Extremity Clinical Episode that has a joint replaced in the opposite leg within 90 Days);

(3) New technology add-on payments made pursuant to 42 C.F.R. § 412.87 and 42 C.F.R. § 412.88;

(4) Payments for items and services for cardiac rehabilitation and intensive cardiac rehabilitation described in 42 C.F.R. § 410.49;

(5) Payments for items and services with transitional pass-through payment status made pursuant to 42 C.F.R. § 419.62 and 42 C.F.R. § 419.64; and

(6) Payment for blood clotting factors made pursuant to 42 C.F.R. § 410.63(b).

The complete list of Medicare Part A and Part B items and services excluded from Clinical Episodes under BPCI Advanced, identified by MS-DRG and HCPCS codes, as applicable, is posted here: https://innovation.cms.gov/initiatives/bpci-advanced ("**BPCI Advanced Exclusions List**"). CMS reserves the right to modify this list at any time to add or remove MS-DRGs and HCPCS codes.

5.4 Prohibition.

(a) The Participant shall not alter care delivery practices, adopt billing practices, or take any other actions for the sole or primary purpose of reducing Medicare FFS expenditures on items and services included in a Clinical Episode by increasing Medicare FFS expenditures on items and services not included in the Clinical Episode (e.g., items and services excluded from the Clinical Episode pursuant to Article 5.3(b)), and shall require all Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and any other individuals or entities performing BPCI Advanced Activities to comply with this same standard.

(b) The Participant shall not take steps to prohibit Downstream Episode Initiators that are participating or had formerly participated in BPCI Advanced pursuant to an agreement with the Participant from rejoining BPCI Advanced pursuant to an agreement with another Convener Participant or Non-Convener Participant or as a Convener Participant or Non-Convener Participant themselves.

5.5 Participant Profile.

(a) General.

(1) The Participant shall maintain a Participant Profile using the Participant Profile template provided to the Participant by CMS in accordance with this Article 5.5.

(2) Clinical Episodes.

(i) The Participant shall be held accountable for all Clinical Episodes identified in its Participant Profile. The Participant commits to identifying at least one Clinical from the Clinical Episode List.

(ii) In the event that a Participant or, if applicable, a Downstream Episode Initiator is also participating in an Innovation Center model implemented via regulation (e.g., the Comprehensive Care for Joint Replacement model), the Participant will not be permitted to commit to be held accountable for clinical episodes included in that model for purposes of BPCI Advanced.

(3) Downstream Episode Initiators. If the Participant is a Convener Participant, the Participant shall include at least one Downstream Episode Initiator in its Participant Profile and indicate whether each of its Downstream Episode Initiators have entered into an SRS Reduction Agreement with CMS. The Participant is accountable for all Clinical Episodes identified on its Participant Profile that are attributed to Downstream Episode Initiators identified on the Participant Profile unless or until CMS allows changes to the Participant Profile in accordance with the terms of this Agreement, regardless of whether any agreement between the Participant and the Downstream Episode Initiator is earlier terminated or not.

(4) Other Elections. The Participant shall include in its Participant Profile the Participant's elections whether to:

(i) engage in Financial Arrangements permitted under Article 8;

(ii) offer beneficiary incentives permitted under Article 10; and

(iii) furnish services to BPCI Advanced Beneficiaries pursuant to one or more of the Payment Policy Waivers described in Article 11 and Appendices E, F, and G of this Agreement.

(b) Initial Participant Profile.

(1) The Parties acknowledge that the Participant submitted to CMS an initial Participant Profile, together with a certification, in the form and manner specified by CMS, stating that 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. The initial Participant Profile becomes effective on the Start Date.

(2) The Participant shall not include a Downstream Episode Initiator on the initial Participant Profile that was not included in the Participant's application for participation in the Model. The Participant may, however, choose not to include a Downstream Episode Initiator that was included in the Participant's application on the initial Participant Profile.

(3) With respect to each Downstream Episode Initiator identified on the initial Participant Profile, CMS will conduct a Program Integrity Screening. CMS may reject any Downstream Episode Initiator listed on the initial Participant Profile on the basis of the results of a Program Integrity Screening, history of program integrity issues, or if CMS determines that the entity does not satisfy the definition of an Episode Initiator.

(c) Updates to the Participant Profile.

(1) No later than 60 Days prior to January 1, 2021, or such other date specified by CMS, the Participant shall submit to CMS, in a form and manner specified by CMS, a updated Participant Profile, together with the a certification, in the form and manner specified by CMS, stating 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.

(2) With respect to each new Downstream Episode Initiator identified on an updated Participant Profile submitted in accordance with Article 5.5(c)(1), CMS will conduct a Program Integrity Screening. CMS may reject any entity listed on the updated Participant Profile on the basis of the results of a Program Integrity Screening, history of program integrity issues, or if CMS determines that the entity does not satisfy the definition of a Downstream Episode Initiator. CMS may also conduct a Program Integrity Screening on the Participant and any Downstream Episode Initiator previously identified on the Participant Profile.

(3) In addition to the updates described in Article 5.5(c)(1) and (2):

(i) CMS will update the Participant Profile to reflect a change reported by the Participant pursuant to Article 3.2(a)(2) or Article 3.2(c)(2) and may remove an entity from the Participant Profile as a result of such notification. Such removal of an Episode Initiator from the Participant Profile by CMS will be effective on the date the entity is so removed.

(ii) The Participant shall notify CMS no later than 30 Days after an entity identified on its Participant Profile has ceased to satisfy the definition of an Episode Initiator.

(iii) 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 a certification, in the form and manner specified by CMS, 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.

(iv) Upon notification from CMS of the termination of any agreement described in Article 7.6(c), the Participant shall submit to CMS an updated Participant Profile reflecting such termination together with a certification, in the form and manner specified by CMS, stating 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.

Article 6
QPP List

6.1 General. CMS will use the Participation List tab of the Quality Payment Program (QPP) List to develop the Participation List as defined in 42 C.F.R. § 414.1305, as may be amended from time to time. CMS will use the Affiliated Practitioner List tab of the QPP List to develop 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.

6.2 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 and 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.

6.3 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.

6.4 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 in 42 C.F.R. § 414.1305, as may be amended from time to time.

CMS may take 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 Article 6.3 and Article 6.4 on the QPP List, for the applicable period. The submission of a blank or incomplete QPP List will not be accepted.

6.5 Initial QPP List. If the Participant is a PGP, ACH, or a Convener Participant with one of more Downstream Episode Initiators that are PGPs or ACHs, then the Participant shall submit to CMS an initial QPP List on or before December 1, 2019, unless CMS specifies a later date in writing. The Participant shall submit a certification, in the form and manner specified by CMS, together with the submission of the initial QPP List that certifies that such 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. The Participant shall update the QPP List in accordance with Article 6.6.

6.6 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 using the template provided by CMS, together with a certification, in the form and manner specified by CMS, that states such 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.

(b) 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.

(c) 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 6.6(c), an individual ceases to be a Participating Practitioner when he or she no longer meets the definition thereof.

(d) 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.

Article 7
Payment

7.1 General.

(a) The Participant will be in a two-sided Risk Arrangement and bear 100 percent financial risk to CMS for up to the 99th percent of national Medicare FFS spending on each item or service included in each Clinical Episode for which the Participant has committed to be held accountable in its Participant Profile. The AFP for each Clinical Episode is Winsorized at the 1st and 99th percentiles of the standardized AFP at the MS-DRG/APC-fiscal year level, during both the baseline year and the Performance Period in accordance with Appendix A of this Agreement.

(b) CMS will continue to pay the standard Medicare FFS payment for items and services furnished to the BPCI Advanced Beneficiary during a Clinical Episode, subject to an initial Reconciliation and at least two subsequent Reconciliation true-ups, as well as the performance of a Post-Episode Spending Calculation, each performed in accordance with this Article 7 and Appendix A of this Agreement.

(c) Depending on the results of the Reconciliation calculations described in Article 7.3 and Appendix A of this Agreement, either CMS will pay the Participant an NPRA, provided that the Participant meets the NPRA eligibility criteria set forth in Article 7.2, or the Participant shall pay CMS a Repayment Amount, each in the amount specified in the Reconciliation Report deemed to be final pursuant to Article 7.3(a)(3), Article 7.3(b)(3), Article 7.3(b)(4), or Article 7.3(c)(3).

(d) Depending on the results of the Post-Episode Spending Calculation described in Article 7.4 and Appendix A, the Participant shall pay CMS an Excess Spending Amount in the amount specified in the Post-Episode Spending Calculation Report deemed to be final in accordance with Article 7.4(a)(3), Article 7.4(b)(3), Article 7.4(b)(4), or Article 7.4(c)(3).

7.2 NPRA Eligibility. The Participant may be eligible to receive an NPRA payment for a Performance Period only if:

(a) The Participant implemented BPCI Advanced Activities in accordance with Article 4 during that Performance Period; and

(b) The sum of all Adjusted Negative Total Reconciliation Amounts and all Adjusted Positive Reconciliation Amounts for the Participant and, if the Participant is a Convener Participant, across all of the Participant's Downstream Episode Initiators, is positive, as determined in accordance with the methodology set forth in Appendix A of this Agreement.

7.3 Reconciliation.

(a) General.

(1) After each Performance Period during the Agreement Performance Period, and at any other times as may be required under this Agreement, CMS will institute a Reconciliation process as described in this Article 7.3 and in Appendix A of this Agreement, resulting in the issuance of a Reconciliation Report to the Participant. See Article 5.2 for additional information regarding the Performance Period in which a given Clinical Episode is included for purposes of Reconciliation.

(2) CMS will make reasonable efforts to issue the initial Reconciliation Report for each Performance Period to the Participant no later than 120 Days after the end of the Performance Period. CMS will conduct at least two true-up Reconciliation processes as described in Appendix A of this Agreement.

(3) The Participant must provide the initial Reconciliation Report and revised Reconciliation Report, for each Performance Period to each of its Downstream Episode Initiators that is a party to an SRS Reduction Agreement with CMS within 10 Days from the date an initial Reconciliation Report or revised Reconciliation Report is issued by CMS. The Participant shall allow its Downstream Episode Initiators the opportunity to communicate suspected errors in the calculation of the Downstream Episode Initiator's apportioned NPRA or Repayment Amount included in the Reconciliation Report.

(4) Unless CMS timely receives a Calculation Error Notice in accordance with Article 7.3(b), an initial Reconciliation Report issued pursuant to Article 7.3(a)(2) and a revised Reconciliation Report issued pursuant to Article 7.3(a)(4) or Article 7.3(b)(5) shall be deemed to be final 30 Days from the date the Reconciliation Report was issued by CMS.

(5) CMS reserves the right, in CMS's sole discretion, to adjust the NPRA or Repayment Amount specified in a Reconciliation Report--either by issuing a revised Reconciliation Report or as part of an initial Reconciliation Report issued for a subsequent Performance Period--as a result of any of the following:

(i) a true-up Reconciliation described in this Article 7 and Appendix A of this Agreement;

(ii) to the extent the Participant is located in an emergency area during an emergency period (as those terms are defined in section 1135(g) of the Act), for which the Secretary of HHS has issued a waiver under section 1135 of the Act, and the Participant also is located in a county, parish, U.S. territory or tribal government designated as a major disaster area under the Stafford Act; or

(iii)for other reasons as may be required under the terms of this Agreement.

(6) Any amounts the Participant is required to pay CMS according to a Reconciliation Report (including a revised Reconciliation Report), once deemed to be final, shall be paid in accordance with Article 7.3(d). Instructions will accompany the

Reconciliation Report regarding CMS' payment of NPRA to the Participant, or the Participant's payment of the Repayment Amount to CMS, as applicable.

(7) CMS will conduct an initial Reconciliation and at least two true-up Reconciliations for the final Performance Period of the Agreement Performance Period, which will include all Clinical Episodes that end prior to the effective date of the expiration of the Agreement Performance Period, in accordance with this Article 7 and Appendix A of this Agreement.

(8) For any Performance Period, CMS reserves the right, in CMS's sole discretion, to conduct more than two true-up Reconciliations, and will inform the Participant in writing prior to conducting any such true-up Reconciliations.

(b) Calculation Error Notice.

(1) The Participant shall have 29 Days from the date an initial Reconciliation Report or a revised Reconciliation Report is issued by CMS to provide CMS with a written notice of a suspected error in the calculation of the NPRA or the Repayment Amount ("**Calculation Error Notice**"). The Participant may use the Calculation Error Notice process only to inform CMS of suspected errors in the calculation of the NPRA or the Repayment Amount in a Reconciliation Report that has not yet been deemed to be final. This process may not be used to contest any other aspects of the Model.

(2) If CMS timely receives a Calculation Error Notice, CMS will respond in writing within 30 Days of receipt of the Calculation Error Notice to either confirm or refute the suspected calculation error ("**CMS Calculation Error Response**"), although CMS may provide notice to the Participant of an extension of this review period at CMS's sole discretion.

(3) If CMS issues a CMS Calculation Error Response refuting the suspected calculation error on the grounds that calculations in the Reconciliation Report are correct and the Participant does not timely file a reconsideration review request pursuant to Article 7.3(c), the Reconciliation Report is deemed to be final on the date such CMS Calculation Error Response is issued.

(4) If CMS issues a CMS Calculation Error Response confirming the suspected calculation error and issues a revised Reconciliation Report correcting that error, the revised Reconciliation Report is deemed to be final on the date this revised Reconciliation Report is issued.

(c) Reconsideration Review Process.

(1) Unless CMS has issued a revised Reconciliation Report pursuant to Article 7.3(b)(4), the Participant may request a reconsideration review of the CMS Calculation Error Response issued pursuant to Article 7.3(b)(2) by a designee of CMS who is authorized to receive such requests and did not participate in the determination that is the subject of the reconsideration request ("**Reconsideration**

Official"). The reconsideration review request must be submitted within 10 Days from the issue date of the CMS Calculation Error Response, in a form and manner and to an individual or office specified by CMS. The reconsideration review request must provide a detailed explanation of the basis for the dispute and include supporting documentation for the Participant's assertion that CMS or its representatives did not accurately calculate the NPRA or Repayment Amount in accordance with this Agreement.

(2) Within 15 Days of receiving the Participant's reconsideration review request, the Reconsideration Official will acknowledge the request and notify the Parties of the issues in dispute, the review procedures, and the procedures (including the format and deadlines) for submission of documentation (the "**Scheduling Notice**").

(3) The Reconsideration Official will make reasonable efforts to review the reconsideration review request and documentation submitted in accordance with the Scheduling Notice no later than 30 Days after such documents are received and will make reasonable efforts to issue a written determination within 30 Days of this review. This determination will be deemed to be final on the date the determination is issued by the Reconsideration Official.

(4) The Participant shall proceed diligently with performance of this Agreement, pending final resolution of any dispute arising under the Agreement unless and until this Agreement expires or is terminated pursuant to Article 21. Neither the Calculation Error Notice process under Article 7.3(b), nor the reconsideration review process under this Article 7.3(c), shall be construed to negate, diminish, or otherwise alter the applicability of existing laws, rules, or determinations made by other Federal Government agencies.

(d) Payment of Amount Owed.

(1) CMS Payment of NPRA.

(i) In accordance with section 1115A(d)(1) of the Act, CMS finds that it is necessary for purposes of testing BPCI Advanced to waive the requirements for beneficiary cost-sharing under section 1833(a)(1)(N) and section 1833(b) of the Act to the extent otherwise applicable for purposes of the NPRA payments and Repayment Amounts.

(ii) If a Reconciliation Report deemed to be final pursuant to Article 7.3(a)(3), Article 7.3(b)(3), Article 7.3(b)(4), or Article 7.3(c)(4) indicates that the Participant has earned a NPRA payment, CMS will issue a payment to the Participant in the amount specified in such final Reconciliation Report. The Participant shall not collect any beneficiary cost sharing with respect to any NPRA payments received from CMS.

(iii) CMS will make reasonable efforts to issue such payment within 30 Days of the date on which the Reconciliation Report is deemed to be final.

(2) Participant Payment of Repayment Amount.

(i) If a Reconciliation Report deemed to be final pursuant to Article 7.3(a)(3), Article 7.3(b)(3), Article 7.3(b)(4), or Article 7.3(c)(3) indicates that the Participant owes CMS a Repayment Amount, the Participant shall make a payment in the full amount of such Repayment Amount to CMS within 30 Days of the date on which the Reconciliation Report is deemed to be final. The Participant shall not seek contributions from beneficiaries with respect to any Repayment Amounts paid by the Participant to CMS.

(ii) Within 30 Days of the date on which the Reconciliation Report or revised Reconciliation Report is deemed to be final, CMS will issue a demand letter requiring payment to be made immediately.

(iii) 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 from the Participant's present and future Medicare payments, from the Participant's Downstream Episode Initiator(s) pursuant to Article 7.6(c)(2), or invoke CMS's rights under the Secondary Repayment Source provided pursuant to Article 7.7, to collect all monies due to CMS.

(iv) The Participant shall be solely liable for the payment of the Repayment Amount to CMS. Where CMS seeks payment through recoupment pursuant to Article 7.6 or the Secondary Repayment Source pursuant to Article 7.7, 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).

(v) Nothing in this Agreement or its Appendices shall be construed to limit the Participant's liability to pay any Repayment Amount or Excess Spending Amount in excess of the Secondary Repayment Source.

7.4 Post-Episode Spending Calculation.

(a) General.

(1) After each Performance Period during the Agreement Performance Period, CMS will conduct a Post-Episode Spending Calculation during the first true-up and issue a Post-Episode Spending Calculation Report to the Participant, which will specify the Excess Spending Amount, if any, as described in this Article 7.4 and in Appendix A of this Agreement.

(2) CMS will make reasonable efforts to issue the Post-Episode Spending Calculation Report for a Performance Period along with the revised Reconciliation Report issued during the first true-up Reconciliation described in Article 7.3(a)(4) for that Performance Period.

(3) Unless CMS timely receives a Post Episode Spending Calculation Error Notice in accordance with Article 7.4(b), the Post-Episode Spending Calculation Report

will be deemed to be final 30 Days from the date the Post-Episode Spending Calculation report was issued by CMS.

(4) Any amounts determined to be owed in a Post-Episode Spending Calculation Report, once deemed to be final, shall be paid in accordance with Article 7.4(d). Instructions will accompany the Post-Episode Spending Calculation Report regarding the Participant's payment of the Excess Spending Amount to CMS.

(5) CMS will conduct the Post-Episode Spending Calculation for the final Performance Period during the Agreement Performance Period in accordance with this Article 7.4 and Appendix A of this Agreement.

(b) Calculation Error Notice.

(1) The Participant shall have 29 Days from the date the Post-Episode Spending Calculation Report is issued by CMS to provide a written notice to CMS of a suspected error in the calculation of the Excess Spending Amount ("**Post-Episode Spending Calculation Error Notice**"). The Participant may use the Post-Episode Spending Calculation Error Notice process only to inform CMS of suspected errors in the calculation of the Excess Spending Amount in a Post Episode Spending Calculation Report not yet deemed to be final. This process may not be used to contest other aspects of the Model.

(2) If CMS timely receives a Post-Episode Spending Calculation Error Notice, CMS will respond in writing within 30 Days of receipt of the Post-Episode Spending Calculation Error Notice to either confirm or refute the suspected calculation error ("**CMS Post-Episode Spending Calculation Error Response**"), although CMS may provide notice to the Participant of an extension of this review period at CMS's sole discretion.

(3) If CMS issues a CMS Post-Episode Spending Calculation Error Response refuting the suspected calculation error on the grounds that the calculations in the Post-Episode Spending Calculation report are correct and the Participant does not file a reconsideration review request pursuant to Article 7.4(c), the Post-Episode Spending Calculation report is deemed to be final on the date such CMS Post-Episode Spending Calculation Error Response is issued.

(4) If CMS issues a CMS Post-Episode Spending Calculation Error Response confirming the calculation error and issues a revised Post-Episode Spending Calculation report correcting that error, then the revised Post-Episode Spending Calculation report is deemed to be final on the date such revised Post-Episode Spending Calculation report is issued.

