Centers for Medicare & Medicaid Services

Center for Medicare & Medicaid Innovation

State Population Health Group

7500 Security Blvd.

Baltimore, MD 21244

Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model

Maryland Hospital Participation Agreement

ACHIEVING HEALTHCARE EFFICIENCY THROUGH ACCOUNTABLE DESIGN (AHEAD) MODEL

HOSPITAL PARTICIPATION AGREEMENT

This participation agreement is between the Centers for Medicare & Medicaid Services ("**CMS**"); the Governor of Maryland, the Maryland Department of Health ("**MDH**"), and the Health Services Cost Review Commission ("**HSCRC**") (collectively, "**State**" or "**Maryland**"); and _____("**Participant Hospital**"). CMS, the State, and the Participant Hospital are herein collectively referred to as 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 Hospital is a Medicare-enrolled Acute Care Hospital, Critical Access Hospital, or Rural Emergency Hospital identified by a single CMS Certification Number ("CCN") or Organization National Provider Identification (ONPI).

CMS is implementing the Achieving Healthcare Efficiency Through Accountable Design (AHEAD) Model ("**Model**" or "**AHEAD**") under section 1115A of the Social Security Act ("**Act**"), which authorizes CMS, through its Center for Medicare and Medicaid Innovation ("**Innovation Center**"), 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 beneficiaries' care.

CMS and the State entered into the Amended and Restated AHEAD State Agreement (the "**State Agreement**") on November 12, 2025, to implement the Model.

AHEAD is a voluntary, state-based alternative payment and service delivery model designed to test whether a flexible framework that includes statewide accountability targets for all-payer and Medicare fee-for-service ("**FFS**") cost growth, primary care investment, and population health outcomes results in lower cost growth, improved population health and behavioral health and greater whole person health among Medicare FFS beneficiaries and all residents of the State.

The Parties hereby agree as follows:

SECTION 1 - AGREEMENT TERM

Section 1.1 Effective Date

This Agreement will become effective upon the last date of signature (the "**Effective Date**"). If a Party signs the Agreement and fails to date the signature, the Party's signature will be deemed recorded when the other Party receives the Party's signature on this Agreement.

Section 1.2 Agreement Term

The term of this Agreement ("**Agreement Term**") begins on the Effective Date and expires two years after the last day of the Agreement Performance Period, as defined in Section 1.3, unless this Agreement is sooner terminated by CMS in accordance with Section 12, in which case the Agreement Term ends on the effective date of such termination.

Section 1.3 Agreement Performance Period

(a) The performance period of this Agreement ("**Agreement Performance Period**") consists of up to ten Performance Years ("**Implementation Period**") and up to five Transition Years ("**Transition Period**"), unless the Agreement Performance Period or the Agreement is sooner terminated pursuant to Section 12.

(b) The Implementation Period begins on January 1, 2026 (the "**Start Date")** and ends at 11:59 PM ET on December 31, 2035, unless the Implementation Period is sooner terminated by a Party in accordance with Section 12.

(i) The Implementation Period consists of 12-month Performance Years ("PY"):

(A) PY 1: January 1, 2026 – December 31, 2026

(B) PY 2: January 1, 2027 – December 31, 2027

(C) PY 3: January 1, 2028 – December 31, 2028

(D) PY 4: January 1, 2029 – December 31, 2029

(E) PY 5: January 1, 2030 – December 31, 2030

(F) PY 6: January 1, 2031 – December 31, 2031

(G) PY 7: January 1, 2032 – December 31, 2032

(H) PY 8: January 1, 2033 – December 31, 2033

(I) PY 9: January 1, 2034 – December 31, 2034

(J) PY10: January 1, 2035 – December 31, 2035

(c) Transition Period.

(i) The Transition Period will consist of up to 60 months beginning upon the expiration or termination of the Implementation Period.

(ii) The length of the Transition Period will consist of 60 months if the State is transitioning to Medicare FFS, unless the following occur:

(A) The AHEAD State Agreement is terminated;

(B) The Transition Period is terminated sooner under Section 12;

(C) The Model is expanded; or

(D) A new model test performance period begins prior to the end of the Transition Period;

Section 1.4 Amended and Restated Agreements.

(a) No later than 90 calendar days prior to the start of the second PY or any subsequent PY or TY, CMS may offer the Participant Hospital the opportunity to sign a bilateral amendment to this Agreement, which may be in the form of an amended and restated version of this Agreement to take effect on the first day of such PY or TY.

(i) If, by a date specified by CMS, the Participant Hospital fails to sign the bilateral amendment offered by CMS pursuant to this Section 1.4, CMS will terminate the Implementation Period or Transition Period on December 31 of the year in which the amendment was offered.

(b) CMS may unilaterally amend the Agreement or any Appendix hereto, which may be in the form of an amended and restated version of this Agreement, without the consent of the Participant Hospital as specified in the Agreement or any Appendix hereto, 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 Hospital with 90 calendar days advance written notice of any unilateral amendment, which notice shall specify the amendment's effective date.

SECTION 2 – DEFINITIONS

(a) **"Acute Care Hospital**" means a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition) (defined as a "subsection (d) hospital" in Section 1886(d)(1)(B) of the Social Security Act).

(b) **"AHEAD Participant Hospital(s)"** means an Eligible Hospital(s) that has executed a Hospital Participation Agreement with CMS and the State to participate in the Model and a global budget revenue (GBR) agreement with the State. The Participant Hospital is considered an AHEAD Participant Hospital.

(c) **"All-Payer" or "all payers"** means Medicare Fee-For-Service (FFS) and Maryland Payers.

(d) **"Annual Payment Adjustment"** means an adjustment made during calculation of the Participant Hospital's Medicare FFS Hospital Global Budget to reflect Medicare FFS updates, such as updates to hospital payments for changes in federal law, changes in IME, DSH, UCC, and wage index, as further described in the Financial Specification Document.

(e) **"Baseline Budget"** means the Participant Hospital's historical Medicare FFS revenue for Eligible Hospital Services for the baseline period, calculated in accordance with this Agreement, the State Agreement, and Financial Specification Document.

(f) "**Beneficiary"** means an individual who is enrolled in Medicare FFS.

(g) "**Beneficiary Engagement Incentive**" means the in-kind items or services the Participant Hospital may choose to make available to Beneficiaries itself, through an individual at the direction of the Participant Hospital in order to support high-value services and allow the Participant Hospital to more effectively manage the care of Beneficiaries.

(h) "**Benefit Enhancement**" means any of the following additional benefits the Participant Hospital may choose to make available to a Beneficiary through the Participant Hospital or Preferred Providers, as applicable, in order to support high-value services and allow the Participant Hospital to more effectively manage the care of Beneficiaries:, the Telehealth Benefit Enhancement, and the Nurse Practitioner and Physician Assistant Services Benefit Enhancement. The Participant Hospital may select one or more Benefit Enhancements as described in Section 8.1.

(i) "**Change in Control**" means, for purposes of this Model: (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 the Participant Hospital representing more than 50% of the Participant Hospital's outstanding voting securities or rights to acquire such securities; (2) the acquisition of the Participant Hospital by any other individual or entity; (3) any merger, division, dissolution, or expansion of the Participant Hospital (including satellite offices); (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 the Participant Hospital; or (5) the approval or completion of a plan of liquidation of the Participant Hospital or an agreement for the sale or liquidation of the Participant Hospital.

(j) "**Change in Hospital Type**" means: (1) the Participant Hospital's change from an eligible hospital type as defined in Section 3.1(a)(iv) to a different eligible hospital type as defined in Section 3.1(a)(iv); or (2) the Participant Hospital's change from an eligible hospital type as defined in Section 3.1(a)(iv) to an ineligible hospital type.

(k) "**CMS Certification Number" or** "**CCN**" means the number assigned by CMS and used to verify Medicare/Medicaid certification for survey and certification, assessment-related activities and communications.

(l) "**Covered Services**" means the scope of health care benefits described in section 1832 of the Act for which payment is available under Part B of Title XVIII of the Act and section 1812 of the Act for which payment is available under Part A of Title XVIII of the Act.