(c) Reconsideration Review Process.

(1) Unless CMS has issued a revised Post-Episode Spending Calculation Report correcting the error pursuant to Article 7.4(b)(4), the Participant may request a reconsideration review of the CMS Post-Episode Spending Calculation Error Response provided pursuant to Article 7.4(b)(2) by a designee of CMS who is authorized to receive such requests and did not participate in the determination

that is the subject of the reconsideration request ("**Reconsideration Official**"). The reconsideration review request must be submitted within 10 Days from the issue date of the CMS Post-Episode Spending Calculation Error Response, in a form and manner and to an individual or office specified by CMS. The reconsideration review request must provide a detailed explanation of the basis for the dispute and include supporting documentation for the Participant's assertion that CMS or its representatives did not accurately calculate the Excess Spending Amount in accordance with this Agreement.

(2) Within 15 Days of receiving the Participant's reconsideration review request pursuant to Article 7.4(c)(1), the Reconsideration Official will acknowledge the request and notify the Parties of the issues in dispute, the review procedures, and the procedures (including the format and deadlines) for submission of documentation (the "**Scheduling Notice**").

(3) The Reconsideration Official will make reasonable efforts to review the reconsideration review request and documentation submitted in accordance with the procedures specified in the Scheduling Notice no later than 30 Days after such documents are received, and will make reasonable efforts to issue a written determination within 30 Days of this review. This determination will be deemed to be final on the date the determination is issued by the Reconsideration Official.

(4) The Participant shall proceed diligently with performance of this Agreement, pending final resolution of any dispute arising under the Agreement unless and until this Agreement expires or is terminated pursuant to Article 21. Neither the Calculation Error Notice process under Article 7.4(b) nor the reconsideration review process under this Article 7.4(c) shall not be construed to negate, diminish, or otherwise alter the applicability of existing laws, rules, and regulations or determinations made by other Federal Government agencies.

(d) Payment of Excess Spending Amount.

(1) If a Post-Episode Spending Calculation Report deemed to be final pursuant to Article 7.4(a)(3), Article 7.4(b)(3), Article 7.4(b)(4), or Article 7.4(c)(3) indicates that the Participant owes CMS an Excess Spending Amount, the Participant shall make payment in that full amount of such Excess Spending Amount to CMS within 30 Days of the date on which the Post-Episode Spending Calculation Report is deemed to be final.

(2) Within 30 Days of the date on which the Post-Episode Spending Calculation Report or revised Post-Episode Spending Calculation Report is deemed to be final, CMS will issue a demand letter requiring payment to be made immediately.

(3) If the Participant fails to pay CMS the amount owed by the date indicated in the demand letter, CMS will either recoup owed monies from the Participant's present and future Medicare payments, from the Participant's Downstream Episode Initiator(s) pursuant to Article 7.6(b)(2), or invoke CMS's rights under the Secondary Repayment Source provided pursuant to Article 7.7, to collect all monies due to CMS.

(4) The Participant shall be solely liable for the payment of the Excess Spending Amount to CMS. Where CMS seeks payment through recoupment pursuant to Article 7.6 or the Secondary Repayment Source pursuant to Article 7.7 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).

(5) Nothing in this Agreement or its Appendices shall be construed to limit the Participant's liability to pay any Excess Spending Amount or other monies owed in excess of the Secondary Repayment Source.

7.5 Delinquent Debt. If the Participant fails to pay the amount due CMS in full by the date indicated in the demand letter described in Article 7.3(d)(2)(ii) or 7.4(d)(2), then CMS shall assess simple interest on the unpaid balance at the rate applicable to other Medicare debts under 42 C.F.R. § 405.378 and 45 C.F.R. § 30.18. Interest shall be calculated in 30-Day periods and shall be assessed for each 30 Day period that payment is not made in full.

7.6 Recoupment.

(a) Definitions.

(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 is not listed as an Episode Initiator with at least one selected Clinical Episode on its Participant Profile and 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 an 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 Article 7.6(b)(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, plus any apportioned interest accrued on the monies owed.

(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 an SRS Reduction Agreement with CMS.

(2) SRS Reduction Agreements 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 shall ensure that each and every Downstream Episode Initiator that participates in BPCI Advanced pursuant to an agreement with the Participant is a party to an SRS Reduction Agreement with CMS.

(4) The Participant shall share any initial Reconciliation Reports or revised Reconciliation Reports pursuant to Articles 7.3 and 7.4, respectively, with each Downstream Episode Initiator that is a party to an SRS Reduction Agreement with CMS within 10 Days from the date any initial Reconciliation Report or revised Reconciliation Report is issued by CMS for purposes of this Article 7.6.

7.7 Secondary Repayment Source.

(a) A Convener Participant must obtain a SRS if it is not listed as an Episode Initiator with at least one Clinical Episode selected on its Participant Profile and it has at least one Downstream Episode Initiator that is not a party to an SRS Reduction Agreement. The Participant shall maintain the SRS in accordance with the requirements of this Article 7.7 and Appendix B.

(1) The amount guaranteed by the Participant's SRS 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.

(2) The SRS 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 ongoing at the end of the Agreement Performance Period 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.

(3) The Participant shall scan and submit to CMS by email, and for a Letter of Credit, mail the original to the address provided in Article 23.1, prior to the date specified by CMS (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, CMS may terminate the Agreement pursuant to Article 21.

Article 8
Financial Arrangements

8.1 General.

(a) As described in Article 5, the Participant may elect to enter into Financial Arrangements permitted under this Article 8 during a Model Year, or such other period specified by CMS, by specifying in its Participant Profile whether, for that Model Year or other period, the Participant elects to engage in such Financial Arrangements.

(b) The Participant shall not make an NPRA Shared Payment, receive a Shared Repayment Amount, or contribute or receive Internal Cost Savings, as applicable, unless such payments are made pursuant to a Financial Arrangement that satisfies the requirements set forth in this Article 8.

(c) If the Participant will permit NPRA Sharing Partners to enter into Partner Distribution Arrangements with NPRA Sharing Group Practice Practitioners, the Participant shall ensure that such NPRA Sharing Partners do not make a Partner Distribution Payment to, or apportion any portion of a Shared Repayment Amount to, an NPRA Sharing

Group Practice Practitioner, as applicable, unless such payments are made pursuant to a Partner Distribution Arrangement that satisfies the requirements set forth in this Article 8.

(d) The Participant shall maintain contemporaneous documentation regarding its Financial Arrangements, including the relevant written agreements, a record of the date and amount of all NPRA Shared Payments, Shared Repayment Amounts, Partner Distribution Payments, and contributions of Internal Cost Savings, a record of the identity of each NPRA Sharing Partner who received a NPRA Shared Payment, made a Shared Repayment Amount, or made a contribution of Internal Cost Savings, a record of the identity of each NPRA Sharing Group Practice Practitioner who received a Partner Distribution Payment or paid any portion of a Shared Repayment Amount, and a description of the methodology and accounting.

(e) CMS may require the Participant to report information on the use of Financial Arrangements to CMS. Such information shall be reported by a date and in a form and in a manner specified by CMS.

(f) If the Participant intends to contract with a BPCI Advanced Entity to administer the Participant's Financial Arrangements:

(1) The Participant shall have an agreement in place with that BPCI Advanced Entity prior to the administration of the Participant's Financial Arrangements, which requires the BPCI Advanced Entity to provide Administrative Services in compliance with the applicable terms and conditions of this Agreement ("**BPCI Advanced Entity Agreement**") and to retain funds distributed from the BPCI Advanced Savings Pool solely for Administrative Services actually performed by the BPCI Advanced Entity; and

(2) The Participant shall ensure that the BPCI Advanced Entity meets the following eligibility criteria:

(i) the BPCI Advanced Entity is identified as a BPCI Advanced Entity on the relevant CMS-approved Financial Arrangement List;

(ii) the BPCI Advanced Entity is legally authorized to distribute NPRA Shared Payments to, and receive Shared Repayment Amounts from, each NPRA Sharing Partner; and

(iii)the BPCI Advanced Entity is not a Medicare-enrolled provider or supplier.

8.2 Financial Arrangement Requirements. The Participant shall ensure that each of the Financial Arrangements identified in its Participant Profile complies with all of the applicable requirements of this Article 8.2.

(a) General.

(1) The Financial Arrangement must comply with all applicable laws and regulations.

(2) An individual's or entity's participation in the Financial Arrangement and SRS Reduction Agreement must be voluntary and without penalty for nonparticipation.

(3) The Financial Arrangement must not restrict the ability of a NPRA Sharing Partner or NPRA Sharing Group Practice Practitioner, as applicable, to make decisions in the best interests of its patients, including the selection of drugs, devices, supplies, and treatments.

(4) All NPRA Shared Payments, Partner Distribution Payments, Shared Repayment Amounts, and Internal Cost Savings contributions must be administered, received, and apportioned by the Participant, a BPCI Advanced Entity on behalf of the Participant, or an NPRA Sharing Partner, as applicable, in accordance with generally accepted accounting principles.

(5) All NPRA Shared Payments, Partner Distribution Payments, Shared Repayment Amounts, and all payments of apportioned Shared Repayment Amounts and of Internal Cost Savings payments must be made by check, electronic funds transfer, or another traceable transaction.

(b) Internal Cost Savings.

(1) Eligibility Requirements. The Participant shall not permit an NPRA Sharing Partner to contribute, and if the Participant is a Non-Convener Participants, shall not itself contribute, Internal Cost Savings to the BPCI Advanced Savings Pool for a Performance Period, unless the following requirements are satisfied:

(i) The achieved actual Internal Cost Savings are realized from Care Redesign undertaken by the NPRA Sharing Partner or the Non-Convener Participant, as applicable, in connection with furnishing items and services to BPCI Advanced Beneficiaries within the Clinical Episodes for which the Participant has committed to be held accountable in its Participant Profile;

(ii) In the case of Internal Cost Savings contributions made by a Participant, the Participant is a Non-Convener Participant and the Internal Cost Savings are realized from Care Redesign undertaken in Model Year 3 or a subsequent Model Year;

(iii) In the case of Internal Cost Savings contributions made by an NPRA Sharing Partner, the NPRA Sharing Partner –

a. is identified on the Financial Arrangement List during the applicable Performance Period;

b. engaged in BPCI Advanced Activities during the applicable Performance Period; and

c. has entered into an NPRA Sharing Arrangement with the Participant that satisfies the requirements set forth in Article 8.3.

The Participant shall not permit any NPRA Sharing Partner to contribute, and if the Participant is a Non-Convener Participant, shall not itself contribute, Internal Cost Savings if CMS has notified the Participant or the NPRA Sharing Partner, as applicable, that the Participant or NPRA Sharing Partner is subject to any action for noncompliance with the fraud and abuse laws, for the provision of substandard care to BPCI Advanced Beneficiaries, or for other program integrity issues.

(2) Internal Cost Savings Requirements.

(i) All Internal Cost Savings contributions, if any, must:

(A) be made in compliance with all provisions of this Article 8.2 and all other applicable provisions of this Agreement and all applicable laws and regulations;

(B) be made solely and directly to the BPCI Advanced Savings Pool;

(C) be clearly identified as described in Article 8.1(d) and derived solely from actual Internal Cost Savings realized from Care Redesign undertaken by the NPRA Sharing Partner (or by either the NPRA Sharing Partner or the Non-Convener Participant, in the case of Internal Cost Savings contributions made by a Participant) in connection with furnishing services to BPCI Advanced Beneficiaries within the Clinical Episodes for which the Participant has committed to be held accountable in its Participant Profile; and

(D) be determined in accordance with a methodology that complies with applicable law and is substantially based on criteria related to quality of care and the provision of BPCI Activities.

(ii) The Participant shall treat all NPRA Sharing Partners the same regarding the contribution of Internal Cost Savings, meaning that the NPRA Sharing Arrangement terms described in Articles 8.3(b)(4) and 8.3(b)(5) include a uniform methodology for calculating contributions of Internal Cost Savings across all of the Participant's NPRA Sharing Partners, which may differ by healthcare provider type.

(c) NPRA Shared Payments and Partner Distribution Payments.

(1) Eligibility Requirements. For an NPRA Shared Payment to be made by the Participant, and for a Partner Distribution Payment to be made by an NPRA Sharing Partner, the recipient NPRA Sharing Partner or NPRA Sharing Group Practice Practitioner, as applicable, must:

(i) be identified on the Financial Arrangement List during the applicable Performance Period;

(ii) be engaged in BPCI Advanced Activities during the applicable Performance Period;

(iii) have entered into an NPRA Sharing Arrangement with the Participant that satisfies the requirements set forth in Article 8.3 or a Partner Distribution Arrangement with the NPRA Sharing Partner that satisfies the requirements set forth in Article 8.4, as applicable; and

(iv) have achieved the quality performance targets necessary to receive NPRA Shared Payments, as specified in the NPRA Sharing Arrangement or Partner Distribution Arrangement, as applicable.

The Participant shall not make an NPRA Shared Payment to any NPRA Sharing Partner, and shall not permit an NPRA Sharing Partner to make a Partner Distribution Payment to an NPRA Sharing Group Practice Practitioner, if CMS has notified the Participant or the NPRA Sharing Partner, as applicable, that such NPRA Sharing Partner or such NPRA Sharing Group Practice Practitioner is subject to any action for noncompliance with the fraud and abuse laws, for the provision of substandard care to BPCI Advanced Beneficiaries, or for other program integrity issues.

(2) NPRA Shared Payment and Partner Distribution Payment Requirements.

(i) All NPRA Shared Payments and Partner Distribution Payments, if any, must:

(A) be made in compliance with all provisions of this Article 8.2 and all other applicable provisions of this Agreement and all applicable laws and regulations;

(B) be clearly identified as described in Article 8.1(d) and derived solely, either directly (in the case of NPRA Shared Payments) or indirectly (in the case of Partner Distribution Payments) from the BPCI Advanced Savings Pool;

(C) be determined in accordance with a methodology that complies with applicable law and is substantially based on criteria related to quality of care and the provision of BPCI Advanced Activities (which may

take into account the amount of BPCI Advanced Activities performed by a NPRA Sharing Partner or NPRA Sharing Group Practice Practitioner, as applicable, relative to other NPRA Sharing Partners or NPRA Sharing Group Practice Practitioners); and

(D) not be a loan or advance payment of an expected or potential NPRA Shared Payment or Partner Distribution Payment.

(ii) In a given calendar year, the aggregate amount of all Partner Distribution Payments distributed by each NPRA Sharing Partner must not exceed the amount of NPRA Shared Payments received by that NPRA Sharing Partner from the Participant;

(d) Shared Repayment Amounts.

(1) Eligibility Requirements. No Shared Repayment Amount may be received by the Participant, and no Shared Repayment Amount may be apportioned by an NPRA Sharing Partner among its NPRA Sharing Group Practice Practitioners, unless the Participant owes CMS a Repayment Amount, as set forth in a Reconciliation Report that is deemed final in accordance with Article 7.3(a)(4), Article 7.3(b)(3), Article 7.3(b)(4), or Article 7.3(c)(3), and unless such NPRA Sharing Partner or NPRA Sharing Group Practice Practitioner:

(i) is identified on the Financial Arrangement List during the applicable Performance Period;

(ii) engaged in BPCI Advanced Activities during the applicable Performance Period; and

(iii) has entered into an NPRA Sharing Arrangement with the Participant that satisfies the requirements set forth in Article 8.3 or a Partner Distribution Arrangement with the NPRA Sharing Partner that satisfies the requirements set forth in Article 8.4, as applicable.

(2) Shared Repayment Amount Requirements. All Shared Repayment Amounts and any apportionment thereof, if any, must –

(i) be made in compliance with all provisions of this Article 8.2 and all other applicable provisions of this Agreement and all applicable laws and regulations;

(ii) be clearly identified as described in Article 8.1(d) and made solely, directly (in the case of Shared Repayment Amounts) or indirectly (in the case of Shared Repayment Amounts apportioned among NPRA Sharing Group Practice Practitioners) to the BPCI Advanced Savings Pool;

(iii) be paid at an interval that is agreed upon by the Participant and the NPRA Sharing Partner or the NPRA Sharing Partner and the NPRA Sharing Group Practice Practitioner, as applicable;

(iv) be made solely for the purpose of repaying a portion of the Repayment Amount owed by the Participant to CMS or repaying a portion of the Shared Repayment Amount owed by the NPRA Sharing Partner to the Participant, as applicable;

(v) not be a loan; and

(vi) not be made prior to the date on which the Reconciliation Report that contains the Repayment Amount described in Article 8.2(d)(2)(iv) is deemed to be final in accordance with Article 7.3(a)(3), Article 7.3(b)(3), Article 7.3(b)(4), or Article 7.3(c)(3).

8.3 NPRA Sharing Arrangements. The Participant shall ensure that all NPRA Sharing Arrangements satisfy the following requirements:

(a) The NPRA Sharing Arrangement is in writing and executed by the Participant and the NPRA Sharing Partner contemporaneously with the establishment of the arrangement and executed before care is furnished to BPCI Advanced Beneficiaries under the arrangement.

(b) The writing memorializing the NPRA Sharing Arrangement must specify the following:

(1) the parties to the NPRA Sharing Arrangement;

(2) the term of the NPRA Sharing Arrangement, which shall be for at least one year, but early termination may be permitted if CMS requires or allows the Participant to remove the NPRA Sharing Partner from the Financial Arrangement List pursuant to Article 20.2(e);

(3) whether the NPRA Sharing Arrangement involves Shared Repayment Amounts, NPRA Shared Payments, or both;

(4) whether the NPRA Sharing Partner and, if applicable, the Non-Convener Participant, must contribute a set percentage of its Internal Cost Savings to the BPCI Advanced Savings Pool, in which case the percentage of Internal Cost Savings to be contributed must be specified in the NPRA Sharing Arrangements and the set percentage to be contributed by an NPRA Sharing Partner must be consistent across all NPRA Sharing Partners, or whether the NPRA Sharing Partner and, if applicable, the Non-Convener Participant, is prohibited from contributing Internal Cost Savings achieved by the NPRA Sharing Partner to the BPCI Advanced Savings Pool; and

(5) the financial or economic terms of the Financial Arrangement, including: the frequency of payment; the methodology and accounting formula for determining the amount of any NPRA Shared Payment or Shared Repayment Amount, as applicable; the specific methodology for accruing and calculating Internal Cost Savings that is transparent, measurable, and verifiable; and the quality performance targets that must be achieved in order for the NPRA Sharing Partner to receive a NPRA Shared Payment pursuant to Article 8.2(c)(1)(iv).

(c) The NPRA Sharing Arrangement requires that:

(1) the NPRA Sharing Partner and its employees, contractors, and agents, if any, must comply with the applicable terms and conditions of this Agreement and all other applicable laws and regulations. The Participant shall provide a copy of this Agreement to each NPRA Sharing Partner;

(2) the NPRA Sharing Partner must furnish care pursuant to the CMS-accepted Care Redesign Plan described in Article 4.2;

(3) any NPRA Sharing Partner that is a Medicare-enrolled provider or supplier must be and remain in compliance with all Medicare enrollment requirements at 42 C.F.R. § 424.500, et seq., including having a valid and active TIN, CCN, NPI, or other identifier, and reporting all changes to the NPRA Sharing Partner's Medicare enrollment information to CMS consistent with 42 C.F.R. § 424.516;

(4) any NPRA Sharing Partner that is a Medicare-enrolled provider or supplier must be and remain in compliance with any applicable certification and participation requirements of the Act; and

(5) the NPRA Sharing Partner must repay the Participant, or the BPCI Advanced Entity on the Participant's behalf, if the NPRA or NPRA Shared Payment was based on the submission of false or fraudulent data by the NPRA Sharing Partner to the Participant.