(m)"**Critical Access Hospital" or** "**CAH**" means a critical access hospital as defined in section 1861(mm)(l) of the Act.

(n) **"Care Redesign Program" or "CRP"** means the program established by the State and CMS facilitating financial arrangements under the Model.

(o) "**CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology**" means the methodology designed by the State and approved by CMS for use in calculating all-payer Hospital Global Budgets.

(p) "**CMS-Designed Medicare FFS Hospital Global Budget Methodology**" means the methodology designed by CMS for use in calculating Medicare FFS Hospital Global Budgets.

(q) "**Commercial Payer**" means a third-party payer of covered services, other than Medicare and Medicaid, including any state government, employer, Health Maintenance Organization ("HMO"), Medicare Advantage, or any third-party administrator contracting on behalf of any such entity.

(r) **Critical Access Hospital**" or "**CAH**" means a critical access hospital as defined in Section 1861(mm)(l) of the Act.

(s) "**Day(s)**" or "**day(s)**" means calendar day(s) unless otherwise specified in the Agreement.

(t) "**Demographic Adjustment**" or "**DA**" means an adjustment made to reflect changes in status of the population (population size, age, Medicare status, medical risk, etc.) served by the Participant Hospital.

(u) "**Descriptive AHEAD Materials and Activities**" means the general audience materials such as brochures, advertisements, outreach events, letters to Beneficiaries, webpages published on a website, mailings, social media, or other materials sent or activities conducted by or on behalf of the Participant Hospital or its Preferred Providers when used to educate, notify, or contact Beneficiaries regarding the Model. Descriptive AHEAD Materials do not include communications that do not directly or indirectly reference the Model (for example, information about care coordination generally would not be considered Descriptive AHEAD Materials); materials that cover Beneficiary-specific billing and claims issues; educational information on specific medical conditions; referrals for health care items and services; and any other materials that are excepted from the definition of "marketing" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule (45 CFR Part 160 & Part 164, subparts A & E).

(v) "**Eligible Hospital**" means an acute care hospital (including related freestanding medical facilities as defined in Health General Article of the Annotated Code of Maryland, § 19-3A-01), Critical Access Hospital, or Rural Emergency Hospital that provides inpatient and/or outpatient services and is located in the State and meets all eligibility criteria for participation in the AHEAD model as described in this Agreement and Financial Specifications Document.

(w) "**Eligible Hospital Services**" means inpatient and outpatient facility services covered under Medicare Part A and certain outpatient facility services covered under Medicare Part B furnished by the Participant Hospital, unless the service is otherwise excluded or carved out of Medicare FFS Hospital Global Budgets in accordance to Section 12 of the State Agreement or as specified in the Financial Specifications Document.

(x) "**Effectiveness Adjustment**" means the adjustment to the Participant Hospital's Medicare FFS Hospital Global Budget based on the Participant Hospital's Medicare FFS potentially avoidable utilization (PAU) performance as further described in the Financial Specifications Document.

(y) **"Financial Settlement"** means the process after termination of the Implementation Period or Transition Period pursuant to Section 12 during which CMS calculates the monies owed that the Participant Hospital must repay to CMS or that CMS must pay to the Participant Hospital.

(z) **"Financial Specifications Document**" means the published final specification document that provides a detailed description of the financial methodology and operational payment features of the Medicare FFS Hospital Global Budgets under the CMS-Designed Medicare FFS Hospital Global Budget Methodology.

(aa) **"Hospital Global Budget"** means the method by which the Participant Hospital receives a predetermined, fixed annual budget.

(bb) **Hospital Population Health Accountability Plan**" or **"Hospital PHAP"** means the population health plan developed by the Participant Hospital in accordance with the requirements of this Agreement and Statewide Population Health Accountability Plan and reviewed by the Model Governance Structure or other State-selected governing body.

(cc) "**Legacy TIN**" means a TIN that a Preferred Provider previously used for billing Medicare Parts A and B services but no longer uses to bill for those services, and includes a "sunsetted" Legacy TIN (a TIN that is no longer used for billing for Medicare Parts A and B services by any Medicare-enrolled provider or supplier) or an "active" Legacy TIN (a TIN that may be in use by a Medicare-enrolled provider or supplier that is not a Preferred Provider).

(dd) **"Maryland Payers**" means the health care purchasers, including Maryland Medicaid, which the State requires to reimburse Eligible Hospitals on the basis of rates established by the HSCRC. The term Maryland Payers shall not be construed to refer to Medicare FFS.

(ee) "**Market Shift Adjustment" or "MSA**" means a volume-based adjustment made to reflect revenue changes as patient volumes realign or shift between hospitals within a market and service category and between hospitals participating in the Model and Eligible Hospitals not participating in the Model.

(ff) **"Medicare FFS TCOC Target"** is the per-beneficiary per-year (PBPY) Medicare FFS expenditure target calculated by CMS for each Performance Year.

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

(hh) "**Medicare FFS**" stands for "**Medicare Fee-For-Service**" and means Medicare Part A and Part B, and does not include Medicare Part C (Medicare Advantage) or Medicare Part D.

(ii) **"Medicare FFS Hospital Global Budget**" means the prospectively set annual budget that is the basis for reimbursement to the Participant Hospital in place of Medicare FFS reimbursement for facility inpatient and outpatient services, calculated using the CMS-Designed Medicare FFS Global Budget Methodology beginning in PY 3 and each subsequent PY.

(jj) **"Medicare FFS Primary Care Investment Target"** means the statewide financial target comprised of Medicare FFS primary care spending as a percentage of the total cost of care ("TCOC") for Medicare FFS

(kk) **"Medicare FFS TCOC Target"** is the per-beneficiary per-year (PBPY) Medicare FFS expenditure target calculated by CMS for each Performance Year.

(ll) **"Medicare Performance Adjustment" or "MPA"** means the percentage adjustment that CMS will apply to Medicare FFS payments to the Participant Hospital in accordance with the CMS-Approved State-Designed Hospital Global Budget Methodology for PY1 and PY2.

(mm) **"Model Governance Structure"** means a multi-sector entity that may be convened by the State to provide input on Model activities.

(nn) "**Outlier Adjustment**" means a volume-based adjustment to account for changes in the proportion of outlier payments.

(oo) "**Performance Year" or "PY**" means a 12-month period beginning on January 1 and ending on December 31 of a calendar year during the Implementation Period. The first Performance Year begins on the Start Date.

(pp) **"PGP"** stands for "physician group practice."

(qq) **"Preferred Provider"** means an individual or entity that: is a Medicare-enrolled provider (as defined at 42 C.F.R. § 400.202) or supplier (as defined at 42 C.F.R. § 400.202); is identified on the Preferred Provider List; bills for items and services it furnishes to Medicare FFS beneficiaries under a Medicare billing number assigned to the Participant Hospital in accordance with applicable Medicare regulations; and has agreed to furnish one or more Benefit Enhancements.

(rr) **"Preferred Provider List"** means the list of Preferred Providers who are approved by CMS to furnish one or more Benefit Enhancements and that is established in accordance with Section 8.

(ss) **"Program Integrity Screening"** means a review of an individual's or entity's program integrity history and current status, which may include a review of the individual's or entity's eligibility, history of exclusion or other sanctions imposed with respect to participation in Medicare, Medicaid, or CHIP; history of failure to pay Medicare debts in a timely manner; current or prior law enforcement investigations or administrative actions; affiliations with individuals or entities that have a history of program integrity issues; and other information pertaining to the trustworthiness of the individual or entity.

(tt) "**Rural Emergency Hospital" or "REH**" means a rural emergency hospital as defined in Section 1861(kkk)(2) of the Act and 42 C.F.R. § 419.91.

(uu) "**Rural Health Clinic**" **or** "**RHC**" means a clinic that is located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases, and meets all other requirements specified in Section 1861(aa)(2) of the Act.

(vv) "**Social Risk Adjustment**" or "SRA" means the upside-only adjustment to account for hospital-to-hospital differences in social risk for Beneficiary populations.