(d) In the case of a PGP NPRA Sharing Partner, the NPRA Sharing Arrangement must also require that:

(1) no Partner Distribution Payment is made to, and no apportionment of a Shared Repayment Amount is made among, NPRA Sharing Group Practice Practitioners, as applicable, unless such payments are made:

(i) to or from an NPRA Sharing Group Practice Practitioner that satisfies the eligibility criteria described in Article 8.2(c)(1) (for Partner Distribution Payments) or Article 8.2(d)(1) (for the apportionment of Shared Repayment Amounts), as applicable; and

(ii) in accordance with a Partner Distribution Arrangement that satisfies the requirements set forth in Article 8.4.

(2) The NPRA Sharing Partner maintains current and historical lists of NPRA Sharing Group Practice Practitioners, if any, that have entered into a Partner Distribution Arrangement with the NPRA Sharing Partner; and

(3) The NPRA Sharing Partner maintains contemporaneous documentation regarding Partner Distribution Arrangements, including copies of the relevant written agreements, a record of the date and amount of any Partner Distribution Payment or apportionment of Shared Repayment Amounts, a record of the identity of each NPRA Sharing Group Practice Practitioner who received a Partner Distribution Payment or paid a portion of a Shared Repayment Amount, and a description of the applicable methodology and accounting.

8.4 Partner Distribution Arrangement Requirements. The Participant shall ensure that all Partner Distribution Arrangements satisfy the following criteria:

(a) The Partner Distribution Arrangement is in writing and executed by the NPRA Sharing Partner and NPRA Sharing Group Practice Practitioner contemporaneously with the establishment of the Financial Arrangement and executed before care is furnished to BPCI Advanced Beneficiaries under the terms of the Financial Arrangement.

(b) The writing memorializing the Partner Distribution Arrangement must specify the following:

(1) The parties to the Partner Distribution Arrangement;

(2) The term of the Partner Distribution Arrangement, which shall be for at least one year, but early termination may be permitted if CMS requires the Participant to remove the NPRA Sharing Partner or NPRA Sharing Group Practice Practitioner from the Financial Arrangement List pursuant to Article 20.2(e);

(3) Whether the Partner Distribution Arrangement involves Partner Distribution Payments, apportionment of Shared Repayment Amounts, or both; and

(4) The financial or economic terms of the Financial Arrangement, including the frequency of payment, the methodology and accounting formula for determining the amount of any Partner Distribution Payment, and the quality performance targets that must be achieved in order for the NPRA Sharing Group Practice Practitioner to receive a Partner Distribution Payment pursuant to Article 8.2(c)(1)(iv).

(c) The Partner Distribution Arrangement requires that:

(1) The NPRA Sharing Group Practice Practitioner and its employees, contractors, and agents, if any, must comply with the applicable terms and conditions of this Agreement and all other applicable laws and regulations. The NPRA Sharing Partner must provide a copy of this Agreement to each NPRA Sharing Group Practice Practitioner;

(2) The NPRA Sharing Group Practice Practitioner must furnish care in accordance with the CMS-accepted Care Redesign Plan described in Article 4.2;

(3) The NPRA Sharing Group Practice Practitioner must be and remain in compliance with all Medicare enrollment requirements at 42 C.F.R. § 424.500, et seq., including having a valid and active TIN, NPI, or other identifier, and reporting all changes to the NPRA Sharing Group Practice Practitioner's Medicare enrollment information to CMS consistent with 42 C.F.R. § 424.516;

(4) The NPRA Sharing Group Practice Practitioner must be and remain in compliance with any applicable certification and participation requirements of the Act; and

(5) The NPRA Sharing Group Practice Practitioner must repay the NPRA Sharing Partner if the Partner Distribution Payment was based on the submission of false or fraudulent data by the NPRA Sharing Group Practice Practitioner to the NPRA Sharing Partner or the Participant.

8.5 Financial Arrangement List.

(a) General.

(1) If the Participant elects to enter into Financial Arrangements for a Model Year or other period as specified by CMS, the Participant shall maintain a Financial Arrangement List in accordance with this Article 8.5 using the template Financial Arrangement List provided to the Participant by CMS.

(2) CMS shall maintain the Participant's current Financial Arrangement List in a manner that permits the Participant to review the list on demand via the Participant web portal. CMS will provide additional information regarding the Participant web portal to the Participant in a separate communication.

(3) The Participant shall maintain copies of historical Financial Arrangement Lists in accordance with Article 19.3.

(4) The presence of an NPRA Sharing Partner, NPRA Sharing Group Practice Practitioner, or BPCI Advanced Entity on a current or historical Financial Arrangement List does not imply or constitute a determination that the NPRA Sharing Partner, NPRA Sharing Group Practice Practitioner, or BPCI Advanced Entity has no program integrity issues. Such presence also does not

preclude CMS or any other Federal Government authority from enforcing any and all applicable laws, rules, and regulations or from initiating or continuing any audit or investigation of the Participant, a BPCI Advanced Entity, NPRA Sharing Partner, or NPRA Sharing Group Practice Practitioner.

(b) Initial Financial Arrangement List.

(1) The Parties acknowledge that the Participant submitted to CMS prior to the Effective Date a proposed initial Financial Arrangement List, identifying by name, address, TIN, CCN, NPI and other identifier specified by CMS, each individual and entity that the Participant expected to participate in BPCI Advanced as an NPRA Sharing Partner, NPRA Sharing Group Practice Practitioner, or BPCI Advanced Entity during the Participant's initial Model Year and until the Financial Arrangement List is updated in accordance with Article 8.5(c) ("**Proposed Initial Financial Arrangement List**"), together with the certification, in the form and manner specified by CMS, that such list is a true, accurate, and complete list signed by an executive of the Participant authorized to sign such certification on behalf of the Participant.

(2) CMS will conduct a Program Integrity Screening of this proposed Initial Financial Arrangement List. CMS may remove any proposed NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, or BPCI Advanced Entities from the Proposed Initial Financial Arrangement List:

(i) On the basis of the results of a Program Integrity Screening or information otherwise obtained regarding an individual's or entity's past or present program integrity issues, which may also result in CMS subjecting the Participant to additional monitoring; or

(ii) If CMS determines that such individual or entity is unlikely to be able to engage in BPCI Advanced Activities or has demonstrated evidence of substandard patient care.

(3) CMS will submit to the Participant in writing a list of individuals and entities that CMS has approved to be NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities (the "**Tentative Initial Financial Arrangement List**").

(4) The Participant shall review the Tentative Initial Financial Arrangement List and remove from it any NPRA Sharing Partner with which the Participant does not have a fully executed NPRA Sharing Arrangement, any NPRA Sharing Group Practice Practitioner that does not have a fully executed Partner Distribution Arrangement, and any BPCI Advanced Entity that does not have a fully executed BPCI Advanced Entity

Agreement. The Participant shall not add any individuals or entities to the Tentative Initial Financial Arrangement List at this time.

(5) By a date specified by CMS, the Participant shall submit to CMS the Financial Arrangement List that the Participant has certified is a true, accurate and complete list, identifying all of the Participant's NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities who are approved by CMS to participate in BPCI Advanced and that have a fully executed NPRA Sharing Arrangement, Partner Distribution Arrangement, or BPCI Advanced Entity Agreement, as applicable, that satisfies the requirements of this Agreement (the "**Initial Financial Arrangement List**"). Such Initial Financial Arrangement List will reflect the current list of NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities effective as of the Start Date.

(6) CMS will update the Initial Financial Arrangement List to reflect a change reported by the Participant pursuant to Article 3.2(a)(2) or Article 3.2(c) and reserves the right, in its sole discretion, to remove NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, or BPCI Advanced Entities from the Initial Financial Arrangement List as a result of such notification or pursuant to Article 20.2(e) at any time.

(c) Updates to the Financial Arrangement List.

(1) The Participant shall update its Initial Financial Arrangement List and any subsequent Updated Financial Arrangement Lists in accordance with this Article 8.5(c), subject to CMS review and approval.

(2) On at least a semi-annual basis, but no more than every calendar quarter, at a time and in a manner specified by CMS, the Participant shall submit to CMS, a proposed updated Financial Arrangement List identifying each individual or entity by name, address, NPI, CCN, TIN, and other identifier specified by CMS that the Participant expects will participate in BPCI Advanced as an NPRA Sharing Partner, NPRA Sharing Group Practice Practitioner, or BPCI Advanced Entity during such calendar quarter or such other period ("**Proposed Updated Financial Arrangement List**"), together with a certification, in the form and manner specified by CMS, stating that such list is a true, accurate, and complete list, signed by an executive of the Participant who is authorized to sign such certification on behalf of the Participant.

(i) In submitting a Proposed Updated Financial Arrangement List, the Participant shall specifically identify, in a form and manner specified by CMS, any NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities that have not previously been listed on the Participant's Financial Arrangement List ("**New**

Entities"), as well as any NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities currently on the Financial Arrangement List for whom the information on the Financial Arrangement List has changed. The Participant shall also separately provide a list of any NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities that are being removed from the Financial Arrangement List in accordance with Article 8.5(c)(3).

(ii) With respect to each New Entity identified on the Proposed Updated Financial Arrangement List, CMS will conduct a Program Integrity Screening. CMS may also conduct a Program Integrity Screening on the Participant and any NPRA Sharing Partner, NPRA Sharing Group Practice Practitioner, and BPCI Advanced Entity previously identified on the Financial Arrangement List.

(iii) After completion of the Program Integrity Screenings described in Article 8.5(c)(2)(ii), CMS will submit to the Participant a list of all individuals and entities that CMS has accepted to be NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities effective at the start of the next calendar quarter or such other date specified by CMS ("**Tentative Updated Financial Arrangement List**").

(iv) The Participant shall review the Tentative Updated Financial Arrangement List and remove from it any NPRA Sharing Partner with which the Participant does not have a fully executed NPRA Sharing Arrangement, any NPRA Sharing Group Practice Practitioner that does not have a fully executed Partner Distribution Arrangement, and any BPCI Advanced Entity that does not have a fully executed BPCI Advanced Entity Agreement. The Participant shall not add any individuals or entities to the Tentative Updated Financial Arrangement List at this time.

(v) By a date specified by CMS, the Participant shall submit to CMS an updated Financial Arrangement List together with a certification, in the form and manner specified by CMS, stating that such list is a true, accurate and complete list, signed by an executive of the Participant who is authorized to sign such certification on behalf of the Participant, identifying all of the Participant's BPCI Advanced Entities, NPRA Sharing Partners, and NPRA Sharing Group Practice Practitioners that are approved by CMS to participate in BPCI Advanced and that have a fully executed NPRA Sharing Arrangement, Partner Distribution Arrangement, or BPCI Advanced Entity Agreement, as applicable, that satisfies the requirements of this Agreement ("**Updated Financial Arrangement List**"). Such Updated

Financial Arrangement List will become effective on the first day of the next calendar quarter or such other date specified by CMS.

(3) Removals and Updates.

(i) Prior to each calendar quarter, and at such other times specified by CMS, the Participant shall submit to CMS by a date and in a manner specified by CMS, a list identifying each individual or entity on the Financial Arrangement List that has ceased to be an NPRA Sharing Partner, NPRA Sharing Group Practice Practitioner, or BPCI Advanced Entity, and the date on which the individual or entity ceased to be a NPRA Sharing Partner, NPRA Sharing Group Practice Practitioner, or BPCI Advanced Entity.

(ii) The removal of an individual or entity from the Financial Arrangement List will become effective on the date the individual or entity ceased to be a NPRA Sharing Partner, NPRA Sharing Group Practice Practitioner, or BPCI Advanced Entity, not the date on which the updated Financial Arrangement List was submitted to CMS.

(iii) CMS will update the Initial Financial Arrangement List to reflect a change reported by the Participant pursuant to Article 3.2(a)(2) or Article 3.2(c)(2) and reserves the right, in its sole discretion, to remove NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, or BPCI Advanced Entities from the Updated Financial Arrangement List as a result of such notification or pursuant to Article 20.2(e) at any time.

Article 9
BPCI Advanced Beneficiary Protections

9.1 BPCI Advanced Beneficiary Notification Plans**.** The Participant shall develop a plan for ensuring that each BPCI Advanced Beneficiary receives a Beneficiary Notification Letter described in Article 9.2. The Participant shall implement the beneficiary notification plan developed by the Participant in accordance with this Article 9.1 and shall share a copy of this plan with CMS, upon request.

9.2 Beneficiary Notification Letter.

(a) Prior to discharge from the Anchor Stay, or prior to the completion of the Anchor Procedure, as applicable, the Participant shall ensure that the BPCI Advanced Beneficiary receives a copy of a template beneficiary notification letter provided by CMS (the "**Beneficiary Notification Letter**"), which will describe:

(1) the existence and purpose of BPCI Advanced;

(2) the BPCI Advanced Beneficiary's right of access to Medically Necessary Covered Services; and

(3) the BPCI Advanced Beneficiary's right to choose any provider or supplier of Covered Services.

(b) The Participant shall not in any way alter the content of a template Beneficiary Notification Letter that CMS provides, except as expressly permitted by CMS.

9.3 Descriptive Materials. The Participant shall not use or distribute Descriptive Materials that are inaccurate or misleading and shall ensure that its Downstream Episode Initiators, Participating Practitioners, BPCI Advanced Entities, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and other entities performing functions or services related to BPCI Advanced Activities do not use or distribute Descriptive Materials that are inaccurate or misleading. The Participant shall retain documentation of all Descriptive Materials in a manner consistent with Article 19.3.

9.4 Availability of Services.

(a) The Participant shall make Medically Necessary Covered Services available to BPCI Advanced Beneficiaries in accordance with applicable laws, regulations, and guidance, and shall require its Participating Practitioners, Downstream Episode Initiators, NPRA Sharing Partners, and NPRA Sharing Group Practice Practitioners to do the same. BPCI Advanced Beneficiaries and their assignees retain the right to appeal claims determinations in accordance with 42 C.F.R. Part 405, Subpart I.

(b) The Participant shall not take any action to avoid treating "at risk beneficiaries" (as defined at 42 C.F.R. § 425.20) or to target certain BPCI Advanced Beneficiaries for services with the purpose of cost shifting, and shall hold its Participating Practitioners, Downstream Episode Initiators, NPRA Sharing Partners, and NPRA Sharing Group Practice Practitioners to the same standard.

9.5 BPCI Advanced Beneficiary Choice.

(a) Consistent with Section 1802(a) of the Act, neither the Participant nor any Participating Practitioners, Downstream Episode Initiators, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, or other individuals or entities performing functions or services related to BPCI Advanced Activities shall commit any act or omission, nor adopt any policy, that inhibits BPCI Advanced Beneficiaries from exercising their freedom to obtain healthcare services from providers and suppliers who are not the Participant and its Participating Practitioners, Downstream Episode Initiators, NPRA Sharing Partners, or NPRA Sharing Group Practice Practitioners. This prohibition shall not apply to referrals made by employees or contractors who are operating within the scope of their employment or contractual arrangement with the employer or contracting entity, provided that the employees and contractors remain free to make referrals without restriction or limitation if a BPCI Advanced Beneficiary expresses a preference for a different provider or supplier, or the referral is not in the BPCI Advanced Beneficiary's best medical interests in the judgment of the referring party.

(b) Notwithstanding the foregoing, the Participant may communicate to BPCI Advanced Beneficiaries the advantages of receiving care with the Participant. All such communications shall be deemed Descriptive Materials. CMS may require the Participant to use scripts, talking points, or other materials furnished or approved by CMS to explain these advantages.

9.6 HIPAA Requirements.

(a) The Participant shall maintain the privacy and security of all Model-related information that identifies individual beneficiaries in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules and all relevant HIPAA Privacy and Security guidance applicable to the use and disclosure of protected health information (PHI) by covered entities, as well as applicable state laws and regulations.

(b) The Participant acknowledges that it is a covered entity or a business associate, as those terms are defined in 45 C.F.R. § 160.103, of its Downstream Episode Initiators or Participating Practitioners that are covered entities.

(c) The Participant shall have all appropriate administrative, technical, and physical safeguards in place before the Start Date to protect the privacy and security of PHI in accordance with 45 C.F.R. § 164.530(c).

Article 10
Beneficiary Incentives

10.1 Beneficiary Incentives.

(a) Prohibition. Except as set forth in Article 10.1(b) or as otherwise permitted by law, neither the Participant nor any Participating Practitioners, Downstream Episode Initiators, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, BPCI Advanced Entities, nor other individuals or entities performing functions or services related to BPCI Advanced Activities may provide gifts or other remuneration to beneficiaries to induce them to receive items or services from the Participant, Participating Practitioners, Downstream Episode Initiators, NPRA Sharing Partners, or NPRA Sharing Group Practice Practitioners, or to induce them to continue to receive items or services from the Participant, Participating Practitioners, Downstream Episode Initiators, NPRA Sharing Partners, or NPRA Sharing Group Practice Practitioners.

(b) Exception.

(1) Consistent with the prohibition set forth in Article 10.1(a), and subject to compliance with all other applicable laws and regulations, the Participant may furnish in-kind items and services to BPCI Advanced Beneficiaries during the Agreement Performance Period if all of the following conditions are satisfied:

(i) the items or services are reasonably connected to the medical care provided to the BPCI Advanced Beneficiary;

(ii) the items or services are preventive care items and services or advance a clinical goal for the BPCI Advanced Beneficiary, including adherence to a treatment regime, adherence to a drug regimen, adherence to a follow-up care plan, or management of a chronic disease or condition;

(iii) the items or services are provided by the Participant or a Participating Practitioner, Downstream Episode Initiator, NPRA Sharing Partner, or NPRA Sharing Group Practice Practitioner participating in BPCI Advanced pursuant to an agreement with the Participant (or, as applicable, with an NPRA Sharing Partner) to a BPCI Advanced Beneficiary during a Clinical Episode in accordance with the terms of this Agreement; and

(iv) the in-kind item or service is not a Medicare-covered item or service for the Beneficiary on the date the in-kind item or service is furnished to that Beneficiary. For purposes of this exception, an item or service that could be covered pursuant to a Payment Policy Waiver is considered a Medicare-covered item or service, regardless of whether the Participant has elected to participate in such Payment Policy Waiver.

(2) The Participant shall maintain, and shall require its Participating Practitioners, Downstream Episode Initiators, NPRA Sharing Partners, and NPRA Sharing Group Practice Practitioners to maintain contemporaneous records of the in-kind items and services furnished pursuant to this Article 10. Such records must include the following:

(i) the nature and value of the in-kind item or service;

(ii) the identity of the individual or entity that furnished the in-kind item or service;

(iii) the identity of the BPCI Advanced Beneficiary who received the in-kind item or service; and

(iv) the date the in-kind item or service was furnished.

The Participant shall provide CMS copies of such records, upon request.

Article 11
Medicare Payment Policy Waivers

11.1 General.

(a) In accordance with Section 1115A(d)(1) of the Act, CMS finds that it is necessary solely for purposes of testing the Model to waive the requirements of Title XVIII of the Act as set forth in Appendices E, F, and G. CMS may also determine, in its sole discretion, that it is necessary to waive other Medicare payment requirements for purposes of testing BPCI Advanced. CMS reserves the right to reconsider these waivers and, where the public interest requires, to modify or terminate these waivers at any time.

(b) If the Participant wishes to use a Payment Policy Waiver, it shall comply with the terms of the applicable Payment Policy Waiver, as set forth in this Article 11 and the applicable Appendix (Appendix E, F, or G). If the Participant satisfies all the applicable requirements to furnish services to BPCI Advanced Beneficiaries pursuant to one or more of the Payment Policy Waivers, the Participant and all Participating Practitioners and Downstream Episode Initiators may submit claims for items and services furnished pursuant to the Payment Policy Waiver as described in this Article 11 and the applicable Appendices (Appendices E, F, and/or G).

(c) CMS may require the Participant to report information on the use of Payment Policy Waivers to CMS. Such information must be reported in a form and in a manner specified by CMS.

11.2 3-Day SNF Rule Payment Policy Waiver.

(a) To be eligible to submit claims for services furnished to BPCI Advanced Beneficiaries pursuant to the 3-Day SNF Rule Payment Policy Waiver (Appendix E), an entity must be a Qualified SNF, as defined in Appendix E of this Agreement.

(b) In the event the 3-Day SNF Rule Payment Policy Waiver is not used in accordance with the terms and conditions in this Article 11.2 or Appendix E of this Agreement with respect to Medicare post-hospital extended care services ("**SNF Services**"), CMS will make no payments to the SNF for such services, the Participant must ensure that the SNF does not charge the BPCI Advanced Beneficiary for the expenses incurred for such services (and returns any applicable cost-sharing amounts already paid), and the Participant may be liable for the cost of the uncovered SNF Services, subject to the exceptions and applicable conditions outlined in Appendix E of this Agreement.

11.3 Post-Discharge Home Visits Payment Policy Waiver.

(a) To be eligible to bill for post-discharge home visits furnished to BPCI Advanced Beneficiaries pursuant to the Post-Discharge Home Visits Payment Policy Waiver (Appendix F), the supervising physician (or other practitioner) must be:

(1) a Participating Practitioner; and

(2) eligible under Medicare rules to submit claims for "incident to" services as defined in Chapter 15, Section 60 of the Medicare Benefit Policy Manual (CMS Internet Only Manual, Pub. 100-02).

(b) The individual performing services under this waiver must be "auxiliary personnel" as defined under 42 C.F.R. § 410.26(a)(1).

(c) The Participant shall ensure that post-discharge home visits are not used to prevent or deter a BPCI Advanced Beneficiary from seeking or receiving other Medically Necessary Covered Services.

11.4 Telehealth Payment Policy Waiver.

(a) To be eligible to bill for telehealth services furnished to BPCI Advanced Beneficiaries pursuant to the Telehealth Payment Policy Waiver (Appendix G), an individual or entity must be:

(1) a Participating Practitioner; and

(2) authorized under relevant Medicare rules and applicable state law to bill for telehealth services.

(b) The Participant shall ensure that Participating Practitioners do not substitute telehealth services for in-person services when in-person services are more clinically appropriate.

(c) The Participant shall ensure that Participating Practitioners only furnish Medically Necessary telehealth services and do not use telehealth services to prevent or deter a BPCI Advanced Beneficiary from seeking or receiving in-person care when such care is Medically Necessary.

11.5 Requirements for Termination of Payment Policy Waivers.

CMS may terminate the Participant's use of one or more of the Payment Policy Waivers at any time in accordance with Article 20.2.

11.6 Termination of Payment Policy Waivers upon Model Termination.

If this Agreement is terminated by the Participant pursuant to Article 21, the Payment Policy Waivers will expire upon the effective date of termination, unless CMS specifies a later date in writing. If this Agreement is terminated by CMS pursuant to Article 21, CMS will specify in writing the date on which the Participant's Payment Policy Waivers terminate. The Participant shall notify all Downstream Episode Initiators, Participating Practitioners, and Qualified SNFs (if applicable) regarding termination of the Payment Policy Waivers. Such notice shall be furnished at least 10 Days prior to the effective date of such termination or by other date as specified in writing by CMS.

Article 12
Data Sharing by CMS

12.1 General.

(a) Subject to the limitations discussed in this Agreement, and in accordance with applicable law, in advance of the Start Date of this Agreement, and any other time deemed necessary by CMS, CMS will offer the Participant an opportunity to request certain data and reports, which are described in Article 12.2(c) and the BPCI Advanced Model Participant Data Request and Attestation ("**Data Request and Attestation**") form for the applicable Model Year(s). The Participant must update its Data Request and Attestation form if the assertions therein become inaccurate over the course of the Model through changes to the Participant's Participant Profile, changes in data needs, or otherwise. Furthermore, to ensure periodic confirmation of continued accuracy, CMS will require the Participant to review and attest to the accuracy of the assertions in the Participant's current Data Request and Attestation form on at least an annual basis in a form and manner specified by CMS. The Participant must attest to the continued accuracy of the Data Request and Attestation form, or submit a new or updated Data Request and Attestation form, as applicable, as a condition of the Participant's continued receipt of the data specified on such form.

(b) The data and reports provided to the Participant will not include any beneficiary-level claims data regarding utilization of substance use disorder services.

(c) CMS will share the following types of de-identified, aggregated data with the Participant in a form and manner determined by CMS:

(1) Summary Clinical Episode Data. On a monthly basis, provided that the Participant has a fully executed and approved Data Request and Attestation form, CMS will provide the Participant with data files that have been de-identified in accordance with HIPAA requirements that describe Medicare FFS spending data at a high level of aggregation, including data regarding the number of Clinical

Episodes attributed to each Episode Initiator and the total average Medicare FFS spending for each such Clinical Episode.

(2) Target Prices. CMS will provide the Participant with Target Price files on at least an annual basis, which will contain simple workbooks that display the preliminary Episode Initiator-specific Target Prices for each Clinical Episode. Preliminary Target Prices will be updated on an annual basis, prior to the upcoming Model Year. Additionally, preliminary Target Prices will be updated every fiscal year and calendar year to correspond with Medicare payment rate updates.

12.2 Provision of Certain Beneficiary-Identifiable Claims Data.

(a) CMS believes that the care coordination and quality improvement work of the Participant (that is acting on its own behalf as a HIPAA covered entity ("**CE**") or that is a business associate ("**BA**") acting on behalf of its Downstream Episode Initiators or Participating Practitioners that are HIPAA covered entities) would benefit from the receipt of certain beneficiary-identifiable claims data for BPCI Advanced Beneficiaries. CMS will therefore offer to the Participant an opportunity to request specific beneficiary-identifiable claims data by completing the Data Request and Attestation form. All requests for beneficiary-identifiable claims data will be granted or denied at CMS' sole discretion based on CMS' available resources, the limitations in this Agreement, and applicable law.

(b) In offering an opportunity to request this beneficiary-identifiable claims data, CMS does not represent that the Participant or any Downstream Episode Initiator or Participating Practitioner has met all applicable HIPAA requirements for requesting data under 45 C.F.R. § 164.506(c)(4). The Participant and its Downstream Episode Initiators and Participating Practitioners should consult with their own counsel to make those determinations prior to requesting this data from CMS.

(c) The beneficiary-identifiable claims data available for request by the Participant is the data described below and in the Data Request and Attestation form, including:

(1) Line-Level Beneficiary Claims Data. These files will include raw claims data for BPCI Advanced Beneficiaries whose Clinical Episodes are attributed to the Participant or to the Participant's Downstream Episode Initiators within all of the following data element categories: inpatient; outpatient carrier/Part B; home health; skilled nursing facility; durable medical equipment; and hospice records and data fields. In addition, these data files will include summaries of the attributed BPCI Advanced Clinical Episodes, corresponding MS-DRGs and HCPCS codes, and Medicare enrollment and dual eligibility information for BPCI Advanced Beneficiaries whose Clinical Episodes have been attributed to the Participant or to the Participant's Downstream Episode Initiators.

(2) Reconciliation Data. Together with each Reconciliation Report, CMS will provide the Participant with reports that contain the AFP in relation to the final Target Price for each Clinical Episode across all Clinical Episodes attributed to the

Participant and to the Participant's Downstream Episode Initiators. If the Participant has a fully executed and approved Data Request and Attestation form for the Model Year(s), the Participant will also receive a claims file that contains all of the Clinical Episodes that were attributed to the Participant and to the Participant's Downstream Episode Initiators and included in the Reconciliation calculations used to determine the NPRA or the Repayment Amount, as applicable. The Reconciliation Report will break down the NPRA or Repayment Amount, as applicable, into the component Positive Total Reconciliation Amounts, Adjusted Positive Total Reconciliation Amounts, Negative Total Reconciliation Amounts, Adjusted Negative Total Reconciliation Amounts, CQS, and CQS Adjustment Amount for each Episode Initiator. Upon the expiration or termination of this Agreement Performance Period, the Participant will continue to receive these workbooks and files until the final Reconciliation true-up process described in Article 7 and Appendix A of this Agreement has been fully completed.

(d) The Parties mutually agree that, except for data covered by Article 12.2(m), CMS retains all ownership rights to the data files described in the Data Request and Attestation, and the Participant does not obtain any right, title, or interest in any of the data furnished by CMS.

(e) The Participant represents, and in furnishing the data files specified in the Data Request and Attestation CMS relies upon such representation, that such data files will be used solely for the purposes described in this Agreement. The Participant agrees not to disclose, use, or reuse the data except as specified in this Agreement or except as CMS shall authorize in writing or as otherwise required by law. The Participant further agrees not to sell, rent, lease, loan, or otherwise grant access to the data covered by this Agreement.

(f) The Participant intends to use the requested information as a tool to improve quality and deliver coordinated care for patients with Medicare to promote better care, better health, and lower growth in expenditures. Information derived from the CMS files specified in the Data Request and Attestation may be shared and used within the legal confines of the Participant and its Downstream Episode Initiators and Participating Practitioners in a manner consistent with Article 12.2(g) to enable the Participant to improve care integration and be a patient-centered organization.

(g) The Participant may reuse original or derivative data without prior written authorization from CMS for clinical treatment, care management and coordination, quality improvement activities, and healthcare provider incentive design and implementation, but shall not disseminate individually identifiable original or derived information from the files specified in the Data Request and Attestation to anyone who is not a HIPAA CE Downstream Episode Initiator or Participating Practitioner in a treatment relationship with the subject BPCI Advanced Beneficiary; a HIPAA BA of such a CE Downstream Episode Initiator or Participating Practitioner; the Participant's BA, where that Participant is itself a HIPAA CE; the Participant's sub-BA, which is hired by the Participant to carry out work on behalf of the CE

Downstream Episode Initiators or Participating Practitioners; or a non-participant HIPAA CE in a treatment relationship with the subject BPCI Advanced Beneficiary. When using or disclosing PHI or personally identifiable information (PII), obtained from files specified in the Data Request and Attestation, the Participant must make "reasonable efforts to limit" the information to the "minimum necessary" to accomplish the intended purpose of the use, disclosure, or request. The Participant shall further limit its disclosure of such information to the types of disclosures that CMS itself would be permitted make under the "routine uses" in the applicable systems of records listed in the Data Request and Attestation. Subject to the limits specified above and elsewhere in this Agreement and applicable law, the Participant may link individually identifiable information specified in the Data Request and Attestation (including directly or indirectly identifiable data) or derivative data to other sources of individually-identifiable health information, such as other medical records available to the Participant and its Episode Initiator or Participating Practitioner. The Participant may disseminate such data that has been linked to other sources of individual identifiable health information provided such data has been de-identified in accordance with HIPAA requirements in 45 C.F.R. § 164.514(b).

(h) The Participant agrees to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it. The safeguards shall provide a level and scope of security that is not less than the level and scope of security requirements established for federal agencies by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix I--Responsibilities for Protecting and Managing Federal Information Resources (https://www.whitehouse.gov/omb/circulars_default) as well as Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" (http://csrc.nist.gov/publications/fips/fips200/FIPS-200-final-march.pdf); and, NIST Special Publication 800-53 "Recommended Security Controls for Federal Information Systems" (http://nvlpubs.nist.gov/nistpubs/SpecialPublications/NIST.SP.800-53r4.pdf). The Participant acknowledges that the use of unsecured telecommunications, including the Internet, to transmit directly or indirectly identifiable information from the files specified in the Data Request and Attestation or any such derivative data files is strictly prohibited. Further, the Participant agrees that the data specified in the Data Request and Attestation must not be physically moved, transmitted or disclosed in any way from or by the site of the custodian indicated in the Data Request and Attestation other than as provided in this Agreement without written approval from CMS, unless such movement, transmission or disclosure is required by a law.

(i) The Participant agrees to grant access to the data and/or the facility in which the data is maintained to the authorized representatives of CMS or the HHS Office of Inspector General, including at the site of the custodian indicated in the Data Request and Attestation, for the purpose of inspecting to confirm compliance with the terms of this Agreement.

(j) The Participant agrees that any use of CMS data in the creation of any document concerning the purpose specified in this section and the Data Request and Attestation must adhere to CMS' current cell size suppression policy. This policy stipulates that no cell (e.g., admittances, discharges, patients, services) representing 10 or fewer beneficiaries may be displayed. Also, no use of percentages or other mathematical formulas may be used if they result in the display of a cell representing 10 or fewer beneficiaries.

(k) The Participant agrees to report any breach of PHI or PII from or derived from the CMS data files, loss of these data or improper use or disclosure of such data to the CMS Action Desk by telephone at (410) 786-2850 or by email notification at cms_it_service_desk@cms.hhs.gov within one hour. Furthermore, the Participant agrees to cooperate fully in any federal incident security process that results from such improper use or disclosure.

(l) The Parties mutually agree that the individual named in the Data Request and Attestation form is designated as Custodian of the CMS data files on behalf of the Participant and will be responsible for the observance of all conditions of use and disclosure of such data and any derivative data files, for the periodic review of the Data Request and Attestation form to ensure continued accuracy, and for the establishment and maintenance of security arrangements as specified in this Agreement to prevent unauthorized use or disclosure. Furthermore, such Custodian is responsible for contractually binding any downstream recipients of such data to the terms and conditions in this agreement as a condition of receiving such data. The Participant agrees to notify CMS within fifteen (15) days of any change of custodianship. The Parties mutually agree that CMS may disapprove the appointment of a custodian or may require the appointment of a new custodian at any time.

(m) Data disclosed to the Participant pursuant to the Data Request and Attestation form may be retained by the Participant until the termination or conclusion of the Agreement. The Participant is permitted to retain any individually identifiable health information from such data files or derivative data files after the termination or conclusion of the Agreement if the Participant is a HIPAA CE, and the data has been incorporated into the subject beneficiaries' medical records that are part of a designated record set under HIPAA. Furthermore, any HIPAA CE to whom the Participant provides such data in the course of carrying out the Model initiative may also retain such data if the recipient entity is a HIPAA CE or BA and the data is incorporated into the subject beneficiaries' medical records that are part of a designated record set under HIPAA. The Participant shall destroy all other data and send written certification of the destruction of the data files and/or any derivative data files to CMS within 30 days following the termination or conclusion of the Agreement. Except for disclosures for treatment purposes, the Participant shall bind any downstream recipients to these terms and conditions as a condition of disclosing such data to downstream entities and permitting them to retain such records under this paragraph. These retention provisions survive termination of the Agreement.

Article 13
Monitoring and Compliance

13.1 Compliance with Laws**.** The Participant shall comply with, and shall require all Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and all entities and individuals that perform BPCI Advanced Activities to comply with all applicable statutes and regulations including, without limitation:

(a) Federal criminal laws;

(b) the Federal False Claims Act (31 U.S.C. § 3729, et seq.);

(c) the federal anti-kickback statute (42 U.S.C. § 1320a-7b(b));

(d) the federal civil monetary penalties law (42 U.S.C. § 1320a-7a);

(e) the federal physician self-referral law (42 U.S.C. § 1395nn); and

(f) applicable state laws.

This Agreement does not waive any obligation of the Participant to comply with the terms of any other CMS contract, agreement, model, or demonstration, unless specifically authorized by this Agreement.

13.2 Compliance Plan. The Participant shall have a compliance plan that addresses the prevention, detection, and correction of fraud and abuse and noncompliance with the terms and conditions of this Agreement. The Participant shall update its compliance plan to reflect changes in applicable statutes, regulations, and Model requirements, including any amendments to this Agreement. The Participant may modify, use, and share its existing compliance plans or the compliance plans of a Downstream Episode Initiator, NPRA Sharing Partner, or BPCI Advanced Entity to meet the requirements of this section.

13.3 Notification. The Participant shall notify CMS within 15 Days after becoming aware that the Participant or any Downstream Episode Initiator, Participating Practitioner, NPRA Sharing Partner, NPRA Sharing Group Practice Practitioner, or BPCI Advanced Entity is under investigation or has been sanctioned by the Federal, state, or local 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).

13.4 CMS Compliance Monitoring Activities.

(a) CMS will conduct compliance monitoring activities to evaluate compliance by the Participant, its Downstream Episode Initiators, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities with the terms and conditions of this Agreement. Such compliance monitoring activities may include:

(1) interviews of the staff and leadership of the Participant, its Downstream Episode Initiators, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities;

(2) interviews of Participating Practitioners;

(3) interviews of beneficiaries and their representatives;

(4) audits of charts, medical records, federal healthcare program claims data, and other data from the Participant, its Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities;

(5) site visits to the Participant, its Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities; and

(6) documentation requests sent to the Participant, its Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities, including surveys and questionnaires.

(b) The Participant shall cooperate with, and shall require its Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, BPCI Advanced Entities, and other individuals and entities performing functions and services related to BPCI Advanced Activities to cooperate with all CMS compliance monitoring requests and activities.

Article 14
Participation in Shared Learning Activities

14.1 CMS will conduct shared learning activities designed to improve Model results and share learning that emerges from participation in the Model. Shared learning activities may include, at CMS's discretion, periodic conference calls, site visits, virtual or in-person meetings, or other activities.

14.2 The Participant shall participate in shared learning activities required by CMS and shall also require its Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and other individuals and entities performing functions and services related to BPCI Advanced Activities to participate in such shared learning activities, as applicable. As part of the shared learning activities, CMS may require the Participant, its Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, and NPRA Sharing Group Practice Practitioners to share non-proprietary resources used to implement participation in the Model.

Article 15
Participation in Model Evaluation Activities

15.1 CMS or its designee will conduct an independent evaluation to assess the impact of the Model on the cost and quality of healthcare services furnished to BPCI Advanced Beneficiaries, Medicare beneficiaries generally, and beneficiaries of other federal healthcare programs in accordance with Section 1115A(b)(4) of the Act ("**Model Evaluation**").

15.2 In conducting the Model Evaluation, CMS or its designee may obtain data from a variety of sources, including the following: site visits; interviews with Participating Practitioners and the staff and leadership of the Participant and its Downstream Episode Initiators, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, BPCI Advanced Entities, and other individuals and entities performing functions and services related to BPCI Advanced Activities; interviews with BPCI Advanced Beneficiaries and their representatives; surveys; claims data; and clinical data (including medical records).

15.3 In accordance with 42 C.F.R. § 403.1100, et seq., the Participant shall participate in the Model Evaluation and shall collect and report information, including "protected health information" (as defined at 45 C.F.R. § 160.103), that CMS determines is necessary to monitor and evaluate the Model. The Participant shall submit such information at the time and in the form and manner specified by CMS (see 42 C.F.R. § 403.1100, et seq.). All information will be provided to CMS in a manner consistent with all applicable Federal and state laws and regulations, including the HIPAA Privacy and Security Rules.

15.4 The Participant shall require its Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, BPCI Advanced Entities, and other individuals and entities performing functions and services related to BPCI Advanced Activities to participate in the Model Evaluation and to cooperate with data requests made by CMS or its designee for purposes of conducting the Model Evaluation, to the extent permitted by law.

15.5 CMS or its designee shall have the right to collect information from Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, BPCI Advanced Entities, and other individuals and entities performing functions and services related to BPCI Advanced Activities outside the presence of the Participant for purposes of conducting the Model Evaluation. If CMS or its designee collects information from Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, and NPRA Sharing Group Practice Practitioners, BPCI Advanced Entities, and other individuals and entities performing functions and services related to BPCI Advanced Activities outside the presence of the Participant, CMS or its designee will give the Participant no fewer than 15 Days advance notice to the extent practicable under the circumstances.

15.6. CMS will administer and analyze a BPCI Advanced Beneficiary experience survey for purposes of conducting the Model Evaluation.

Article 16
Site Visits

16.1 Except as provided in Articles 16.2 and 16.3, CMS or its designee will provide the Participant with no fewer than 15 Days advance notice of a site visit to be conducted as part of compliance monitoring activities (Article 13.4), shared learning activities (Article 14.1), or the Model Evaluation (Article 15). To the extent practicable, CMS will attempt to accommodate the Participant's request for particular dates in scheduling site visits, but the Participant shall not request a date that is more than 30 Days after the date of the initial site visit notice from CMS.

16.2 CMS may perform unannounced site visits at any physical location of the Participant or its Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, BPCI Advanced Entities, and other individuals and entities performing functions and services related to BPCI Advanced Activities at any time to investigate concerns about the health or safety of beneficiaries or other program integrity issues.