(ww) "**Statewide Accountability Target**" means, collectively, the Medicare FFS TCOC Target, All-Payer TCOC Growth Target, the Medicare FFS Primary Care Investment Target, the All-Payer Primary Care Investment Targets, the Statewide Quality and Population Health Targets, and the All-Payer Revenue Limit.

(xx) "**Statewide Population Health Accountability Plan**" **or "Statewide PHAP"** means the population health plan developed by the State, in collaboration with the Model Governance Structure or another State-selected governing body, that describes the State's collective vision and strategy for improving population health under the Model.

(yy) **"Statewide Quality and Population Health Targets"** means statewide quality and population health targets for the five (5) statewide core and one (1) required supplemental quality measures as defined in the Statewide Population Health Accountability Plan.

(zz) **"Service Line Adjustment**" means a volume-based adjustment to account for planned changes in service lines, such as additions, expansions, eliminations, or contractions within a given market.

(aaa) "**TCOC Performance Adjustment**" means the upward or downward adjustment based on the Participant Hospital's performance against a total cost of care benchmark for beneficiaries residing in the geographies the Participant Hospital serves.

(bbb) **"TIN"** means federal Taxpayer Identification Number

(ccc) **"Transition Year"** means a period of up to 12 consecutive months during the Transition Period.

(ddd) "**Unintended Negative Consequences**" means unintended circumstances identified by CMS during the Implementation Period or Transition Period that have a negative effect, including, but not limited to: volatile increased spending in the Participant Hospital's Medicare FFS total cost of care; worsened performance on health outcomes or quality measures in the Participant Hospital's geographic service area or the geographic boundaries of the State; and inappropriate reductions in utilization or access to care by Beneficiaries in the Participant Hospital's geographic service area or the geographic boundaries of the State.

SECTION 3 – PARTICIPANT HOSPITAL REQUIREMENTS

Section 3.1 Hospital Participation Requirements

(a) As of the Effective Date, and throughout the Agreement Term, the Participant Hospital shall:

(i) Be a legal entity formed under applicable state, federal, or tribal law, and authorized to conduct business in each state in which it operates for the purpose of carrying out the activities required by this Agreement;

(ii) Be a Medicare-enrolled facility in good standing with CMS identified by a single CCN;

(iii) Be located within the state of Maryland.

(iv) Be an Acute Care Hospital, CAH, or REH; and

(v) Not be a cancer hospital, children's hospital, long-term care facility, psychiatric hospital, rehabilitation hospital, as those hospital types are described in section 1886(d)(1)(B) of the Act; or a hospital operated by the U.S. Department of Veterans Affairs.

(b) As of the Start Date, and throughout the Agreement Term, the Participant Hospital shall use certified electronic health record technology ("**CEHRT**"), as such term is defined under 42 C.F.R. § 414.1305(3).

Section 3.2 Participation in Other CMS Models, Programs, and Demonstrations

(a) Current Medicare Programs, Models, or Demonstrations.

(i) The Participant Hospital shall not simultaneously participate in the Model and any of the following CMS models and programs:

(A) ACO REACH Model, if the Participant Hospital is a participant provider or preferred provider under the terms of the ACO REACH Model and receives Total Care Capitation (TCC), Primary Care Capitation (PCC), and/or the Advanced Payment Option (APO);

(B) Comprehensive Kidney Care Choices (CKCC) Model; or

(C) Any other model that does not allow simultaneous participation in AHEAD.

(ii) The Participant Hospital may simultaneously participate in the Model and any of the following CMS models and programs:

(A) Medicare Shared Savings Program (SSP) and its related ACO Primary Care Flex (PC Flex) Model;

(B) ACO REACH Model, if the Participant Hospital is not a participant provider or preferred provider under the terms of ACO REACH and does not receive TCC, PCC, and/or the APO;

(C) Increasing Organ Transplant Access (IOTA) Model;

(D) Enhancing Oncology Model (EOM) Model;

(E) Guiding an Improved Dementia Experience (GUIDE) Model; or

(F) Cell and Gene Therapy (CGT) Access Model; or

(G) Any other model that allows simultaneous participation in the AHEAD model.

(b) Interaction with Other Medicare Programs, Models, or Demonstrations.

(i) Current Medicare Programs, Models, or Demonstrations.

(A) CMS may adjust the Participant Hospital's Medicare FFS Hospital Global Budget or HGB Payments as may be necessary to avoid duplicative accounting of, or payments or penalties for, amounts received by the Participant Hospital under another Medicare program, model, or demonstration. These adjustments may be applied during the Agreement Performance Period or in accordance with Section 12.6 of this Agreement. To the extent practicable, CMS will provide at least 90 calendar days advance notice of any such adjustments to the Participant Hospital.

(ii) New Medicare Programs, Demonstrations, or Models.

(A) CMS may exclude the Participant Hospital from simultaneous participation in the Model and any other Medicare programs, demonstrations, or models that begin after the Effective Date, including but not limited to those that involve shared savings or incentive payments.

(B) If the Participant Hospital participates in a Medicare program, demonstration or model that starts after the Effective Date, CMS may, in its sole discretion, make adjustments to the calculation of the Participant Hospital's Medicare FFS Hospital Global Budget or HGB Payments to avoid duplicative accounting of, and payment or penalties for, amounts received by the Participant Hospital under such new Medicare program, demonstration, or model. The adjustments may be applied during the Agreement Performance Period or in accordance with Section 12 of this Agreement. To the extent practicable, CMS will provide at least 90 calendar days advance notice of any such adjustments to the Participant Hospital.

(c) Notice of Participation.

(i) Current Medicare Programs, Models, or Demonstrations. No later than the Start Date, the Participant Hospital shall notify CMS of the Participant Hospital's participation in any other Medicare programs, demonstrations, or models. The Participant Hospital shall notify CMS of any changes to its participation in any other Medicare programs, demonstrations, or models, no later than 30 calendar days after the change occurs.

(ii) New Medicare Programs, Models, or Demonstrations. If the Participant Hospital will begin participating in another Medicare program, demonstration, or model during any Performance Year or Transition Year, it shall notify CMS of such fact promptly, but no later than 90 calendar days before it begins to participate in such Medicare program, demonstration, or model.

(d) CMS Guidance

(i) In a form and manner and by a date to be determined by CMS, CMS will issue guidance on policies related to participation in other CMS models, programs, and demonstrations.

Section 3.3 Quality Reporting

(a) For PY1 and PY2, the Participant Hospital shall comply with State requirements for hospital quality and value-based payment programs administered by the State as further described in Section 11.h. of the State Agreement. The data submitted by the Participant

Hospital's under the Hospital Inpatient Quality Reporting (IQR) Program, Hospital Outpatient Quality Reporting (OQR), and Readmissions Reduction Program will be included in national Medicare measures and published by CMS in an accurate and appropriate manner. CMS will include data for Participant Hospitals in the Clinical Data Abstraction Center for auditing purposes.

(b) For PY3 and each subsequent PY or TY, the Participant Hospital shall comply with requirements for the CMS hospital quality and value-based programs established under Section 1886(o) (Hospital Value Based Purchasing program), Section 1886(p) (Hospital Acquired Condition Reduction program), Section 1886(q) (Hospital Readmissions Reduction program), Section 1886(b) (Hospital Inpatient Quality Reporting Program), and Section 1833(t) (Hospital Outpatient Quality Reporting Program) of the Act.

(i) CMS and the State may agree to defer the implementation of the transition to CMS hospital quality and value-based programs in the CMS-Designed Hospital Global Budget Methodology to PY4 or PY5.

(ii) In a form and manner and by a date determined by CMS and the State, the State shall notify the Participant Hospital if CMS and the State decide to delay the implementation of hospital quality and value-based programs administered by CMS, and the decision for the State to continue to implement the State's hospital quality and value-based payment programs, as described in Section 3.3(a). of this Agreement and Section 11 of the State Agreement.

(c) For PY3 and each subsequent PY or TY, CMS will adjust the payments calculated under the Medicare FFS Hospital Global Budget for the Participant Hospital based on the Participant Hospital's performance under the applicable hospital quality and value-based programs, in accordance with Section 5 of this Agreement and the Financial Specifications Document.

(d) If the Participant Hospital is a CAH, the Participant Hospital shall report to CMS, in a form and manner specified by CMS, the quality measures described in Appendix C.

Section 3.4 Hospital Population Health Accountability Plan

(a) The Participant Hospital shall submit to the State, which may choose to collaborate with the Model Governance Structure or another State-selected governing board, in a form and manner and by the date(s) specified by the State, a plan Hospital PHAP that is in alignment with the Statewide Population Health Accountability Plan developed by the State in accordance with the State Agreement.

(b) The Hospital PHAP must identify information regarding the Participant Hospital's local community health needs, approaches, and resources the Participant Hospital will implement to improve population health, including but not limited to the fields of the CMS-provided Hospital Population Health Accountability Plan template provided to the State. The Participant Hospital and all other individuals or entities performing functions

or services related to the Hospital PHAP must comply with all applicable Federal anti-discrimination laws and regulations.

(c) The State will share a report with CMS summarizing findings across all AHEAD Participant Hospitals' Hospital PHAPs. CMS will not collect information based on Beneficiaries' race, ethnicity, national origin, religion, or gender if these fields are reported to the State.

Section 3.5 Changes to Participant Hospital

(a) Change of Participant Hospital Legal Name. The Participant Hospital shall provide written notice to CMS at least 60 calendar days before any change in the Participant Hospital's legal name becomes effective. The Participant Hospital shall forward to CMS a copy of the document effectuating the name change, authenticated by the appropriate state official, and the parties shall execute an agreement reflecting the change of the Participant Hospital's name. This obligation remains in effect until the later of the effective date of termination of this Agreement or when final payment by or to the Participant Hospital has been made under this Agreement.

(b) Change in Participant Hospital CCN. The Participant Hospital shall provide at least 90 calendar days' advance written notice to CMS before the effective date of any change in the Participant Hospital's CCN. Such notice must be submitted in a form and manner specified by CMS. In response to a change in the Participant Hospital's CCN, CMS may terminate the Agreement or Agreement Performance Period, or take any other actions consistent with the terms of this Agreement. This obligation remains in effect until the later of the effective date of termination of this Agreement or when final payment by or to the Participant Hospital has been made under this Agreement.

(c) Change in Control and Assignment.

(i) The Participant Hospital shall provide written notice to CMS at least 90 calendar days before the effective date of any Change in Control. This obligation remains in effect until the later of the effective date of termination of this Agreement or when final payment by or to the Participant Hospital has been made under this Agreement.

(ii) Upon learning of a Change in Control, CMS may conduct a Program Integrity Screening and take other appropriate action to ensure compliance with the terms of the Model by the new successor in interest. Depending on the type of Change in Control, CMS may require the successor in interest to execute a novation agreement with CMS, the Participant Hospital and the State and/or terminate this Agreement and require the successor in interest to enter into a new participant agreement between CMS and the State.

(iii) If the Participant Hospital undergoes a Change in Control that renders it ineligible for participation in the Model or creates a program integrity risk, CMS may take one or more of the following actions: terminate this Agreement; terminate the

Agreement Performance Period; or issue a financial settlement in accordance with Section 5.4 of this Agreement.

SECTION 4 – BENEFICIARY PROTECTIONS

Section 4.1 Availability of Services

(a) The Participant Hospital shall make, and shall require its Preferred Providers to make, Medically Necessary Covered Services available to Beneficiaries in accordance with applicable laws, regulations, and guidance. 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 Hospital shall not, and shall require its Preferred Providers to not, take any action to avoid treating "at risk beneficiaries" (as defined at 42 C.F.R. § 425.20) or to target certain Beneficiaries for any reason that could compromise the integrity of the Model, the Medicare or Medicaid programs, other federal health care programs, or the safety of Beneficiaries, or with the purpose of trying to ensure attribution in a future Performance Year or Transition Year.

(c) The Participant Hospital shall not, and shall require its Preferred Providers to not, take any action to reduce a Beneficiary's length of stay or change the setting of care where a Beneficiary receives Medically Necessary Covered Services unless such action is deemed appropriate in the clinical judgment of the treating healthcare provider.

Section 4.2 Beneficiary Choice

Consistent with section 1802(a) of the Act, the Participant Hospital shall not, and shall require its Preferred Providers to not, commit any act or omission, nor adopt any policy, that inhibits Beneficiaries from exercising their freedom to obtain health services from providers and suppliers who are not the Participant Hospital or its Preferred Providers. This prohibition does not apply to referrals made by employees or contractors who are operating within the scope of their employment or contractual arrangements with the employer or contracting entity, provided that the employees and contractors remain free to make referrals without restriction or limitation if a Beneficiary expresses a preference for a different provider or supplier, or the referral is not in the Beneficiary's best medical interests in the judgment of the referring party.

Section 4.3 HIPAA Requirements

(a) The Participant Hospital acknowledges that it is a HIPAA Covered Entity ("**CE**") as defined in 45 CFR § 160.103.

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

(c) The Participant Hospital shall maintain the privacy and security of all Model-related information that identifies individual Beneficiaries in accordance with the HIPAA

Privacy and Security Rules and all relevant HIPAA Privacy and Security guidance applicable to the use and disclosure of PHI by covered entities and their business associates, as well as all other applicable federal and state laws and regulations.

Section 4.4 Descriptive AHEAD Materials and Activities

(a) Descriptive AHEAD Materials and Activities shall not discriminate Beneficiaries based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability, geographic location, or income.

(b) The Participant Hospital shall ensure that Descriptive AHEAD Materials and Activities do not use the logo, seal, identity mark, or symbols of HHS or CMS.

(c) To ensure that Beneficiaries are not misinformed or misled about the Model, CMS may develop and provide the Participant Hospital template language for certain Descriptive AHEAD Materials and Activities.

(d) Pursuant to Section 11.1 and Section 11.2, CMS may request review of Descriptive AHEAD Materials and Activities. CMS may issue written notice of approval or disapproval of such requested Descriptive AHEAD Materials and Activities.

(i) The Participant Hospital shall immediately discontinue, and shall require its Preferred Providers to immediately discontinue, use of any Descriptive AHEAD Materials and Activities disapproved by CMS.

(ii) If CMS reviews and approves the Participant Hospital's Descriptive AHEAD Materials and Activities in accordance with this Section 4.4(d), any material change to such CMS-approved Descriptive AHEAD Materials and Activities must be submitted to CMS in a form and manner and by one or more dates specified by CMS and must be approved by CMS before use of the revised version of the CMS-approved Descriptive AHEAD Materials and Activities.

(e) The Participant Hospital must retain copies of all written and electronic Descriptive AHEAD Materials and Activities and appropriate records for all other Descriptive AHEAD Materials and Activities provided to Beneficiaries.

SECTION 5 – HOSPITAL GLOBAL BUDGETS

Section 5.1 State-Designed Hospital Global Budgets

(a) General. For PY1 and PY2, the State will calculate the Participant Hospital's Hospital Global Budget for all payers using the CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology in accordance with the State Agreement. For PY3 and each subsequent PY or TY, the State will set Hospital Global Budgets for Maryland

Payers in accordance with the requirements and authorities outlined in the State Agreement.

(b) Payments. For PY1 and PY2, CMS will pay the Participant Hospital through the applicable Medicare Administrative Contractor(s) ("MAC") on the basis of the rates to be charged included on the Medicare FFS claims the Participant Hospital submits to the MAC, less the Public Payer Differential described in Section 5.1(c), and subject to the Medicare Performance Adjustment described in Section 5.1(d). The Public Payer Differential will be applied prior to subtracting any applicable deductible or coinsurance amount, and prior to any applicable Medicare secondary payment.