16.3 Nothing in this Agreement limits the authority of CMS to conduct a site visit permitted by applicable law or regulations.

Article 17
CMS Rights in Data and Intellectual Property

17.1 To the extent permitted by applicable law, except as provided in Article 17.2, CMS or its designee(s) may use and publicly disseminate any data obtained pursuant to the Model or this Agreement, including care management techniques, factors associated with performance, results of patient experience of care and quality of life surveys, as well as cost and quality data.

17.2 All proprietary trade secret information and technology of the Participant and its Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, BPCI Advanced Entities, and other individuals and entities performing functions and services related to BPCI Advanced Activities is and shall remain the sole property of the Participant and its Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, BPCI Advanced Entities, and other individuals and entities performing functions and services related to BPCI Advanced Activities, and, except as required by Federal law, shall not be released by CMS or its designee(s) without the express written consent of the Participant. The regulation at 48 C.F.R. § 52.227-14, "Rights in Data-General," as may be amended from time to time, is hereby incorporated by reference into this Agreement. CMS does not acquire by license or otherwise, whether express or implied, any intellectual property right or other rights to the Participant's or Downstream Episode Initiators', Participating Practitioners', NPRA Sharing Partners', NPRA Sharing Group Practice Practitioners', BPCI Advanced Entities', or and other individuals' and entities' performing functions and services related to BPCI Advanced Activities proprietary information or technology.

17.3 If the Participant submits any proprietary or confidential information to CMS, the Participant shall label or otherwise identify the information as proprietary or confidential, and shall require its Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, BPCI Advanced Entities, and other individuals and entities performing functions and services related to BPCI Advanced Activities to do the same.

Article 18
Participant Public Release of Information

18.1 During the Agreement Term and for six months thereafter, the Participant and its Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, BPCI Advanced Entities, and other individuals and entities

performing functions and services related to BPCI Advanced Activities shall include the following statement on the first page of all Analytical Materials (as defined in Article 18.2) or Descriptive Materials that such entities and individuals publicly disseminate: "The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document."

18.2 For purposes of Article 18.1, the term "**Analytical Material**" means any document that materially and substantially references the Participant's or its Downstream Episode Initiators', Participating Practitioners', NPRA Sharing Partners', NPRA Sharing Group Practice Practitioners', BPCI Advanced Entities', and other individuals' and entities' performing functions and services related to BPCI Advanced Activities or participation in the Model generally, including, without limitation, reports, papers, articles, professional publications, speeches, and testimony.

Article 19
Audits and Record Retention

19.1 Right to Audit**.** The Participant shall permit, and shall require all of its Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, BPCI Advanced Entities, and other individuals or entities performing functions or services related to BPCI Advanced Activities to permit the Federal Government, including CMS, HHS, and the Comptroller General or their designees, to audit, inspect, investigate, and evaluate any books, contracts, records, documents and other evidence maintained by the Participant and its Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities, and other individuals or entities performing functions or services related to BPCI Advanced Activities that pertain to the Model including without limitation:

(a) the Participant's compliance with this Agreement, as well as the compliance of the Participant's Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities, and other individuals or entities performing functions or services related to BPCI Advanced Activities;

(b) the quality of services performed under this Agreement;

(c) the ability of the Participant or its Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities, and other individuals or entities performing functions or services related to BPCI Advanced Activities to bear financial risk and to repay any amounts due to CMS;

(d) calculation, allocation, and distribution of NPRA Shared Payment amounts, Repayment Amounts, or Internal Cost Savings contributions;

(e) NPRA Sharing Arrangements and Partner Distribution Arrangements;

(f) beneficiary incentives;

(g) patient safety; and

(h) Medicare Parts A and B billings during a Clinical Episode.

This obligation shall survive for 10 years after the expiration or termination of this Agreement.

19.2 Right to Correct**.** If the Federal Government discovers as the result of an audit, inspection, investigation, monitoring, or evaluation that any payment made pursuant to this Agreement is incorrect, CMS shall, consistent with applicable law, make payment to, or demand payment from, the Participant.

19.3 Maintenance of Records. The Participant shall comply with, and shall require all Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities, and individuals and entities performing functions or services related to BPCI Advanced Activities to comply with the following obligations:

(a) to give the Federal Government, including CMS, HHS, and the Comptroller General or their designees, access to all books, contracts, records, documents, and other evidence sufficient to enable the audit, evaluation, inspection, or investigation of the Model.

(b) to maintain such books, contracts, records, documents, and other evidence for a period of 10 years after the expiration or termination of this Agreement or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later, unless:

(1) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the Participant at least 30 Days before the normal disposition date; or

(2) there has been a termination, dispute, or allegation of fraud or similar fault against the Participant, its Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities, or other individuals or entities performing functions or services related to BPCI Advanced Activities, in which case the relevant records shall be maintained for an additional six years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault.

Article 20
Remedial Action

20.1 Grounds for Remedial Action. CMS may take remedial action if CMS determines that the Participant, a Downstream Episode Initiator, Participating Practitioner, NPRA Sharing Partner, NPRA Sharing Group Practice Practitioner, BPCI Advanced Entity, or another individual or entity performing functions or services related to BPCI Advanced Activities –

(a) has failed to comply with any applicable provision of this Agreement, including any appendices thereto;
(b) has failed to comply with any applicable Medicare program requirement, rule, or regulation;
(c) has taken any action that threatens the health or safety of a beneficiary or other patient;
(d) has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the Model;
(e) is subject to sanctions or other actions of an accrediting organization or a Federal, state or local government agency, including without limitation revocation of Medicare billing privileges, termination of Medicare provider agreement or supplier approval, Medicare or Medicaid program exclusion, or debarment;
(f) is subject to investigation or action by HHS (including the HHS Office of Inspector General and CMS) or the Department of Justice due to an allegation of fraud or significant misconduct, including being subject to the filing of a complaint, filing of a criminal charge, being subject to an indictment, being named as a defendant in a False Claims Act qui tam matter in which the Federal Government has intervened, or similar action; or
(g) has failed to demonstrate improved performance following any remedial action imposed pursuant to Article 20.2.

20.2 Types of Remedial Action. If CMS determines that remedial action is warranted pursuant to Article 20.1, CMS may take one or more of the following actions:

(a) require the Participant to provide additional information to CMS or its designees;

(b) conduct site visits, interview Beneficiaries, or take other actions to gather information;

(c) subject the Participant to additional monitoring, auditing, or both;

(d) remove a Downstream Episode Initiator from the Participant Profile;

(e) remove an NPRA Sharing Partner, an NPRA Sharing Group Practice Practitioner, or a BPCI Advanced Entity from the Initial Financial Arrangement List or the Updated Financial Arrangement List;

(f) require the Participant to terminate its relationship with any other individual or entity with respect to the individual's or entity's performance of functions or services related to BPCI Advanced Activities;

(g) deny, suspend, or recoup NPRA payments;

(h) require the Participant to amend its Participant Profile to terminate or modify any election to pursue Financial Arrangements, offer Beneficiary Engagement Incentives, or furnish services to BPCI Advanced Beneficiaries pursuant to one or more Payment Policy Waivers;

(i) prohibit the Participant from making payments from the BPCI Advanced Savings Pool, to include any NPRA Shared Payment to an NPRA Sharing Partner and any payment for Administrative Services to a BPCI Advanced Entity;

(j) suspend or terminate the Participant's ability to initiate new Clinical Episodes under BPCI Advanced;

(k) require the Participant to submit to CMS a proposed corrective action plan (**"CAP"**) in accordance with Article 20.3, and to implement that CAP once approved by CMS;

(l) amend this Agreement without the consent of the Participant to limit or deny the applicability of any or all waivers of existing law made pursuant to Section 1115A(d)(1) of the Act;

(m) discontinue the provision of data sharing and reports to the Participant under Article 12;

(n) suspend or terminate the Participant's ability to utilize one or more of the Payment Policy Waivers; or

(o) Impose additional remedial actions, including termination of this Agreement pursuant to Article 21, if CMS determines that remedial actions were insufficient to correct noncompliance with the terms of this Agreement.

20.3 Corrective Action Plans.

(a) If CMS requires the Participant to submit a CAP, the Participant shall submit the CAP in a form and manner and by a deadline specified by CMS.

(b) The proposed CAP must address what actions the Participant will take, or will require any Downstream Episode Initiator, Participating Practitioner, NPRA Sharing Partner, NPRA Sharing Group Practice Practitioner, BPCI Advanced Entity, or other individual or entity performing functions or services related to BPCI Advanced Activities to take in order to ensure that all deficiencies will be corrected and that the Participant will be in compliance with the terms of this Agreement.

(c) CMS may accept or reject the CAP. If CMS does not accept the CAP, CMS may: require the Participant to submit a revised CAP for CMS review; impose another remedial action pursuant to Article 20.2; or terminate this Agreement pursuant to Article 21.

(d) If the Participant (and, if applicable, any Downstream Episode Initiator, Participating Practitioner, NPRA Sharing Partner, NPRA Sharing Group Practice Practitioner, BPCI Advanced Entity, or other individual or entity performing functions or services related to BPCI Advanced Activities) fails to fully implement and comply with a CAP or fails to demonstrate improved performance after completion of the CAP, CMS may: require the Participant to submit a revised CAP for CMS review; impose another remedial action pursuant to Article 20.2; or terminate this Agreement pursuant to Article 21.

(e) CMS may require the Participant to implement a CAP in a form and manner and by a deadline specified by CMS.

20.4 Notice of Remedial Action. CMS must notify the Participant and, if CMS deems appropriate, a Downstream Episode Initiator, Participating Practitioner, NPRA Sharing Partner, NPRA Sharing Group Practice Practitioner, BPCI Advanced Entity, or other individual or entity performing functions or services related to BPCI Advanced Activities of the violation before taking any remedial action under this Article 20.

Article 21
Termination

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

(a) The Participant must provide such advance written notice in the form of an email to CMS sent to: BPCIAdvanced@cms.hhs.gov. Submission of an updated Participant Profile indicating that all Clinical Episodes and Episode Initiators are being removed is not sufficient notice of termination by the Participant.

(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 1.3. No Clinical Episodes may be initiated under this Agreement on or after the effective date of such termination.

21.2 Termination by CMS. CMS may immediately or with advance notice terminate this Agreement if:

(a) CMS determines that any of the grounds for remedial action set forth in Article 20.1 exist;

(b) one or more of the states in which BPCI Advanced Beneficiaries reside enters into an arrangement with CMS to implement a global or per-capita payment for services furnished to a population that includes BPCI Advanced Beneficiaries;

(c) CMS determines that it no longer has the funds to support BPCI Advanced or that the Model should be terminated for other reasons;

(d) CMS terminates or modifies the Model for any reason, including pursuant to Section 1115A(b)(3)(B) of the Act; or

(e) 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.

The effective date of termination of this Agreement by CMS is also the effective date of termination of the Agreement Performance Period described in Article 1.3. No Clinical Episodes may be initiated under this Agreement on or after the effective date of such termination.

21.3 Notice of Termination by CMS. In the event CMS terminates this Agreement pursuant to Article 21.2, CMS will provide written notice specifying the grounds for termination of this Agreement and the effective date of such termination.

21.4 Notice of Termination to Third Parties. If the effective date of termination of this Agreement is after the Start Date, then the Participant shall notify all Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities at least 60 Days before the effective date of termination, or if notice of termination pursuant to Article 21.3 is provided fewer than 60 Days before the effective date of termination, the Participant shall notify all Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities as soon as practicable after receiving notice.

21.5 Financial Settlement upon Termination. In the event the Agreement is terminated by either Party in accordance with this Article 21, the Participant shall be liable for all Repayment Amounts and Excess Spending Amounts owed to CMS for Clinical Episodes included in the Reconciliation calculation and Post-Episode Monitoring Spending Calculation in accordance with Article 5.2(a)(4) and Article 5.2(b)(3).

(a) Upon termination of this Agreement, CMS will continue to issue Reconciliation Reports and Post-Episode Spending Calculation Reports to the Participant, in accordance with the processes set forth in Article 7, to account for the Clinical Episodes included in the Reconciliation calculation and Post-Episode Monitoring Spending Calculation in accordance with Article 5.2(a)(4) and Article 5.2(b)(3).

(b) Upon termination of this Agreement, CMS will make NPRA payments in accordance with the requirements of Article 7, to include the NPRA eligibility requirements, and

the Participant shall pay CMS all Repayment Amounts and Excess Spending Amounts in accordance with Article 7, calculated with respect to Clinical Episodes included in the Reconciliation calculation and Post-Episode Monitoring Spending Calculation in accordance with Article 5.2(a)(4) and Article 5.2(b)(3).

(c) The Participant shall not distribute or otherwise remove any monies from the BPCI Advanced Savings Pool after the effective date of termination of this Agreement unless and until CMS has issued a written notice informing the Participant that all outstanding Repayment Amounts and Excess Spending Amounts owed to CMS for Clinical Episodes included in the Reconciliation calculation and Post-Episode Monitoring Spending Calculation in accordance with Article 5.2(a)(4) and Article 5.2(b)(3) have been settled to CMS' satisfaction.

(d) The obligations of the Parties under this Article 21.5 shall survive the termination of this Agreement.

Article 22
Limitations on Review

22.1 Limitations on Review. There is no administrative or judicial review under Sections 1869 or 1878 of the Act or otherwise for the following:

(a) the selection of models for testing or expansion under Section 1115A of the Act;

(b) the selection of organizations, sites, or participants to test the selected models, including the decision by CMS to terminate this Agreement or to require the termination of any entity's status as a Participant;

(c) the elements, parameters, scope, and duration of such models for testing or dissemination;

(d) determinations regarding budget neutrality under Section 1115A(b)(3) of the Act;

(e) the termination or modification of the design and implementation of a model under Section 1115A(b)(3)(B) of the Act;

(f) determinations about expansion of the duration and scope of a model under Section 1115A(c) of the Act, including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such section;

(g) a Reconciliation Report, revised Reconciliation Report, Post-Episode Excess Spending Report, or revised Post-Episode Excess Spending Report deemed to be final pursuant to Article 7, including without limitation the determination of:

(1) the applicable Target Price;

(2) the AFP;

(3) Clinical Episode attribution;

(4) whether the Participant owes a Repayment Amount or Excess Spending Amount, or is owed an NPRA payment; and

(5) the amount of such Repayment Amount, Excess Spending Amount, and/or NPRA payment;

(h) The determination of the Reconsideration Official issued pursuant to Article 7.3(c)(4) and Article 7.4(c)(3);

(i) the selection of quality performance standards; and

(j) the assessment of the quality of care furnished by the Participant.

Article 23
Miscellaneous

23.1 Notices and Communications. Unless otherwise stated in writing after the Effective Date, all notifications and information required to be submitted under this Agreement shall be submitted to the Parties at the addresses set forth below:

Participant: Name: _____

Address: _____

Phone: _____

Email: _____

CMS: BPCI Advanced
Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mailstop: WB-06-05, Baltimore, MD 21244
Email: BPCIAdvanced@cms.hhs.gov

Notices and communications will be sent via email unless otherwise indicated by CMS.

23.2 Notice of Bankruptcy. If the Participant enters into proceedings relating to bankruptcy, whether voluntary or involuntary, the Participant shall furnish, by certified mail, written notification of the bankruptcy to CMS and the local U.S. Attorney Office. The Participant shall furnish the notification within 5 Days after the initiation of the proceedings relating to bankruptcy filing. This notification shall include the date on which the bankruptcy petition was filed, the identity of the court in which the bankruptcy petition was filed, and a listing of Federal Government contracts, project agreements, contract officers, and project officers for all Federal Government contracts and project agreements against which final payment has not been made, as well as all agreements related to the Participant's participation in the Medicare program. This obligation remains in effect until the expiration or termination of this Agreement and final payment under this Agreement has been made and all administrative and judicial review proceedings

relating to any payments under this Agreement, if any, have been fully and finally resolved.

23.3 Severability. In the event that any one or more of the provisions of this Agreement is, for any reason, held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provisions of this Agreement. This Agreement shall be construed as if such invalid, illegal, or unenforceable provisions had never been included in the Agreement, unless the deletion of such provision or provisions would result in such a material change to the Agreement so as to cause continued participation under the terms of the Agreement to be unreasonable.

23.4 Entire Agreement; Amendment. This Agreement, including all appendices, as may be modified from time to time under the terms of this Agreement, constitutes the entire agreement between the Parties. The Parties may amend this Agreement at any time by mutual written agreement; provided, however, that CMS may unilaterally amend this Agreement as specified in this Agreement, or for good cause, or as necessary to comply with applicable federal or State law, regulatory requirements, accreditation standards or licensing guidelines or rules. To the extent practicable, CMS shall provide the Participant with at least 30 Days advance written notice of any such unilateral amendment, which notice must specify the amendment's effective date.

23.5 Survival. Termination of this agreement by either Party will not affect the rights and obligations of the Parties accrued prior to the effective date of the termination of this Agreement, except as provided in this Agreement. The following provisions survive the expiration or termination of this Agreement:

(a) Participant Changes (Article 3.2)

(b) Payment (Article 7);

(c) Financial Arrangements (Article 8);

(d) Data Sharing by CMS (Article 12);

(e) Participation in Model Evaluation Activities (Article 15);

(f) Site Visits (Article 16);

(g) CMS Rights in Data and Intellectual Property (Article 17);

(h) Participant Public Release of Information (Article 18);

(i) Audits and Record Retention (Article 19);

(j) Financial Settlement upon Termination (Article 21.5);

(k) Notice of Bankruptcy (Article 23.2);

(l) Survival (Article 23.5); and

(m) Prohibition on Assignment (Article 23.6)

23.6 Prohibition on Assignment. Except with the prior written consent of CMS, the Participant shall not transfer, including by merger (whether the Participant is the surviving or disappearing entity), consolidation, dissolution, or otherwise:

(a) any discretion granted it under this Agreement;

(b) any right that it has to satisfy a condition under this Agreement;

(c) any remedy that it has under this Agreement; or

(d) any obligation imposed on it under this Agreement.

The Participant shall provide CMS with 90 Days advance written notice of any such proposed transfer. This obligation remains in effect after the termination of this Agreement until final payment under this Agreement has been made and all administrative and judicial review proceedings relating to any payments under this Agreement have been fully and finally resolved. CMS may condition its consent to such proposed transfer on: (1) the Participant's immediate payment of all amounts owed to CMS under this Agreement; and/or (2) the execution of a novation agreement with the Participant transferor and the transferee. Any purported transfer in violation of this Article 23.6 is voidable at the discretion of CMS.

23.7 Reservation of Rights.

(a) Nothing contained in this Agreement or in the application process for the Model is intended to, nor shall be construed as:

(1) limiting the authority of the HHS Office of Inspector General or any other Federal Government or state government authority to audit, evaluate, investigate, or inspect the Participant or its Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, BPCI Advanced Entities, and other individuals and entities performing functions and services related to BPCI Advanced Activities; or

(2) limiting the right of the Federal Government to obtain relief under any federal statutes or regulations for noncompliance with the terms of this Agreement or any other provision of law; or

(3) a waiver by CMS, the HHS Office of Inspector General, or any other Federal Government authority of any right to institute any proceeding or action against the Participant, its Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, BPCI Advanced Entities, or other individuals and entities performing functions and services related to BPCI Advanced Activities for violations of any statutes, rules, or regulations administered by the Federal Government.

(b) This Agreement shall not be construed to bind any Federal Government agency except CMS.

(c) The submission of any information, business plans, or documents during the Model application process does not imply that CMS has reviewed or approved the information, business plans or documents, and does not in any way imply or constitute a determination that the submitted information, business plans, or documents comply with federal statutes or regulations or the terms of this Agreement.

(d) The failure by CMS to require performance of any provision of this Agreement shall not affect CMS's right to require performance at any time thereafter, nor shall a

waiver of any breach or default of this Agreement constitute a waiver of any subsequent breach or default or a waiver of the provision itself.