(c) Public Payer Differential. Prior to the start of PY1, the State shall provide a percentage difference between the rate established by the State for the Participant Hospital for a given charge, in accordance with this Section 5.1(c), and the lesser rate to be paid by public payers (Medicare including Medicare Advantage plans, Medicaid including Medicaid Managed Care Organizations, and CHIP) to the Participant Hospital for the same charge ("**Public Payer Differential**"). This Public Payer Differential will remain in effect for PY1 and PY2 unless and until CMS approves a change in the Public Payer Differential proposed by the State in accordance with the State Agreement. For PY3 and each subsequent PY or TY, the Public Payer Differential will not apply to Medicare FFS.

(d) Medicare Performance Adjustment ("MPA"). After PY1 as well as the calendar year immediately preceding PY1 of this Agreement, the State shall calculate the MPA for the Participant Hospital in accordance with the State Agreement, which CMS will apply to Medicare FFS payments to the Participant Hospital in accordance with the CMS-Approved State-Designed Hospital Global Budget Methodology for PY1 and PY2 as applicable.

(e) Hospital Global Budget Notification. Prior to each of PY1 and PY2, the State will provide written notification to the Participant Hospital regarding the Participant Hospital's Hospital Global Budget for that Performance Year.

Section 5.2 CMS-Designed Hospital Global Budgets

(a) General. For PY3, each subsequent PY, and as applicable each TY, CMS shall calculate and pay the Medicare FFS Hospital Global Budget for the Participant Hospital in accordance with the CMS-Designed Medicare FFS Hospital Global Budget Methodology as described in Section 5.2 of this Agreement, the State Agreement and the Financial Specifications Document.

(b) Public Comment on Financial Specifications Document.

(i) For PY3, CMS will post online the draft Financial Specifications Document describing the CMS-Designed Medicare FFS Hospital Global Budget Methodology by September 1, 2026, and will provide up to 60 calendar days for public comment. CMS shall finalize and publish online the Financial

Specifications Document for PY 3 by January 15, 2027. The finalized financial specifications will be reflected in the Financial Specifications Document for PY3.

(ii) For PY4 and each subsequent PY or TY, CMS will post online the draft Financial Specifications Document describing the CMS-Designed Medicare FFS Hospital Global Budget Methodology by no later than June 30 or as otherwise agreed upon date by CMS and the State of each year preceding the start of the applicable PY or TY, and will provide up to 30 calendar days for public comment before publishing online the finalized Financial Specifications by no later than September 30th or as otherwise agreed upon by CMS and the State.

(iii) CMS may not respond to each comment. CMS will consider commenters' feedback but may finalize the Financial Specifications Document as drafted.

(c) Payments.

(i) For PY3 and for each subsequent PY or TY, the Medicare FFS Hospital Global Budget shall be considered payment for all Eligible Hospital Services during the applicable PY or TY. The Participant Hospital shall accept payment for all furnished Eligible Hospital Services from CMS based only on the Medicare FFS Hospital Global Budget for the PY or TY, as determined in accordance with the CMS-Designed Medicare FFS Hospital Global Budget Methodology.

(ii) For PY3 and each subsequent PY or TY, CMS shall administer Medicare FFS rates to the Participant Hospital for services that are excluded from the CMS-Designed Hospital Global Budget Methodology, as described in the Financial Specifications Document and Section 12 of the State Agreement. In accordance with Medicare laws and regulations, these Medicare FFS rates to the Participant Hospital shall be set at a hospital-specific rate. The hospital-specific rate shall be set at the reimbursement level for services under the CMS-Designed Medicare FFS Hospital Global Budget Methodology.

(d) Methodology.

(i) General. For Performance Year 3 to establish the Participant Hospital's Medicare FFS Hospital Global Budget, CMS will calculate the Baseline Budget for the Participant Hospital then trend forward the Baseline Budget by the applicable annual adjustments as described in Section 5.5(d)(v) and as further described in the Financial Specifications Document.

(ii) For Performance Year 4 and for each subsequent PY or TY, to establish the Participant Hospital's Medicare FFS Hospital Global Budget, CMS will make annual adjustments as described in Section 5.5(d)(v) to the Participant Hospital's Medicare FFS Hospital Global Budget for the immediately preceding PY or TY, as further described in the Financial Specifications Document.

(iii) Baseline Budget: For PY3, CMS will calculate the baseline budget derived from baseline revenue, Medicare Inpatient Prospective System (IPPS) and Medicare Outpatient Prospective System (OPPS) claims data for calendar year 2026 as further described in the Financial Specifications Document.

(A) Baseline revenue for purposes of Section 5.2(d)(iii) will be derived from the Participant Hospital's 2026 actual Medicare FFS hospital revenue in the State, except as described in Section 5.5(d)(iv).

(iv) Alternate Baseline: In accordance with the State Agreement, if the update factors for 2025 and 2026 exceed the cumulative United States Per Capita Cost trend for 2025 and 2026, CMS will not use the baseline revenue as described in Section 5.2(d)(iii)(A). Instead, CMS will implement either of the following for the Participant Hospital's baseline revenue:

(A) Participant Hospital's calendar year 2024 actual Medicare FFS hospital baseline revenue in the State with an adjustment factor applied to PY3 in the form of an annual payment adjustment, as further described in the Financial Specifications Document; or

(B) Implement pro rata reduction to CY 2026 IPPS and OPPS claims data used in the calculation of the baseline at the Participant Hospital's individual hospital level.

(v) Annual Adjustments. Beginning in PY3 and for each subsequent PY or TY, CMS will apply, as applicable, an Annual Payment Adjustment, volume-based adjustments, performance-based adjustments, a Social Risk Adjustment, or other adjustments as described in the State Agreement, in calculating the Participant Hospital's Medicare FFS Hospital Global Budget.

(A) Volume-Based Adjustments include a Market Shift Adjustment, Service Line Adjustment, Demographic Adjustment; and an Outlier Adjustment, as further described in the Financial Specifications Document and this paragraph.

(B) Performance Based Adjustments include a quality adjustment as described in Section 3.3, hospital community improvement bonus, Effectiveness Adjustment, and a Total Cost of Care Performance Adjustment, as further described in the Financial Specifications Document.

(vi) State Adjustment or otherwise referred to as the Bridge Period Adjustment (PY3, PY4, and PY5 only).

(A) In a form, manner, and by PY3, the State will notify the Participant Hospital of the State's policy for Bridge Period Adjustments to the Participant Hospital's Medicare FFS Hospital Global Budget.

(B) For PY3, PY4, and PY5, the State may adjust the Participant Hospital's Medicare FFS Hospital Global Budget amount as calculated in accordance with the CMS-Designed Hospital Global Budget Methodology. The State Adjustment would be applied after adjustments discussed in Section 5.2(d)(v).

(C) In a form, manner, and by a date agreed upon by CMS and the State, CMS will notify Participant Hospital of the amount of any State Adjustment prior to the applicable PY.

(D) The State must adhere to the following requirements when determining a State Adjustment for the Participant Hospital:

(1) For PY3, the State can redistribute no more than 30% of the total Medicare hospital global budget revenue for all AHEAD Participant Hospitals to other AHEAD Participant Hospitals for that PY.

(2) For PY4, the State can redistribute no more than 20% of the total Medicare hospital global budget revenue for all AHEAD Participant Hospitals to other AHEAD Participant Hospitals for that PY.

(3) For PY5, the State can redistribute no more than 10% of the total Medicare hospital global budget revenue for all AHEAD Participant Hospitals to other AHEAD Participant Hospitals for that PY.

(vii) Savings Adjustment. If the State exceeds the Medicare FFS TCOC Target in any PY, CMS will apply a downward savings adjustment to the Participant Hospital's Medicare FFS Hospital Global Budget to ensure the State meets its Medicare FFS TCOC Targets as described in Section 10 of the State Agreement.

(viii) CMS will apply an upward savings adjustment to the Participant Hospital's Medicare FFS Hospital Global Budget in a subsequent PY if the State meets the Medicare FFS TCOC Target in a previous PY, as described in the State Agreement.

(ix) The savings adjustment would be applied after the State Adjustment.

(e) Planned Service Line Adjustment Requests. For PY3 and each subsequent PY, the Participant Hospital shall submit in writing any request that CMS adjust the calculation of the Medicare FFS Hospital Global Budget for service line additions, expansions, eliminations, or contractions ("**Planned Service Line Adjustment Request**") in accordance with Appendix F, and the Financial Specifications Document. A Planned Service Line Adjustment Request shall be submitted by the Participant Hospital and approved or denied by CMS in accordance with Appendix F.

(f) Claims Processing. For PY3 and each subsequent PY or TY, the Participant Hospital shall submit claims to the applicable MAC and accept biweekly Medicare payments ("**HGB Payments**") issued by CMS through the MAC for all Eligible Hospital Services, based on CMS-Designed Medicare FFS Hospital Global Budgets Methodology. Each HGB Payment shall equal one twenty-sixth (1/26) of the total Medicare FFS Hospital Global Budget calculated by CMS for each applicable PY or TY.

(g) The Participant Hospital shall continue to submit Medicare FFS inpatient and outpatient claims for Eligible Hospital Services, as well as Medicare Hospital Cost Reports to CMS; however these claims will be treated as no pay-claims. CMS will process all other Medicare FFS claims submitted by the Participant Hospital in accordance with its usual and customary procedures.

(i) Such claims will be used to determine Beneficiary cost sharing and to inform the calculation of the Medicare FFS Hospital Global Budget for future PYs or TYs, as well as to assess the State's performance against the Statewide Accountability Targets, and inform program integrity efforts.

(ii) Such claims may be used to determine whether the Participant Hospital's claims for Eligible Hospital Services meet or exceed eighty (80) percent of the Medicare FFS Hospital Global Budget as set forth in Section 12.1(a)(x); and to attribute Medicare FFS Hospital Global Budget costs to relevant accountable care organizations and any other risk-based CMS efforts as applicable.

(h) HGB Notification. For PY3 and each subsequent PY or TY, CMS shall provide to the Participant Hospital a report setting forth the Medicare FFS Hospital Global Budget (the "**Medicare FFS Hospital Global Budget Report**"). A final report shall be issued to Participant Hospital at least 90 calendar days prior to the start of the PY or TY in which such Medicare FFS Hospital Global Budget will take effect.

Section 5.3 Medicare FFS Hospital Global Budget Error Requests

(a) For PY3 and each subsequent PY or TY, CMS will deem any Medicare FFS Hospital Global Budget Report final 30 calendar days after the Medicare FFS Hospital Global Budget Report is issued, unless the Participant Hospital submits to CMS a Medicare FFS Hospital Global Budget Report Calculation Error Notice, in accordance with Section 5.3(a)(i) or a Medicare FFS Hospital Global Budget Report Non-Calculation Error Notice in accordance with Section 5.3(a)(ii).

(i) Medicare FFS Hospital Global Budget Report Calculation Error Notice.

(A) The Participant Hospital may submit a written notice of an error in mathematical calculations or methodological application in the Medicare FFS Hospital Global Budget Report ("**Medicare FFS Hospital Global Budget Report Calculation Error Notice**") to CMS and the State within

30 calendar days after the Medicare FFS Hospital Global Budget Report is issued.

(B) Upon receipt of a Medicare FFS Hospital Global Budget Report Calculation Error Notice, CMS will review the calculations in question and any mathematical issues raised by the Participant Hospital in its written notice.

(C) CMS will issue to the Participant Hospital and State either a written determination that the Medicare FFS Hospital Global Budget Report is correct, or a revised Medicare FFS Hospital Global Budget Report. Such written determination or revised Hospital Global Budget Report is final on the date it is issued by CMS.

(D) If it is determined that the Medicare FFS Hospital Global Budget amount due to the Participant Hospital from CMS has been calculated in error, CMS shall, to the extent necessary, adjust the amount of future HGB Payments such that by the end of the Performance Year, the Participant Hospital shall have received an amount equal to the corrected Medicare FFS Hospital Global Budget. For example, if the corrected Medicare FFS Hospital Global Budget amount is less than the original Medicare FFS Hospital Global Budget amount, CMS will reduce the amount of future HGB Payments in equal parts such that the total amount paid by the end of the Performance Year will equal the corrected Medicare FFS Hospital Global Budget.

(E) Notwithstanding the above, if the corrected Medicare FFS Hospital Global Budget amount is greater than the original Medicare FFS Hospital Global Budget, CMS may, in its sole discretion and in a form and manner specified by CMS, issue a one-time lump sum payment to the Participant Hospital that is equal to the difference between the HGB Payments already made to the Participant Hospital and the HGB Payments that would have been made if such payments were based on the corrected Medicare FFS Hospital Global Budget.

(ii) Medicare FFS Hospital Global Budget Report Non-Calculation Error Request.

(A) The Participant Hospital may submit a request for a modification to the Participant Hospital's Medicare FFS Hospital Global Budget due to local factors, otherwise unaccounted for, that may result in a substantial deviation in projected cost growth from estimates derived from the CMS-Designed Medicare FFS Hospital Global Budget Methodology ("Medicare FFS Hospital Global Budget Report Non-Calculation Error Request") to CMS and the State 30 calendar days after the Medicare FFS Hospital Global Budget Report is issued. The local factors that may be considered

as part of this assessment will be outlined in the Financial Specifications Document.

(B) Upon receipt of a Medicare FFS Hospital Global Budget Report Non-Calculation Error Request, CMS, in consultation with the State, will review the request.

(C) To the extent practical, CMS will notify the State and the Participant Hospital of its decision to approve or deny the Medicare FFS Hospital Global Budget Report Non-Calculation Error Request within 45 calendar days of the Participant Hospital's submission to CMS. If approved, CMS will indicate in its written correspondence when the approved updates are expected to be reflected in the Participant Hospital's Medicare FFS Hospital Global Budget.

(D) If CMS denies the Participant Hospital's Medicare FFS Hospital Global Budget Report Non-Calculation Error Request, the Participant Hospital may submit a letter to CMS requesting reconsideration of the decision, accompanied by any additional data and justification.

(iii) There shall be no further administrative or judicial review of a State Adjustment, final Medicare FFS Hospital Global Budget Report, written determination, or revised Medicare FFS Hospital Global Budget Report.

Section 5.4 Financial Settlement

(a) Financial Settlement Upon Termination

(i) Financial Settlement Report

(A) Upon the expiration or termination of the Implementation Period or Transition Period, whichever is later, CMS will issue to the Participant Hospital a financial settlement report that sets forth the type and amount of any monies owed that the Participant Hospital must repay to CMS or that CMS must pay to the Participant Hospital, in accordance with this Agreement **(**"**Financial Settlement Report**").

(B) If the Financial Settlement Report indicates that CMS owes the Participant Hospital additional payment, CMS shall make such payment within 30 calendar days after the Financial Settlement Report is deemed final in accordance with Section 5.4(b).

(C) If the Financial Settlement Report indicates that the Participant Hospital owes CMS repayment, CMS will issue the Participant Hospital a demand letter for any amounts determined to be owed to CMS. The Participant Hospital shall pay CMS any monies owed within 30 calendar days of the date of the demand letter. If CMS does not timely receive payment in full,

the remaining monies owed shall be considered a delinquent debt in accordance with Section 5.4(d).

(b) Error Notice

(i) CMS will deem any Financial Settlement Report final 30 calendar days after the date it is issued, unless the Participant Hospital submits to CMS a written notice of an error in mathematical calculations in the Financial Settlement Report within 30 calendar days after the Financial Settlement Report is issued **(**"**Timely Error Notice**").

(ii) Upon receipt of a Timely Error Notice, CMS will review the calculations in question and any mathematical issues raised by the Participant Hospital in its written notice.

(iii) CMS will issue to the Participant Hospital either a written determination that the Financial Settlement Report is correct, or a revised Financial Settlement Report. Such written determination or revised Financial Settlement Report is final on the date it is issued by CMS.

(iv) There shall be no further administrative or judicial review of a final Financial Settlement Report, written determination, or revised Financial Settlement Report.