23.8 Execution in Counterpart. If the Parties sign this Agreement and any amendments to it in counterparts, each counterpart will be deemed to be an original, but all counterparts taken together will constitute one instrument. If any signature is delivered by e-mail of a ".pdf" data file, such signature will create a valid and binding obligation of the Party executing (or on whose behalf such signature is executed) with the same force and effect as if such ".pdf" signature page were an original.

23.9 Interpretation of the Agreement. The Parties are sophisticated and have been represented (or have had the opportunity to be represented) by their separate attorneys in connection with the negotiation and drafting of this Agreement and any agreements and instruments executed in connection herewith. As a consequence, the Parties do not intend that the presumptions of laws or rules relating to the interpretation of contracts against the drafter of any particular clause should be applied to this Agreement or any document or instrument executed in connection herewith, and therefore waive their effects.

[SIGNATURE PAGE FOLLOWS]

Each Party is signing this Agreement on the date stated opposite that Party's signature. If a Party signs but fails to date a signature, 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 Agreement.

PARTICIPANT:

Date: _____

By: _____

_____

Name of authorized signatory

_____

Title

BPID: _____

CMS:

Date: _____

By: _____

_____

Name of authorized signatory

_____

Title

APPENDIX A
BPCI Advanced Payment Policies

The purpose of this Appendix A is to inform the Participant of the relevant payment policy principles used to set Target Prices for Clinical Episodes and to conduct Reconciliation calculations.

Reconciliation will occur on a semi-annual basis. Following each Performance Period, CMS will issue a Reconciliation Report to the Participant, as described in Article 7 of the Agreement, which will specify the Aggregate Fee-for-Service Payment (AFP) and the Episode Initiator-specific Target Price for all Clinical Episodes for which the Participant has committed to be held accountable, an Episode Initiator-specific Composite Quality Score (CQS) Adjustment Amount, if applicable, and either the Net Payment Reconciliation Amount (NPRA) or the Repayment Amount for the Performance Period, as applicable. The Reconciliation Report will also include adjustments to Reconciliation calculations from previous Performance Periods that result from the true-up process or other adjustments described in Article 7 of the Agreement and this Appendix A. As specified in the Reconciliation Report, the Participant will either owe a Repayment Amount to CMS or CMS will pay the Participant an NPRA payment for the Performance Period, net of adjustments to NPRA payments or Repayment Amounts from previous Reconciliation Reports, if applicable. The NPRA payment and the Repayment Amount will be subject to a 20 percent stop-gain/stop-loss policy as described in this Appendix A. Additional information regarding reconciliation specifications can be found on the CMS website: https://innovation.cms.gov/initiatives/bpci-advanced ("**Reconciliation Specifications**"). CMS reserves the right to modify this document at any time.

I. Clinical Episode Attribution

A. General

A list of all Clinical Episodes offered under BPCI Advanced (the "**Clinical Episode List**") can be found on the CMS website: https://innovation.cms.gov/initiatives/bpci-advanced. The duration of Clinical Episodes under BPCI Advanced, as well as the items and services included in (and excluded from) such Clinical Episodes are each described in Article 5 of the Agreement. A list of items and services specifically excluded from BPCI Advanced Clinical Episodes is available on the CMS website: https://innovation.cms.gov/initiatives/bpci-advanced ("**BPCI Advanced Exclusions List**"). A description of how Clinical Episodes are constructed is also available on the CMS website ("**BPCI Advanced Clinical Episode Construction Specifications**"). CMS reserves the right to modify this document at any time. Inpatient Clinical Episodes are initiated by an Anchor Stay, while outpatient Clinical Episodes are initiated by an Anchor Procedure.

The Participant's Reconciliation calculations for a Performance Period will include all Clinical Episodes for which: (1) the Episode Initiator that submitted a claim for the Anchor Stay or Anchor Procedure is either the Participant or, if the Participant is a Convener Participant, a Downstream Episode Initiator participating in BPCI Advanced pursuant to an agreement with the Convener Participant; (2) to the extent that the Episode Initiator that submitted the claim for

the Anchor Stay or Anchor Procedure is a PGP, the attending or operating physician's NPI must appear on the institutional claim (UB-04) and a corresponding carrier claim (Part B claim) with the participating PGP's TIN that is billed during the Anchor Stay or Anchor Procedure; (3) the Clinical Episode was initiated within the period of time that defines the applicable Performance Period (see Article 5.2 of the Agreement for additional information regarding the Performance Period in which a given Clinical Episode is deemed to be included); (4) the AFP for that Clinical Episode was not subject to Reconciliation for a prior Performance Period; (5) the Clinical Episode was not initiated prior to the Start Date or after the end of the Agreement Performance Period (except for those Clinical Episodes described in Article 5.2(a)(4) and Article 5.2(b)(4)); and (6) the Clinical Episode has not been attributed to another Participant pursuant to the precedence rules described below.

B. Precedence Rules

These steps are implemented to ensure that a given Clinical Episode is attributed to only one Episode Initiator. The Precedence Rules are (in order of priority):

(1) In cases where a Clinical Episode could potentially be attributed to both a PGP Episode Initiator and a non-PGP Episode Initiator, the Clinical Episode will be attributed to the PGP Episode Initiator (subject to (2) and (3)).

(2) In cases where a Clinical Episode could potentially be attributed to two or more PGP Episode Initiators, if the NPI for the attending physician appears on the institutional claim for the Anchor Stay or Anchor Procedure, as applicable, and on an associated Part B claim with the TIN of one such PGP Episode Initiator, the Clinical Episode will be attributed to that PGP Episode Initiator.

(3) In cases where a Clinical Episode could potentially be attributed to two or more PGPs, neither of which has the NPI for the attending physician listed on a Part B claim corresponding to the claim for the Anchor Stay or Anchor Procedure, if the NPI for the operating physician appears on the institutional claim for the Anchor Stay or Anchor Procedure, as applicable, and on a corresponding Part B claim with the TIN of one such PGP Episode Initiator, the Clinical Episode will be attributed to that PGP Episode Initiator.

(4) In cases where a Clinical Episode cannot be attributed to a PGP Episode Initiator, the Clinical Episode will be attributed to the ACH where the Anchor Stay or Anchor Procedure occurred.

There are no time-based precedence rules in BPCI Advanced.

II. Methodology for Calculation of the Final Target Price

A. BPCI Advanced Beneficiaries

A BPCI Advanced Beneficiary, as defined in Article 2 of the Agreement includes a beneficiary entitled to benefits under Part A and enrolled under Part B on whose behalf an Episode Initiator submits a claim to Medicare FFS for an Anchor Stay or Anchor Procedure, subject to certain exclusions. In accordance with this definition, CMS will exclude from all Reconciliation calculations Medicare FFS expenditures for items and services furnished to: (1) Medicare beneficiaries covered under United Mine Workers or managed care plans (e.g., Medicare Advantage, Health Care Prepayment Plans, or cost-based health maintenance organizations); (2) beneficiaries eligible for Medicare on the basis of an end-stage renal disease (ESRD) diagnosis; (3) Medicare beneficiaries for whom Medicare is not the primary payer; and (4) Medicare beneficiaries who die during the Anchor Stay or Anchor Procedure. A BPCI Advanced Beneficiary must meet this definition for the full duration of the Clinical Episode

B. Benchmark Price Determination

As defined in Article 2 of the Agreement, the Target Price is calculated as the Benchmark Price multiplied by one minus the applicable CMS Discount. The Benchmark Prices used in calculating the Target Price are calculated for each Episode Initiator using a compound log-normal model followed by an ordinary least squares regression, which provides for the flexibility to include risk adjustment and trending over time. Using a national set of Medicare FFS claims, with discharges occurring within a four-year baseline period (which initially will be between January 1, 2013 and December 31, 2016), all claims submitted by the Episode Initiator that included a qualifying MS-DRG or HCPCS code are identified as the anchor claims. Clinical Episodes are then constructed to include the anchor claim and all Part A and Part B claims for items and services furnished to the beneficiary identified on that anchor claim during the 90-Day period following discharge from the facility or completion of the outpatient procedure. A limited list of MS-DRGs, HCPCS, and other exclusions is also applied (see BPCI Advanced Exclusions List).

The current CMS standardization methodology is applied to each claim included in the Clinical Episode and then the total allowed amounts for each individual claim is summed to calculate the total standardized Medicare FFS spending for each Clinical Episode. Standardized baseline spending is then converted to Performance Period standardized dollars using index price trending, which accounts for interim pricing updates to Medicare payment systems. This update is applied separately for each applicable setting that is part of the Clinical Episode, including inpatient hospital, Part B claims, skilled nursing facility, hospice, home health, inpatient rehabilitation facility, and all other services. Applying the setting-specific update factors results in a baseline spending amount that is adjusted for inflation and Medicare fee schedule updates. As a final step, total Medicare FFS spending for each Clinical Episode is Winsorized at the 1st and 99th percentiles of total standardized allowed amounts at the MS-DRG/APC-fiscal year level within the Clinical Episode during each baseline calendar year.

The Benchmark Price for each Clinical Episode will be calculated in two separate ways: (1) prospectively, using historical patient data from the baseline period described above, which will be used to estimate preliminary Target Prices for each Episode Initiator; and (2) retrospectively, based on the actual patient case mix, which will be used to calculate the final Target Prices. For each Model Year, the prospective Benchmark Price will be calculated prior to the start of the Model Year and, will be updated in October of the Model Year to account for changes to payment rates for SNF and IRF services, as well as hospital payments made under the Medicare Inpatient Prospective Payment System final rule for that fiscal year. It will also be updated in January of the Model Year to account for changes in OPPS, Home Health, and PFS settings. The retrospective Benchmark Price will then be calculated for each Clinical Episode during semi-annual Reconciliation by applying the actual patient case mix to the preliminary Target Price current on the date of discharge (for an Anchor Stay) or the date the Anchor Procedure is completed (for an Anchor Procedure).

C. Target Price Calculation

The CMS Discount will be applied to the Benchmark Prices to calculate the Target Prices. Preliminary Target Prices will be prospectively estimated by applying the CMS Discount to the prospective Benchmark Price calculated based on historical patient case-mix. Final Target Prices will be calculated during semi-annual Reconciliation by applying the CMS Discount to the retrospective Benchmark Price that reflects the realized patient case-mix. Target Prices for the Participant will be calculated on an Episode Initiator-specific basis for each Clinical Episode. An ACH Episode Initiator will receive its own Target Price for each Clinical Episode based on the ACH's baseline spending, subject to certain adjustments. BPCI Advanced bases the PGP's Benchmark Price for each Clinical Episode upon the Benchmark Price specific to the ACH where services were furnished during the Anchor Stay or Anchor Procedure that initiated that Clinical Episode, with adjustments for the following: (1) differences in the PGP's efficiency relative to the ACH where the Anchor Stay or Anchor Procedure occurred; and (2) differences in PGP patient case mix relative to that of each ACH where the Anchor Stay or Anchor Procedure occurred. When appropriate, CMS may update either the preliminary Target Prices or final Target Prices based on applicable payment system updates.

Preliminary Target Prices will only be generated for ACHs with at least 41 Clinical Episodes in the applicable baseline period. If volume is insufficient to generate a preliminary Target Price for a Clinical Episode, for the following Model Year, a preliminary Target Price may be generated if the average volume per year in the two most recent calendar years of the applicable baseline period is more than 10 Clinical Episodes.

CMS may, in CMS's sole discretion and without the consent of the Participant, modify the Target Price calculation methodology described in this Appendix A. To the extent practicable, CMS will notify the Participant of any changes to the Target Price calculation methodology at least 90 Days in advance of the effective date thereof.

III. <u>CQS Adjustment Amount Calculation</u>

BPCI Advanced includes a pay-for-performance mechanism. Under the BPCI Advanced Model, the Participant and all Downstream Episode Initiators and Participating Practitioners will report and be evaluated based on the applicable quality measures sets as described in Article 4.3 and Appendix D of this Agreement. Based on the method of data collection for a particular quality measure, the Participant may need to collect the data from an Episode Initiator or Participating Practitioner and report it to CMS. For each Clinical Episode, a volume-weighted quality score will be determined for each quality measure for which the Participant and its Downstream Episode Initiators and Participating Practitioners are responsible pursuant to Article 4.3 and Appendix D of the Agreement. The Composite Quality Score (CQS) is calculated at the Episode Initiator level by summing the volume-weighted scores scaled for each Clinical Episode attributed to the Episode Initiator. The CQS Adjustment Amount is a continuous function of the CQS and will be used to adjust a portion of any Positive Total Reconciliation Amount and any Negative Total Reconciliation Amount in calculating the Adjusted Positive Total Reconciliation Amount and Adjusted Negative Reconciliation Amount, respectively. The Adjusted Positive Total Reconciliation Amount and Adjusted Negative Reconciliation Amount will be used, in turn, to calculate either the Net Payment Reconciliation Amount (NPRA) paid to the Participant by CMS or the Repayment Amount paid to CMS by the Participant. The CQS Adjustment Amount under BPCI Advanced will apply to only 10 percent of any Positive Total Reconciliation Amount or to only 10 percent any Negative Total Reconciliation Amount that an Episode Initiator may realize under the initiative. In other words, the CQS Adjustment Amount will not adjust the Positive Total Reconciliation Amount down by more than 10 percent, nor will it adjust the Negative Total Reconciliation Amount up (meaning more towards a positive amount) by more than 10 percent.

IV. Reconciliation

A. Reconciliation Calculation

BPCI Advanced will involve a retrospective bundled payment mechanism that involves semi-annual Reconciliation against prospectively determined Clinical Episode-specific Target Prices. If, during the semi-annual Reconciliation, the AFP for a Clinical Episode exceeds the final Target Price for that Clinical Episode, the result is a Negative Reconciliation Amount. If, on the other hand, the AFP for a Clinical Episode is less than the final Target Price for that Clinical Episode, the result is a Positive Reconciliation Amount. Winsorization will be applied to each Clinical Episode at the 1st and 99th percentiles of total standardized allowed amounts at the MS-DRG/APC-fiscal year level prior to the Reconciliation calculation.

CMS will sum the Negative Reconciliation Amounts and Positive Reconciliation Amounts for all Clinical Episodes attributed to an Episode Initiator for the applicable Performance Period. If this results in a positive number, CMS will adjust this Positive Total Reconciliation Amount by the CQS Adjustment Amount described above, resulting in the Adjusted Positive Total Reconciliation Amount. For Non-Convener Participants, this amount is the Net Payment Reconciliation Amount (NPRA). For Convener Participants, CMS will sum all Adjusted Positive Total Reconciliation Amounts and Adjusted Negative Total Reconciliation Amounts for the Convener Participant and its Downstream Episode Initiators. If this results in a positive

amount, it is the NPRA and CMS will pay the resulting amount to the Participant. For both Convener Participants and Non-Convener Participants, the NPRA payment is subject to a stop-gain provision at the Episode Initiator level, which will prevent an Adjusted Positive Total Reconciliation Amount from being in excess of 20 percent of the final Target Price for a given Episode Initiator.

If, on the other hand, the sum of the Negative Reconciliation Amounts and Positive Reconciliation Amounts for all Clinical Episodes attributed to an Episode Initiator results in a negative number, CMS will adjust this Negative Total Reconciliation Amount by the CQS Adjustment Amount described above, resulting in the Adjusted Negative Total Reconciliation Amount. For Non-Convener Participants, this amount is the Repayment Amount. For Convener Participants, CMS will sum all Adjusted Positive Total Reconciliation Amounts and all Adjusted Negative Total Reconciliation Amounts for the Convener Participant and its Downstream Episode Initiators. If this resulting amount is negative, then it is the Repayment Amount and the Participant will pay this resulting amount to CMS. However, the Participant's Repayment Amount is subject to a stop-loss provision at the Episode Initiator level, which will prevent an Adjusted Negative Total Reconciliation Amount from being in excess of 20 percent of the final Target Price for a given Episode Initiator.

B. Reconciliation Process

Semi-annually, CMS will perform an initial Reconciliation for the immediately preceding Performance Period using two months' claims run-out from the end of the Performance Period to determine whether the Participant is eligible for an NPRA payment or owes CMS a Repayment Amount. CMS will adjust the initial Reconciliation calculations for each Performance Period at least twice, through subsequent true-up Reconciliation calculations with additional claims run-out. Data on the quality measures identified in Appendix D of this Agreement will also be used to adjust Reconciliation calculations in accordance with this Appendix.

The first true-up Reconciliation will recalculate the NPRA or Repayment Amount with eight months' claims run-out and newly available data on the quality measures identified in Appendix D of the Agreement. The results of this first true-up Reconciliation for a Performance Period will be compared against the initial Reconciliation calculation for the same Performance Period. Any differences between the initial Reconciliation calculation and the first true-up Reconciliation calculation for a Performance Period will be netted against the NPRA or Repayment Amount specified in the initial Reconciliation Report for that Performance Period, deemed to be final in accordance with Article 7.3(a)(3), Article 7.3(b)(3), Article 7.3(b)(4), or Article 7.3(c)(3) of the Agreement.

The second true-up Reconciliation will recalculate the NPRA or Repayment Amount with fourteen months' claims run-out and newly available data on quality measures identified in Appendix D of the Agreement. The results of the second true-up Reconciliation for a Performance Period will be compared against the first true-up Reconciliation calculation for

that Performance Period, deemed to be final in accordance with Article 7.3(a)(3), Article 7.3(b)(3), Article 7.3(b)(4), or Article 7.3(c)(3), or any subsequent Reconciliation Report.

The sum of any differences between the first true-up Reconciliation amount and the second true-up Reconciliation amount for a Performance Period will be netted against the NPRA or Repayment Amount specified in the initial Reconciliation Report for that Performance Period deemed to be final in accordance with Article 7.3(a)(3), Article 7.3(b)(3), Article 7.3(b)(4), or Article 7.3(c)(4), or any subsequent Reconciliation Report.

An initial Reconciliation Report may specify NPRA payments and Repayment Amounts that have been adjusted as necessary to account for true-up Reconciliations for at least the two preceding Performance Periods. CMS may also make adjustments to the NPRA or Repayment Amount by issuing a revised Reconciliation Report. CMS will inform the Participant prior to conducting additional true-up Reconciliations.

V. Post-Episode Spending Calculation

The Post-Episode Spending Calculation will be performed by CMS on a semi-annual basis during the first true-up Reconciliation. A preliminary Episode Initiator-specific benchmark price for the Post-Episode Spending Monitoring Period will be calculated in the same manner as for the Episode Initiator-specific Target Prices calculated for each Clinical Episode, as described above. If the total dollar amount of Medicare Fee-for-Service (FFS) expenditures for items and services furnished to a BPCI Advanced Beneficiary during the 30-Day Post-Episode Monitoring Period exceeds that benchmark price by a risk threshold, based on a 99.5 percent confidence interval around the expected spending the Post-Episode Spending Monitoring Period, the result would be an Excess Spending Amount that must be repaid to CMS in accordance with Article 7 of the Agreement.

VI. Interactions with Other Initiatives

A. Interactions with Shared Savings Initiatives

In the event that a BPCI Advanced Beneficiary is aligned or assigned to an ACO participating in the Next Generation ACO Model, Vermont Medicare ACO Initiative, the Comprehensive ESRD Care Initiative in tracks with downside risk for financial losses, or any successor track or initiative, the AFP for all items and services furnished to that BPCI Advanced Beneficiary will be excluded from the Reconciliation Calculations under BPCI Advanced. For BPCI Advanced Beneficiaries not aligned or assigned to these models and initiatives, Participants who also participate in the Next Generation ACO Model, Vermont Medicare ACO Initiative, the Comprehensive ESRD Care Initiative, or any successor track or initiative may be able to trigger BPCI Advanced Clinical Episodes. BPCI Advanced will not exclude Medicare FFS expenditures for items and services furnished to Beneficiaries assigned to Shared Savings Program ACOs in Track 1, Track 2, the BASIC track, the ENHANCED track, or the Track 1+ Model.