(c) Settlement Reopening

(i) If as a result of any inspection, evaluation, investigation, or audit conducted by CMS or HHS, it is determined that the amount due to the Participant Hospital from CMS or due to CMS from the Participant Hospital has been calculated in error, CMS may, for a period of six years following the expiration or termination of this Agreement, reopen any Financial Settlement Report or revised Financial Settlement Report to recalculate the monies owed, issue a revised Financial Settlement Report, and make or demand payment of any monies owed to or by the Participant Hospital.

(ii) CMS may reopen and revise any Financial Settlement Report or revised Financial Settlement Report at any time in the event of fraud or similar fault.

(iii) The Parties shall pay any amounts determined to be owed as a result of a reopening under this Section.

(d) Delinquent Debt

(i) If the Participant Hospital fails to pay amounts due to CMS in full by the date specified in any demand letter, CMS shall assess simple interest on the unpaid balance at the rate applicable to other Medicare debts under 42 C.F.R. § 405.378. Interest shall be calculated in 30 calendar day periods and shall be assessed for each 30 calendar day period that payment is not made in full. Any payments

received by CMS first shall be applied toward accrued interest and then to any outstanding principal balance due.

(ii) If the Participant Hospital fails to pay amounts due to CMS in full by the date specified in any demand letter, CMS will recoup the unpaid balance from the Participant Hospital's present and future Medicare payments otherwise owed to the Participant Hospital in accordance with standard Medicare recoupment procedures and regulations. CMS and the U.S. Department of Treasury may use any applicable debt collection tools and procedures available to collect the total amount owed by the Participant Hospital, which includes the recovery of any accrued interest on the delinquent debt. CMS shall refer uncollected debts to the U.S. Treasury for collection, as required by applicable debt collection authorities.

SECTION 6 – {Reserved}

SECTION 7 – FINANCIAL ARRANGEMENTS

Section 7.1 CRP.

(a) If the Participant Hospital elects to participate in one or more CRP Tracks during PY1 or PY2, the Participant Hospital shall comply with Appendix G. In the event of any inconsistency between the Agreement and Appendix G, the Agreement will control.

(b) Prior to PY3, CMS will amend Appendix G in accordance with Section 1.4(a) of this Agreement and as described in the State Agreement.

(c) The CRP Tracks, developed and implemented under the Maryland Total Cost of Care Model, specifically the Episode Care Improvement Program (ECIP) and Episode Quality Improvement Program (EQIP), shall be considered approved CRP Tracks under the Model, as further described in Appendix G. of this Agreement.

SECTION 8 – BENEFIT ENHANCEMENTS AND BENEFICIARY ENGAGEMENT INCENTIVES

Section 8.1 General.

(a) In a form and manner and by a deadline specified by CMS, the Participant Hospital may select to offer one or more Benefit Enhancements for a PY or TY. Appendices D and E shall apply for a PY or TY only if the Participant Hospital has selected to provide the relevant Benefit Enhancement for that PY or TY and that selection was not rejected by CMS.

(b) CMS and the Participant Hospital acknowledge that if the Participant Hospital selected to offer a Benefit Enhancement with, if applicable, its Preferred Providers during PY1, it submitted such selection(s) to CMS prior to the Effective Date.

(c) Prior to PY3, in a form and manner as determined by CMS, CMS will provide the Participant Hospital with the opportunity to select and offer additional benefit enhancements as described in Appendix E. II. 1; Appendix E. II. 2; Appendix E. II. 3; Appendix E. II. 4; and Appendix E. II. 6 of the State Agreement.

Section 8.2 Preferred Providers General Requirements

(a) The Participant Hospital shall not take, and shall ensure that its Preferred Providers do not take, any action to limit the ability of a Preferred Provider to make decisions in the best interests of a Beneficiary, including the selection of devices, supplies, and treatments used in the care of the Beneficiary.

(b) The Participant Hospital shall immediately notify CMS after becoming aware that any Preferred Provider is under investigation or has been sanctioned by the government or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, revocation of Medicare billing privileges, and inclusion on the CMS preclusion list as defined at 42 C.F.R. § 422.2). If a Preferred Provider is under investigation or has been sanctioned but not excluded from Medicare program participation, CMS may take remedial action or terminate the Agreement in accordance with Section 12.

(c) The Participant Hospital shall ensure that any Preferred Provider that has been removed from the Participant Hospital's Preferred Provider List does not engage in any Benefit Enhancements after the effective date of such termination or removal from the list.

Section 8.3 Initial Preferred Provider List

(a) If the Participant Hospital selected one or more Benefit Enhancements in accordance with Section 8.1 to be offered by the Participant Hospital beginning in the first quarter of PY1, CMS and the Participant Hospital acknowledge that the Participant Hospital submitted an initial list of proposed Preferred Providers ("**Proposed Preferred Provider List**") in accordance with the following:

(i) The Proposed Preferred Provider List identified each individual or entity by name, individual national provider identifier (NPI), organizational NPI, TIN, CCN (if applicable), and Legacy TIN or CCN (if applicable); and

(ii) The Proposed Preferred Provider List specified the Benefit Enhancements in which the individual or entity has agreed to participate in for the first quarter of PY1; and

(iii) CMS approved or rejected each individual or entity on the Proposed Preferred Provider List based on the results of a screening using Provider Enrollment, Chain, and Ownership System ("**PECOS**") to confirm the individual's or entity's Medicare enrollment status ("**PECOS Screening**") and whether the individual or entity satisfies the definition of Preferred Provider (as defined in Section 2). CMS notified the Participant Hospital whether CMS has approved or rejected the

inclusion of each individual or entity on the Proposed Preferred Provider List. CMS provided the Participant Hospital with a final Preferred Provider List identifying all individuals and entities that CMS approved to be Preferred Providers. Such Preferred Provider List will become effective on the Start Date.

(b) If the Participant Hospital selected one or more Benefit Enhancements to first be offered by Preferred Providers beginning in the second quarter of PY1 or any subsequent quarter, the Participant Hospital shall submit a Proposed Preferred Provider List in accordance with the following:

(i) The Proposed Preferred Provider List identifies each individual or entity by name, individual NPI, organizational NPI, TIN, CCN (if applicable), and Legacy TIN or CCN (if applicable); and

(ii) The Proposed Preferred Provider List specifies the Benefit Enhancement in which the individual or entity has agreed to participate in beginning in such quarter.

(iii) CMS will approve or reject each individual or entity on the proposed Preferred Provider List based on the results of a PECOS Screening and whether the individual or entity satisfies the definition of Preferred Provider (as defined in Section 2). CMS may, at CMS's sole discretion, also conduct a Program Integrity Screening on any individual or entity on the Proposed Preferred Provider List. CMS will notify the Participant Hospital whether CMS has approved or rejected the inclusion of each individual or entity on the Proposed Preferred Provider List. CMS shall provide the Participant Hospital with a final Preferred Provider List identifying all individuals and entities that CMS approved to be Preferred Providers. Such Preferred Provider List shall become effective in accordance with Section 8.3(b)(iv).

(iv) If the Proposed Preferred Provider List is submitted to CMS on or before the fifteenth calendar day of the second month during the applicable calendar quarter, the Preferred Provider List will become effective on the first calendar day of the first calendar quarter following the submission. If the Proposed Preferred Provider List is submitted after the fifteenth calendar day of the second month during the applicable calendar quarter, the Preferred Provider List will become effective on the first calendar day of the second calendar quarter following the submission.

Section 8.4 Implementation Plan

(a) The Participant Hospital shall submit to CMS, in a form and manner and by a date specified by CMS, a plan for implementing each Benefit Enhancement selected by the Participant Hospital ("**Implementation Plan**") for the first PY that the Benefit Enhancement is selected by the Participant Hospital, in advance of the effective date of

any material change to an Implementation Plan for a Benefit Enhancement previously selected, and at such other times specified by CMS.

(b) Each Implementation Plan is deemed approved within 30 calendar days after submission unless rejected in writing by CMS. This paragraph does not preclude CMS from rejecting or requiring amendment of an Implementation Plan or taking any remedial actions described in Section 12 after the Participant Hospital's selections have been approved.