B. Interactions with Non-SSI Innovation Center Initiatives

In the event that a Participant or, as applicable, a Downstream Episode Initiator is also participating in an Innovation Center model implemented via regulation (e.g., the Comprehensive Care for Joint Replacement (CJR) Model), the Participant will not be permitted to select clinical episodes included in those models under BPCI Advanced. For example, all episodes included in CJR will be excluded from Reconciliation under BPCI Advanced. Furthermore, in the event the Participant is located in one or more Metropolitan Statistical Areas included in an Innovation Center model implemented via regulation (e.g., the CJR Model), CMS will exclude from the BPCI Advanced Reconciliation calculation all Clinical Episodes included in that model.

In the event that a Participant or, as applicable, an Episode Initiator participating in BPCI Advanced pursuant to an agreement with the Participant is also a participant in the Oncology Care Model (OCM), BPCI Advanced Clinical Episodes and OCM Episodes will run concurrently. In the event a BPCI Advanced Clinical Episode overlaps with one or more OCM Episodes, CMS will adjust the OCM performance-based payments to account for the BPCI Advanced NPRA or Repayment Amount, prorated based on the proportion of the BPCI Advanced Clinical Episode that overlaps with the OCM Episode. In the event of overlap with a future episode-based model (other than a model implemented via regulation, as described above), CMS will, in CMS's sole discretion and without the consent of the Participant, update this Appendix A to reflect the methodology that will be used to adjust the BPCI Advanced NPRA or Repayment Amount. To the extent practicable, CMS will notify the Participant of any such methodology at least 90 Days in advance of the effective date thereof.

C. Additions and Removals of Clinical Episodes and Episode Initiators

The Participant may add or remove Clinical Episodes and Episode Initiators by submitting an updated Participant Profile in accordance with Article 5.5 of the Agreement.

For purposes of Reconciliation calculations, the removal of a Clinical Episode or Episode Initiator will be applied only prospectively. Specifically, CMS will reconcile all Clinical Episodes that were initiated prior to the start of the Performance Period in which the removal of the relevant Clinical Episode or Episode Initiator becomes effective, regardless of when the Clinical Episode ends or whether the Clinical Episode extends beyond the start of that Performance Period. In the case of additions, Reconciliation calculations and Reconciliation Reports will include NPRA Payments and Repayment Amounts associated with Clinical Episodes that were initiated on or after the first day of the Performance Period in which the addition of the relevant Clinical Episode type or Episode Initiator becomes effective.

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 3 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) CMS will provide an updated Secondary Repayment Source File to the Participant for each subsequent Model 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.

(d) 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 a Secondary Repayment Source on behalf of the SRS Covered Participant. The Secondary Repayment Source 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 Year 3 is October 1, 2014 through September 30, 2018. 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.

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**").

(b) 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.

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

7. 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 Performance Period ongoing at the end of the Agreement Performance Period or until all of the Participant's financial obligations to CMS pursuant to this Agreement have been fulfilled, whichever is later.

APPENDIX C

Standard Secondary Repayment Source Escrow Agreement Template

****Please do not populate the blank fields in this Appendix**

THIS ESCROW AGREEMENT (the "Agreement") dated as of _____, is by and between _____, [full legal name of Participant] ("Depositor"); the United States Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services ("Recipient" or "CMS"); and _____ [bank or institution name], a national banking association, as Escrow Agent hereunder ("Agent"), collectively, the "Parties" to this Agreement.

Depositor has entered into an agreement with Recipient, effective _____ [Effective Date of the Participation Agreement pursuant to Article 1.1], governing the Depositor's participation in the Bundled Payment for Care Improvement Advanced ("BPCI Advanced") initiative**.** Pursuant to such agreement (the "BPCI Advanced Participation Agreement"), Depositor must guarantee its ability to pay Recipient amounts that Recipient determines, in accordance with the BPCI Advanced Participation Agreement, are owed to it by Depositor ("Amounts Owed"). Accordingly, Depositor shall periodically deposit funds in a segregated escrow account ("Account"), up to the amount specified by Recipient in accordance with BPCI Advanced Participation Agreement, to be held by Agent for the purpose of paying Amounts Owed by Depositor. Should the Depositor fail to pay Recipient the Amounts Owed by the deadline set forth in the BPCI Advanced Participation Agreement, the Assets (as defined below) shall be paid to Recipient in an amount not to exceed the Amounts Owed.

The funds described in Schedule I, below and incorporated herein, including interest thereon, (the "Assets") will be deposited in the Account upon delivery thereof to the Agent at its office

in _____, in the manner and at the time(s) specified in Schedule I. The Agent is hereby authorized and directed by the Depositor and Recipient, as their escrow agent, to hold, deal with and dispose of the Assets as provided in the Instructions set forth in Schedule II attached hereto and incorporated herein; subject, however, to the terms and conditions set forth below, which in all events, shall govern and control over any contrary or inconsistent provisions contained in Schedules I or II attached hereto.

1. **Agent's Duties.** Agent's duties and responsibilities shall be limited to those expressly set forth in this Agreement, and Agent shall not be subject to, or obliged to recognize, any other agreement between or among the Depositor, the Recipient, or any other persons even though reference thereto may be made herein; provided, however, this Agreement may be amended at any time or times by an instrument in writing signed by the Parties hereto. Agent shall not be subject to or obligated to recognize any notice, direction or instruction of the Depositor, the Recipient, or any other person, except as expressly provided for and authorized in Schedule II. In performing any duties under this Agreement, Agent shall not be liable to the Depositor or other party for consequential damages, (including, without limitation lost profits) losses, or expenses, except for gross negligence or willful misconduct on the part of the Agent.
2. **Court Orders or Process.** If any controversy arises between or among the Parties to this Agreement, or with any other person, concerning the subject matter of this Agreement, its terms or conditions, Agent will not be required to determine the controversy or to take any action regarding it. Agent may hold all documents and funds and may wait for settlement of any such controversy by final appropriate legal proceedings or other means as, in Agent's discretion, Agent may require, despite what may be set forth elsewhere in this Agreement. In such event, Agent will not be liable for interest or damage. Agent is authorized, in its sole discretion, to comply with orders issued or process entered by any court with respect to the Account, the Assets or this

Agreement, without determination by the Agent of such court's jurisdiction in the matter. If any Assets are at any time attached, garnished, or levied upon under any court order, or in case the payment, assignment, transfer, conveyance or delivery of any such property shall be stayed or enjoined by any court order, or in case any order, judgment or decree shall be made or entered by any court affecting such property or any part thereof, then in any such events Agent is authorized, in its sole discretion, to rely upon and comply with any such order, writ, judgment or decree which it is advised by legal counsel of its own choosing is binding upon it; and if Agent complies with any such order, writ, judgment or decree, it shall not be liable to the Depositor or to any other person, firm or corporation by reason of such compliance even though such order, writ, judgment or decree may be subsequently reversed, modified, annulled, set aside or vacated.

3. **Agent's Actions and Reliance.** Agent shall not be personally liable for any act taken or omitted by it hereunder if taken or omitted by it in good faith and in the exercise of its own best judgment. Agent shall also be fully protected in relying upon any written notice, instruction, direction, certificate or document which in good faith it believes to be genuine.

4. **Collections.** Unless otherwise specifically indicated in Schedule II, Agent shall proceed as soon as practicable to collect any checks, interest due, matured principal or other collection items with respect to Assets at any time deposited in the Account. All such collections shall be subject to the usual collection procedures regarding items received by Agent for deposit or collection. Agent shall not be responsible for any collections with respect to Assets if Agent is not registered as record owner thereof or otherwise is not entitled to request or receive payment thereof as a matter of legal or contractual right. All collection payments shall be deposited to the Account, except as otherwise provided in Schedule II. Agent shall not be required or have a duty to notify anyone of

any payment or maturity under the terms of any instrument, security or obligation deposited in the Account, nor to take any legal action to enforce payment of any check, instrument or other security deposited in the Account. The Account is a safekeeping escrow account, and no interest shall be paid by Agent on any money deposited or held therein, except as provided in Section 6 hereof.

5. **Agent Responsibility.** Agent shall not be responsible or liable for the sufficiency or accuracy of the form, execution, validity or genuineness of documents, instruments or securities now or hereafter deposited in the Account, or of any endorsement thereon, or for any lack of endorsement thereon, or for any description therein. Agent shall not be responsible or liable in any respect on account of the identity, authority or rights of the persons executing or delivering or purporting to execute or deliver any such document, security or endorsement or this Agreement.

6. **Investments.** All monies held in the Account shall be invested by Agent in its name or its nominee's name, in such instruments or securities and at the written direction of Recipient, as expressly authorized in Schedule II. The Recipient shall furnish the Agent with written instructions to sell securities (including shares or units in any money market mutual funds) to make any payments from the Account as provided hereunder. If no such instructions are received, Agent is authorized to sell any such securities held in the Account as necessary for that purpose. Agent shall not be responsible for the selection, quality or maturity of such investments or for the timely reinvestment of interest or maturity proceeds thereof except as provided in the immediately following paragraph.

   In the absence of duly authorized and complete directions regarding investment of cash held in the Account, Agent shall automatically invest and reinvest the same in units of the interest-bearing money market account identified on Schedule III attached hereto and incorporated herein, which account may be managed by an affiliate of the Agent.

Monies credited to any account or fund maintained hereunder which are uninvested pending disbursement or receipt of proper investment directions or as directed herein, may be deposited to and held in a non-interest-bearing demand deposit account established with the Agent or with any bank affiliated with the Agent, without the pledge of securities to or other collateralization of such deposit accounts.

The Depositor and Recipient acknowledge and agree that the Agent is authorized to invest from or through its trust department or any other bank affiliated with Agent through common control.

7. **Notices/Directions to Agent.** Notices and directions to Agent from Depositor, or from other persons authorized to give such notices or directions as expressly set forth in Schedule II, shall be in writing and signed by an authorized representative as identified pursuant to Schedule II, and shall not be deemed to be given until actually received by Agent's employee or officer who administers the Account. Agent shall not be responsible or liable for the authenticity or accuracy of notices or directions properly given hereunder if the written form and execution thereof on its face purports to satisfy the requirements applicable thereto as set forth in Schedule II, as determined by Agent in good faith without additional confirmation or investigation.

8. **Books and Records.** Agent shall maintain books and records regarding its administration of the Account, and the deposit, investment, collections and disbursement or transfer of Assets, shall retain copies of all written notices and directions sent or received by it in the performance of its duties hereunder, and shall afford Depositor and Recipient reasonable access, during regular business hours, to review and make photocopies (at Depositor's cost) of the same.

9. **Depositor Disputes.** In the event Agent is notified of any dispute, disagreement or legal action between or among the Depositor, the Recipient, and/or any third parties, relating to or arising in connection with the Account, the Assets, or the performance of the

Agent's duties under this Agreement, the Agent shall be authorized and entitled, subject to Section 2 hereof, to suspend further performance hereunder, to retain and hold the Assets then in the Account and take no further action with respect thereto until the matter has been fully resolved, as evidenced by written notification signed by the Depositor and any other parties to such dispute, disagreement or legal action. This paragraph shall not apply in the case of a dispute, disagreement, or legal action taken by Depositor to contest the accuracy of any determination letter that is issued pursuant to the BPCI Advanced Participation Agreement. For purposes of this Agreement, any such dispute, disagreement, or legal action shall be resolved as described in Schedule II.

10. **Notice by Agent.** Any notices which Agent is required or desires to give hereunder to the Depositor or Recipient shall be in writing and shall be delivered by hand or overnight courier service, mailed by United States certified or registered mail, postage prepaid, or sent by facsimile or email (attached as a portable document format (.pdf) only) to the applicable address, facsimile number or email address indicated below (or to such other address as said Depositor or Recipient may have theretofore substituted therefor by written notification to Agent. For all purposes hereof, any notice so mailed shall be as effectual as though served upon the person of the Depositor or Recipient to whom it was mailed at the time it is deposited in the United States mail by Agent whether or not such undersigned thereafter actually receives such notice. Whenever, under the terms hereof the time for Agent's giving a notice or performing an act falls upon a Saturday, Sunday, or holiday, such time shall be extended to the next business day.

Recipient:
Christina Ritter
Director, Patient Care Models Group
Center for Medicare and Medicaid Innovation
CMS
2810 Lord Baltimore Drive

Mailstop: WB-06-05
Baltimore, MD 21244
Email: BPCIAdvanced@cms.hhs.gov

Depositor:

_____
_____
_____
_____
_____
_____
Email: _____

11. **Legal Counsel.** If Agent believes it to be reasonably necessary to consult with counsel concerning any of its duties in connection with the Account or this Agreement, or in case Agent becomes involved in litigation on account of being escrow agent hereunder or on account of having received property subject hereto, then in either case, its costs, expenses, and reasonable attorney's fees shall be paid by the Depositor.
12. **Agent Compensation.** Agent shall be paid a fee for its services as set forth on Schedule IV attached hereto and incorporated herein, which shall be subject to increase upon notice sent to Depositor and Recipient, and reimbursed for its reasonable costs and expenses incurred (including legal fees and expenses of its counsel). If Agent's fees, or reasonable costs or expenses, provided for herein, are not promptly paid, Agent may be paid from interest earned on funds held in or earned on the Account, but the principal shall not be charged, used as an offset, or otherwise encumbered by the Agent or the Depositor. In the event that the conditions of this Agreement are not promptly fulfilled, or if Agent renders any service not provided for in this Agreement, or if the Parties request a substantial modification of its terms, or if any controversy arises, or if Agent is made a Party to, or intervenes in, any litigation pertaining to this escrow or its subject matter, Agent shall be reasonably compensated for such extraordinary services and reimbursed for all costs, attorney's fees, including allocated costs of in-house counsel,

and expenses occasioned by such default, delay, controversy or litigation. The Depositor promises to pay these sums upon demand. The Depositor and its respective successors and assigns agree jointly and severally to indemnify and hold Agent harmless against any and all losses, claims, damages, liabilities, and expenses, including reasonable costs of investigation, counsel fees, including allocated costs of in-house counsel and disbursements that may be imposed on Agent or incurred by Agent in connection with the performance of his/her duties under this Agreement, including but not limited to any litigation arising from this Agreement or involving its subject matter. The obligations of the Parties under this Section 12 shall survive the resignation or removal of the Agent and the termination of this Agreement.

13. **Agent Resignation.** It is understood that Agent reserves the right to resign at any time by giving written notice of its resignation, specifying the effective date thereof, to the Depositor and Recipient. Within 30 days after receiving the aforesaid notice, the Recipient agrees to appoint a successor escrow agent to which Agent may transfer the Assets then held in the Account, less any deduction permitted under this Agreement for its unpaid fees, costs and expenses. If a successor escrow agent has not been appointed and has not accepted such appointment by the end of the 30-day period, Agent may apply to a court of competent jurisdiction for the appointment of a successor escrow agent, and the costs, expenses and reasonable attorney's fees which Agent incurs in connection with such a proceeding shall be paid by the Depositor.

14. **Escrow Termination.** This Agreement shall be terminated as provided in Schedule II, at which time the Assets then held in the Account, less Agent's unpaid fees, costs and expenses shall be returned to the Depositor.

15. **Governing Law.** This Agreement shall be construed, enforced, and administered in accordance with the laws of the State of _____, to the extent not inconsistent with federal law. The undersigned Agent hereby agrees to hold, deal with, and dispose of the

Assets at any time deposited to the Account in accordance with the foregoing Agreement.

16. **Automatic Succession.** Any company into which the Agent may be merged or with which it may be consolidated, or any company to whom Agent may transfer a substantial amount of its Escrow business, shall be the Successor to the Agent without the execution or filing of any paper or any further act on the part of any of the Parties, anything herein to the contrary notwithstanding.

17. **Tax Reporting.** The Agent shall have no responsibility for the tax consequences of this Agreement. The Agent hereby advises each party to this escrow to consult with independent legal counsel concerning the tax ramifications of this transaction.

18. **Facsimile.** This Agreement may be executed in any number of counterparts, each of which shall be deemed to be one and the same instrument. The exchange of copies of this Agreement and of signature pages by facsimile transmission shall constitute effective execution and delivery of this Agreement as to the Parties and may be used in lieu of the original Agreement for all purposes. Signatures of the Parties transmitted by facsimile shall be deemed to be their original signatures for all purposes.

19. **Patriot Act.** To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. For a non-individual person such as a business entity, a charity, a Trust or other legal entity Agent will ask for documentation to verify its formation and existence as a legal entity. Agent may also ask to see financial statements, licenses, identification, and authorization documents from individuals claiming authority to represent the entity or other relevant documentation.

20. **Security Advice Waiver Language**

The Depositor acknowledges that regulations of the Comptroller of the Currency grant the Depositor the right to receive brokerage confirmations of security transactions as they occur. The Depositor specifically waives such notification to the extent permitted by law and acknowledges that the Depositor will receive periodic cash transaction statements, which will detail all investment transactions.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed under seal as of the date first above written.

DEPOSITOR

By: _____
Name: _____
Title: _____
Date: _____

RECIPIENT

By: _____
Name: _____
Title: _____
Date: _____

as Escrow Agent

By: _____
Name: _____
Title: _____
Date: _____

Attachments:
Schedule I
Schedule II
Exhibit A
Schedule III
Schedule IV

SCHEDULE I

Account Assets

Unless otherwise approved in advance by Recipient, all Assets shall be deposited in cash as often as required by Appendix B of the BPCI Advanced Participation Agreement, but not more frequently than on a quarterly basis.

Depositor shall provide Agent with at least two business days advance written notice of the expected amount of any deposit made after the initial deposit.

SCHEDULE II
Instructions of Depositor

1. Immediately upon deposit, all monies held in the Account shall be invested by Agent in Treasury-backed securities. Upon deposit and at such other times as may be requested by Recipient, Agent shall notify Recipient of the date and amount of each deposit and other Account transaction.

2. Agent shall dispose of the Assets only upon periodic written instruction from an authorized representative of Recipient. Such written instructions may be in the form of Exhibit A and shall:

   a) Identify the Amounts Owed, as determined by CMS and set forth in a written notification (the "Demand Letter") issued by CMS to Depositor in accordance with the BPCI Advanced Participation Agreement.

   b) Identify the Amounts Owed that Depositor has failed to pay by the date indicated in the Demand Letter (the "Debt")

   c) Instruct Agent to convert the Assets to cash and dispose of them as follows:

      i. If the cash value of the Assets is less than or equal to the amount of the Debt, Agent shall deliver to Recipient payment by check or wire transfer in the amount of the full cash value of the Assets.
      ii. If the cash value of the Assets exceeds the amount of the Debt, Agent shall deliver to Recipient payment by check or wire transfer in the amount cited of the Debt.

3. The Account shall remain open, and this Agreement shall not terminate, until five days after the date of a letter from Recipient to Agent certifying that the Depositor has satisfied all outstanding Amounts Owed for services performed during the Agreement Term of the BPCI Advanced Participation Agreement. It is anticipated that such a letter would be issued no later than _____. Upon termination of this Agreement, the Agent shall return the remaining full cash value of the Assets, if any, to Depositor, less Agent's unpaid fees, costs and expenses, by [ ] check, or [ ] wire transfer as follows:

   Recipient Receiving Bank:

   _____

   ABA # _____
   Beneficiary Account Name: _____
   Beneficiary Account Number: _____
   Beneficiary Account Address: _____
   _____
   OBI: _____
   Ref: _____
   Contact Name and Phone Number: _____

4. Unless otherwise specified by written notice of the Parties, the following persons are authorized to provide instructions from Depositor or Recipient, as the case may be, to Agent, consistent with the terms of this Agreement:

Depositor:

Name:

Title:

Specimen Signature

Date:

Recipient:

Name:

Title:

Specimen Signature

Date:

Exhibit A

Certification of Amounts Owed

RE: _____, as Escrow Agent ("Agent") under that certain Escrow Agreement (the "Escrow Agreement"), dated _____, 20__, by and among Agent, _____ ("Depositor"), and the United States Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), acting through the Center for Medicare and Medicaid Innovation (CMMI) ("Recipient")

Pursuant to the BPCI Advanced Participation Agreement and Schedule II of the Escrow Agreement, the undersigned hereby certifies to the Agent as follows:

1. Depositor owes $_____ ("Amount Owed"), as determined by CMS and set forth in the demand letter issued by CMS in accordance with the BPCI Advanced Participation Agreement and dated _____(the "Demand Letter");
2. Depositor has failed to pay $_____ of such Amount Owed (the "Debt") as of the date specified in the Demand Letter;
3. Recipient is entitled to payment from the escrow account ("Account") in an amount equal to the lesser of the Debt or the full cash value of the Assets on deposit in the Account; and
4. Agent is instructed to convert the Assets to cash and to remit the amount specified in paragraph 3 above to Recipient by [ ] check, or [ ] wire transfer as follows:

   Recipient Receiving Bank: _____
   ABA # _____
   Beneficiary Account Name: _____
   Beneficiary Account Number: _____
   Beneficiary Account Address: _____
   _____
   OBI: _____
   Ref: _____
   Contact Name and Phone Number: _____

5. Even if Agent's action pursuant to these instructions fully depletes the Account, Agent shall not close Account until it has received from Recipient separate written instructions to close the Account.

All terms used herein but not defined shall have such meaning as is ascribed to them by the Escrow Agreement or the BPCI Advanced Participation Agreement, as the case may be.

United States Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS),

("Recipient")

By:

Name:

Title:

Date:

SCHEDULE III

Money Market Accounts
Account and Description Terms

The _____ is a _____ interest-bearing money market deposit account designed to meet the needs of _____ and other Corporate Trust customers of _____. Selection of this investment includes authorization to place funds on deposit with _____.

_____ uses the daily balance method to calculate interest on this account. This method applies a daily periodic rate to the principal balance in the account each day. Interest is accrued daily and credited monthly to the account. Interest rates are determined at _____'s discretion and may be tiered by customer deposit amount.

The owner of the account is U.S. Bank as Agent for its trust customers. _____'s trust department performs all account deposits and withdrawals.

Account Number: _____

RECIPIENT

By:

_____

Name:

_____

Title:

_____

Date:

_____

SCHEDULE IV
Escrow Agent's Fees

Acceptance Fee: .....$
Escrow Administration Fee: .....$

Transaction Expenses:
Per Wire Transfer or Check: .....$

Per Security Purchase/Sale: .....$
Legal Fees and Expenses:……..$

The above-mentioned Acceptance and Administration Fees will be billed to Depositor. Legal fees and expenses will be billed to Depositor as required. Out-of-pocket expenses shall include, but are not limited to: telephone tolls, stationery, travel and postage expenses.
Charges for performing extraordinary or other services not contemplated at the time of the execution of the transaction or not specifically covered elsewhere in this schedule will be determined by appraisal in amounts commensurate with the service to be provided. Counsel fees, if ever retained as a result of default or other extraordinary occurrence on behalf of the bondholders or _____, will be billed at cost.
Services not included in this Fee Schedule, but deemed necessary or desirable by Depositor or Recipient, may be subject to additional charges based on a mutually agreed upon fee schedule.

In the event we are required to handle a default situation, we will charge an hourly rate for performing extraordinary services in addition to the services covered by our Annual Escrow Agent Fee. The hourly rates charged will be those which are published in the Fee Section of our Bond Administration Policy & Procedure Manual at the time the default occurs.

To help the government fight the funding of terrorism and money laundering activities, Federal Law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. For a non-individual person such as a business entity, a charity, a Trust, or other legal entity, we ask for documentation to verity its formation and existence as a legal entity. We may also ask to see financial statements, licenses, identification, and authorization documents from individuals claiming authority to represent the entity or other relevant documentation. To this extent, please provide all contact information for Parties to the agreement including Tax ID/identification numbers.

Our acceptance of this transaction is subject to the review and approval of our _____.

APPENDIX D
Quality Measures List and Reporting Requirements

The quality measures identified in the table below will be used for the purposes of calculating the Participant's CQS and CQS Adjustment Amount and for monitoring and evaluating the overall quality of care in BPCI Advanced. The measures identified in the table below will be used to evaluate the Participant's performance for each Performance Period.

The Parties acknowledge and agree that CMS may remove any of the quality measures at CMS's discretion from the Required Quality Measures Set below with 30 Days' notice to the Participant, to be provided in writing. Quality measures removed by CMS will no longer be used by CMS to evaluate the Participant, and the Participant will no longer be accountable for such quality measures, applicable at the start of the Performance Period in which the measure is removed. .

The Participant will be accountable for the quality measures in the Required Quality Measures Set. The Participant will be responsible for all applicable quality measures, medical and/or surgical, as well performance on these measures for each Clinical Episode by the Participant, if the Participant is a provider or supplier, and by Downstream Episode Initiators and Participating Practitioners, if the Participant is a Convener Participant.

Required Quality Measures Set

All Clinical Episodes
All-Cause Hospital Readmission Measure (CMS 458; NQF #1789)
Advance Care Plan (CMS 047; NQF #0326*) *NQF-endorsed at the physician-level. See the BPCI Advanced Reconciliation Specifications on the BPCI Advanced webpage for information regarding the applicability of this quality measure.
AHRQ Patient Safety Measures (PSI 90; NQF #0531)
All Surgical Clinical Episodes
Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin (CMS 021; NQF #0268)
Acute Myocardial Infarction
AMI Excess Days: Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (CMS 2706; NQF #2881)
Coronary Artery Bypass Graft Surgery
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery (CABG) (CMS 2264; NQF #2558)
Double joint replacement of the lower extremity
Hospital-Level Risk-Standardized Complication Rate Following Elective Primary THA and/or TKA (NQF #1550)
Hip & femur procedures except major joint

Hospital-Level Risk-Standardized Complication Rate Following Elective Primary THA and/or TKA(NQF #1550)
Major joint replacement of the lower extremity
Hospital-Level Risk-Standardized Complication Rate Following Elective Primary THA and/or TKA (NQF #1550)

APPENDIX E
3-Day SNF Rule Payment Policy Waiver

I. Waiver and Terms

CMS waives the requirement in Section 1861(i) of the Act for a three-day inpatient hospital stay prior to the provision of otherwise covered Medicare post-hospital extended care services ("**SNF Services**") furnished under the terms and conditions set forth in Article 11.2 of the Agreement and this Appendix E ("**3-Day SNF Rule Payment Policy Waiver**"), including without limitation that: the Beneficiary is discharged to a Qualified SNF as such term is defined in Section III of this Appendix E; the SNF Services are provided to a beneficiary who satisfies the eligibility criteria set forth in Section IV of this Appendix E; and all other coverage requirements for SNF Services are met.

II. Qualified SNF

(a) For purposes of this waiver, a "**Qualified SNF**" is a SNF, as defined under Section 1819(a) of the Act, that has an overall rating of three or more stars in the Nursing Home Five-Star Quality Rating System for SNFs on the CMS Nursing Home Compare Website for at least 7 of the 12 preceding months.

(b) The Qualified SNF determination is made by CMS based on the most recent rolling 12 months of SNF star rating data available that includes the date of the beneficiary's admission to the SNF. CMS will post the list of SNFs that CMS determines to be Qualified SNFs on a quarterly basis to the CMS Website. A SNF that otherwise satisfies the definition of a Qualified SNF under this waiver will not be considered to be a Qualified SNF if CMS removes the SNF from the list of Qualified SNFs on the CMS Website on the grounds that the SNF's participation in the SNF 3-Day Rule Payment Policy Waiver might compromise the integrity of the Model.

(c) The Participant must enter into a written agreement with the Qualified SNF in order for the SNF to furnish SNF Services under the 3-Day SNF Rule Waiver under Section II of this Appendix E.

III. Beneficiary Eligibility Requirements

(a) For purposes of the waiver in Section II of this Appendix E, SNF Services must be furnished to a beneficiary who:

(1) satisfies the definition of a BPCI Advanced Beneficiary at the time of discharge from the Anchor Stay;

(2) meets the criteria for inclusion in a BPCI Advanced Clinical Episode at the time of discharge from the Anchor Stay (as described in Section IV(b) of this Appendix E);

(3) satisfies the criteria described in Section IV(c) of this Appendix E; and

(4) is discharged in accordance with the CMS instructions for use of the demonstration code specified by CMS for purposes of the 3-Day SNF Rule Payment Policy Waiver.

(b) A beneficiary meets the criteria for inclusion in a BPCI Advanced Clinical Episode at the time of discharge from the Anchor Stay if, at the time of discharge, the beneficiary's diagnosis (as determined by the ICD-10-PCM codes included on the hospital claim) corresponds to an MS-DRG that is included in a Clinical Episode for which the Participant has committed to be held accountable on the Participant's CMS-accepted Participant Profile described in Article 4.2 of the Agreement.

(c) A SNF admission will be covered for a beneficiary who is discharged from an Anchor Stay to a Qualified SNF after fewer than three days of inpatient hospitalization only if, at the time of discharge from the Anchor Stay:

(1) the beneficiary is medically stable;

(2) the Anchor Stay is assigned a MS-DRG that falls under a Clinical Episode identified on the Participant's Participant Profile;

(3) the beneficiary does not require further inpatient hospital evaluation or treatment; and

(4) the beneficiary has a skilled nursing or rehabilitation need that has been identified by a physician during the Anchor Stay and that cannot be addressed on an outpatient basis.

IV. Responsibility for Denied Claims

In the event the 3-Day SNF Rule Waiver is not used in accordance with the terms and conditions in Article 11.2 of the Agreement and this Appendix E with respect to SNF Services, CMS will make no payments to the SNF for such services, the Participant must ensure that the SNF does not charge the BPCI Advanced Beneficiary for the expenses incurred for such services (and returns any applicable cost-sharing amounts already paid), and the Participant may be liable for the cost of the uncovered SNF stay, subject to the following exceptions.

(a) If a claim for any SNF Services furnished to a beneficiary by a Qualified SNF is denied as a result of a CMS error and the Qualified SNF did not know, and could not reasonably have been expected to know, that the claim would be denied, payment will, notwithstanding such denial, be made by CMS for such SNF Services under the terms and conditions of the waiver in Section II of this Appendix E as though the coverage denial had not occurred.

(b) If a claim for any SNF Services furnished to a beneficiary by a Qualified SNF is denied for any reason other than a CMS error and CMS determines that the Qualified SNF did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services:

(1) CMS will, notwithstanding such determination, pay for such SNF Services under the terms and conditions of the waiver in Section II of this Appendix E as though the coverage denial had not occurred, but CMS will withhold these payments from the Participant's NPRA payment or will add these payments to the Participant's Repayment Amount, as applicable.

(2) the Participant shall not charge, and shall ensure that the Qualified SNF that provided the SNF Services does not charge the beneficiary for the expenses incurred in furnishing such services; and

(3) as applicable, the Participant shall return, or shall ensure that the Qualified SNF that provided the SNF Services returns to the beneficiary any monies collected from the beneficiary.

V. Compliance and Enforcement

(a) The Participant shall submit to CMS, by a time and in a manner determined by CMS, information regarding the Participant's use of the 3-Day SNF Rule Payment Policy Waiver, upon request.

(b) CMS will monitor Participants' use of the 3-Day SNF Rule Payment Policy Waiver to ensure that medical transfers to a SNF are medically appropriate and consistent with the terms and conditions of Article 11.2 of the Agreement and this Appendix E.

(c) In accordance with Article 20.2 of the Agreement, CMS may require the Participant to amend its Participant Profile to terminate or modify the Participant's election to furnish services to BPCI Advanced Beneficiaries pursuant to the 3-Day SNF Rule Payment Policy Waiver, suspend or terminate the Participant's ability to utilize the 3-Day SNF Rule Payment Policy Waiver under Section II of this Appendix E, or take other remedial action, as appropriate, if the Participant fails to comply with the terms and conditions of the Agreement or this Appendix E.

APPENDIX F
Post-Discharge Home Visits Payment Policy Waiver

I. Waiver and Terms

CMS waives the requirement in 42 C.F.R. § 410.26(b)(5) that services and supplies furnished incident to the service of a physician (or other practitioner) (i.e., "incident to" services) be furnished under the direct supervision of the physician (or other practitioner), provided that such services are furnished in compliance with the following criteria:

(a) the services are furnished to a BPCI Advanced Beneficiary who does not qualify for Medicare coverage of home health services as set forth under 42 C.F.R. § 409.42;

(b) the services are furnished in the BPCI Advanced Beneficiary's home during the period after the BPCI Advanced Beneficiary has been discharged from an Anchor Stay by an Episode Initiator;

(c) the services consist of only those services described by the Healthcare Common Procedures Coding System (HCPCS) G-code specified by CMS for purposes of the Post-Discharge Home Visits Payment Policy Waiver;

(d) the services are furnished by "auxiliary personnel," as defined in 42 C.F.R. § 410.26(a)(1), under the general supervision (as defined at 42 C.F.R. § 410.32(b)(3)(i)) of a Participating Practitioner;

(e) the claims for such services are billed by a supervising Participating Practitioner who satisfies the requirements of Article 11.3(b) of the Agreement in accordance with CMS instructions and using the G-code specified by CMS for purposes of the Post-Discharge Home Visits Payment Policy Waiver;

(f) the services are furnished during a Clinical Episode, but not more than 13 times during that Clinical Episode (for a description of the duration of a Clinical Episode, see Article 5.2 of the Agreement), for any Clinical Episode initiated on or after October 1, 2018; and

(g) the services are furnished in accordance with all applicable state and Federal laws and all other Medicare coverage and payment criteria, including the remaining provisions of 42 C.F.R. § 410.26(b).

II. Responsibility for Denied Claims

(a) If a claim for any post-discharge home visit services is denied as a result of a CMS error and the Participating Practitioner who submitted the claim for such services did not know, and could not reasonably have been expected to know, as determined by

CMS, that the claim would be denied, then payment shall, notwithstanding such denial, be made by CMS for such services under the terms and conditions of the waiver in Section II of this Appendix F as though the coverage denial had not occurred.

(b) If a claim for any post-discharge home visits services is denied for any reason other than a CMS error and the Participating Practitioner who submitted the claim for such services did not know, and could not reasonably have been expected to know, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

(1) CMS will, notwithstanding such denial, pay for such post-discharge home visits services under the terms and conditions of the waiver in Section II of this Appendix F as though the coverage denial had not occurred, but CMS will withhold these payments from the Participant's NPRA or will add these payments to the Participant's Repayment Amount, as applicable;

(2) the Participant shall not charge, and shall ensure that the Participating Practitioner does not charge, the beneficiary for the expenses incurred for such services; and

(3) as applicable, the Participant shall return, or shall ensure that the Participating Practitioner returns to the beneficiary, any monies collected from the beneficiary.

(c) If a claim for any post-discharge home visits services is denied and the Participating Practitioner who submitted the claim for such services knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

(1) CMS will not make payment to the Participating Practitioner for such services;

(2) the Participant shall not charge, and shall ensure that the Participating Practitioner does not charge the beneficiary for the expenses incurred for such services; and

(3) as applicable, the Participant shall return, or shall ensure that the Participating Practitioner returns to the beneficiary any monies collected from the beneficiary.

III. Compliance and Enforcement

(a) The Participant shall ensure, through its agreement with each Participating Practitioner participating in the Post-Discharge Home Visits Payment Policy Waiver, that the Participant or Participating Practitioner, as applicable, will require all

auxiliary personnel to comply with the terms and conditions of the Agreement and this Appendix F.

(b) The Participant shall submit information to CMS, by a time and in a manner determined by CMS, upon request regarding the Participant's use of the Post-Discharge Home Visits Payment Policy Waiver.

(c) CMS will monitor Participants' use of the Post-Discharge Home Visits Payment Policy Waiver to ensure that services furnished under the waiver are Medically Necessary and consistent with the terms and conditions of Article 11.3 of the Agreement and this Appendix F.

(d) In accordance with Section 20.2 of the Agreement, CMS may require the Participant to amend its Participant Profile to terminate or modify the Participant's election to furnish services to BPCI Advanced Beneficiaries pursuant to the Post-Discharge Home Visits Payment Policy Waiver, suspend or terminate the Participant's ability to utilize the Post-Discharge Home Visits Payment Policy Waiver under Section II of this Appendix F, or take other remedial action, as appropriate, if the Participant fails to comply with the terms and conditions of the Agreement or this Appendix F.

APPENDIX G
Telehealth Payment Policy Waiver

I. Waiver and Terms

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 in 42 C.F.R. § 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 C.F.R. § 410.78.

II. Eligible Telehealth Providers

For purposes of this Telehealth Payment Policy Waiver, an "**Eligible Telehealth Provider**" is a Participating Practitioner who meets the requirements under Article 12.4(b) of the Agreement.

III. Responsibility for Denied Claims

(a) If a claim for any telehealth services furnished to a BPCI Advanced Beneficiary by an Eligible Telehealth Provider is denied as a result of a CMS error and the Eligible Telehealth Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that the claim would be denied, payment shall, notwithstanding such denial, be made by CMS for such Telehealth services under the terms and conditions of the waiver in Section II of this Appendix G as though the coverage denial had not occurred.

(b) If a claim for any telehealth services furnished to a beneficiary by an Eligible Telehealth Provider is denied for any reason other than a CMS error and CMS determines that the Eligible Telehealth Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

(1) CMS shall, notwithstanding such denial, pay for such telehealth services under the terms and conditions of the waiver in Section II of this Appendix G as though the coverage denial had not occurred, but CMS will withhold these payments from the Participant's NPRA or will add these payments to the Participant's Repayment Amount, as applicable;

(2) the Participant shall not charge, and shall ensure that the Eligible Telehealth Provider who furnished the telehealth services does not charge the beneficiary for the expenses incurred by such services; and

(3) as applicable, the Participant shall return, or shall ensure that the Eligible Telehealth Provider who furnished the telehealth services returns to the beneficiary any monies collected from the beneficiary.

(c) If a claim for any telehealth services furnished to a beneficiary by an Eligible Telehealth Provider is denied and the Eligible Telehealth Provider knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

(1) CMS shall not make payment to the Eligible Telehealth Provider for such services;

(2) the Participant shall not charge, and shall ensure that the Eligible Telehealth Provider who furnished the telehealth services does not charge the beneficiary for the expenses incurred by such services; and

(3) as applicable, the Participant shall return, or shall ensure that the Eligible Telehealth Provider who furnished the telehealth services returns to the beneficiary any monies collected from the beneficiary.

(d) If the Participant, an Episode Initiator, or a Participating Practitioner that is not an Eligible Telehealth Provider submits claims for telehealth services under this Telehealth Payment Policy Waiver for which CMS only would have made payment if the Participant, Episode Initiator, or Participating Practitioner was an Eligible Telehealth Provider participating in this Telehealth Payment Policy Waiver at the time of service:

(1) CMS shall not make payment to the Participant, Episode Initiator, or Participating Practitioner for such services;

(2) the Participant shall not charge, and shall ensure that the Episode Initiator or Participating Practitioner that furnished the telehealth services does not charge the beneficiary for the expenses incurred by such services; and

(3) as applicable, the Participant shall return, or shall ensure that the Episode Initiator or Participating Practitioner that furnished the telehealth services returns to the beneficiary any monies collected from the beneficiary.

IV. Compliance and Enforcement

(a) The Participant shall submit information to CMS, by a time and in a manner determined by CMS, upon request regarding the Participant's use of the Telehealth Payment Policy Waiver.

(b) CMS will monitor Participants' use of the Telehealth Payment Policy Waiver to ensure that services furnished under the waiver are Medically Necessary and consistent with the terms and conditions of Article 11.4 of the Agreement and this Appendix G.

(c) In accordance with Article 20.2 of the Agreement, CMS may require the Participant to amend its Participant Profile to terminate or modify the Participant's election to furnish services to BPCI Advanced Beneficiaries pursuant to the Telehealth Payment Policy Waiver, suspend or terminate the Participant's ability to utilize the Telehealth Payment Policy Waiver, or take other remedial action, as appropriate, if the Participant fails to comply with the terms and conditions of the Agreement or this Appendix G.