(c) If CMS determines that the Participant Hospital's proposed implementation of one or more Benefit Enhancements is inconsistent with the terms of this Agreement or likely to result in program integrity concerns, CMS may reject the Participant Hospital's selection to provide one or more Benefit Enhancements or may require the Participant Hospital to submit a new Implementation Plan. If CMS rejects the Participant Hospital's selection of a Benefit Enhancement for a Performance Year, the Participant Hospital shall not implement the Benefit Enhancement or Beneficiary Engagement Incentive for that PY.

(d) The Participant Hospital shall provide each Preferred Provider with a copy of the Implementation Plan for every Benefit Enhancement in which the Preferred Provider participates.

(e) CMS and the Participant Hospital acknowledge that the Participant Hospital submitted a plan for implementing each Benefit Enhancement that it selected to offer for the first PY.

Section 8.5 Furnishing Selected Benefit Enhancements.

(a) If the Participant Hospital selects to offer one or more Benefit Enhancements for a PY, the Participant Hospital may submit claims for services furnished pursuant to such Benefit Enhancement(s) as described in Appendices D and E of this Agreement during the PY for which the Participant Hospital selected to make the Benefit Enhancement available.

(b) The Participant Hospital must obtain CMS consent before voluntarily terminating a Benefit Enhancement effective during a PY. The Participant Hospital shall provide at least 30 calendar days advance written notice of such termination to CMS. If CMS consents to such termination, the effective date of such termination will be the date specified in the notice of termination or such other date specified by CMS.

(c) If the Participant Hospital selected to offer a Benefit Enhancement during a PY and does not select to offer it for the following PY, the Participant Hospital shall notify all its affected Preferred Providers that the Participant Hospital will not be offering the Benefit Enhancement during the next PY. Such notices must be furnished no later than 30 calendar days after the deadline for selecting Benefit Enhancements that will be offered during the next PY.

(d) If the Participant Hospital selected to offer a Benefit Enhancement for a PY and does not select to offer it for the following PY, CMS shall cease paying claims for services

furnished under the Benefit Enhancement on the last Day of the PY for which the Participant Hospital had selected to offer the Benefit Enhancement.

(e) If during a PY a Benefit Enhancement will cease to be in effect with respect to the Participant Hospital or any Preferred Provider pursuant to Section 12, the effective date of such termination will be the date specified by CMS in the notice to the Participant Hospital.

Section 8.6 Reporting on Benefit Enhancements.

(a) CMS may require the Participant Hospital to report to CMS on the Participant Hospital's and if applicable its Preferred Providers' use of Benefit Enhancements, if any. Such data shall be reported in a form and in a manner and by a date specified by CMS.

Section 8.7 Telehealth Benefit Enhancement

(a) Appendix D shall apply to the Agreement for any PY for which the Participant Hospital has selected the Telehealth Benefit Enhancement, and for which the Participant Hospital has submitted an Implementation Plan under Section 8.4 for the Telehealth Benefit Enhancement and CMS has not rejected the Participant Hospital's selection.

(b) For an individual to provide services under the Telehealth Benefit Enhancement the individual must be identified on the Preferred Provider List as participant in the Telehealth Benefit Enhancement.

(c) CMS may require the Participant Hospital to report data on the use of the Telehealth Benefit Enhancement to CMS. Such data shall be reported in a form and manner and by a date specified by CMS.

(d) If CMS determines that the Participant Hospital's implementation or proposed implementation of the Telehealth Benefit Enhancement does not satisfy the applicable requirements of this Agreement, including the appendices hereto, or is likely to result in program abuse, CMS may reject the Participant Hospital's selection to offer the Telehealth Benefit Enhancement or may reject, or require the amendment of, the Participant Hospital 's Telehealth Benefit Enhancement Implementation Plan. If CMS rejects the Participant Hospital's Telehealth Benefit Enhancement Implementation Plan, the Practice's shall not implement the Telehealth Benefit Enhancement.

Section 8.8 Nurse Practitioner and Physician Assistant Services Benefit Enhancement

(a) Appendix E shall apply to the Agreement for any PY for which the Participant Hospital has selected the Nurse Practitioner and Physician Assistant Services Benefit Enhancement as described in Section 8.1 and for which the Participant Hospital has submitted an Implementation Plan under Section 8.4 for the Nurse Practitioner and Physician Assistant Services Benefit Enhancement and CMS has not rejected the Participant Hospital's selection.

(b) The Participant Hospital shall require that, in order for an individual to certify, establish a plan of care for, or provide a referral for any of the services identified in Appendix E of the Agreement for Beneficiaries pursuant to the Nurse Practitioner and Physician Assistant Services Benefit Enhancement, the individual must be:

(i) A nurse practitioner (as described in 42 CFR § 410.75(b)) and a Preferred Provider identified on the Preferred Provider List as participating in the Nurse Practitioner and Physician Assistant Services Benefit Enhancement and approved by CMS according to the criteria described in this Section 8 and Appendix E of the Agreement ("**Eligible Nurse Practitioner**"); or

(ii) A physician assistant (as described in 42 CFR § 410.74(a)) and a Preferred Provider identified on the Preferred Provider List as participating in the Nurse Practitioner and Physician Assistant Services Benefit Enhancement and approved by CMS according to the criteria described in this Section 8 and Appendix E of the Agreement ("**Eligible Physician Assistant**").

(c) If CMS notifies the Participant Hospital that a nurse practitioner or physician assistant that is a Preferred Provider has not been approved for participation in the Nurse Practitioner and Physician Assistant Services Benefit Enhancement under this Section 8, but the nurse practitioner or physician assistant is otherwise eligible to be a Preferred Provider, the Participant Hospital may either remove the nurse practitioner or physician assistant from the Preferred Provider List, or amend the relevant list to reflect that the nurse practitioner or physician assistant will not participate in the Nurse Practitioner and Physician Assistant Services Benefit Enhancement. The Participant Hospital shall amend the relevant list no later than 30 calendar days after the date of the notice from CMS.

(d) The Participant Hospital shall ensure that Preferred Providers only certify, establish a plan of care for, or provide a referral for Medically Necessary services under the Nurse Practitioner and Physician Assistant Services Benefit Enhancement and that certification of, establishment of a plan of care for, or referral for services pursuant to the Nurse Practitioner and Physician Assistant Services Benefit Enhancement is not used to prevent or deter a Beneficiary from seeking or receiving other Medically Necessary care.

Section 8.9 Beneficiary Engagement Incentives.

(a) General. Except as otherwise permitted by applicable law, the Participant Hospital shall not provide gifts or other remuneration, and shall prohibit individuals or entities performing functions or providing services related to AHEAD from providing gifts or other remuneration to Beneficiaries to induce them to receive, or to continue receiving, items or services from the Participant Hospital.

(b) Availability of Safe Harbor Protection for In-Kind Remuneration and Beneficiary Engagement Incentives.

(i) CMS has determined that the Federal anti-kickback statute safe harbor for CMS-sponsored Model Patient Incentives (42 C.F.R. § 1001.952(ii)(2)) is available to protect remuneration furnished by the Participant Hospital, an agent of the Participant Hospital operating under the Participant Hospital's direction and control to a Beneficiary that meets all safe harbor requirements set forth in 42 C.F.R. § 1001.952(ii)(2) and the requirements of Section 8 of this Agreement, in the case of in-kind remuneration furnished by the Participant Hospital.

(c) Exception for Certain In-Kind Remuneration

(i) Consistent with the provisions of paragraphs (a) and (b) and subject to compliance with all other applicable laws and regulations, beginning on the first day of the Implementation Period, the Participant Hospital or an agent of the Participant Hospital operating under the Participant Hospital's direction and control may provide certain in-kind items or services to Beneficiaries if the following conditions are satisfied:

(A) The in-kind items or services are preventive care items and services or will advance one or more of the following clinical goals for the Beneficiary: adherence to a treatment regime, adherence to a drug regime, adherence to a follow-up care plan, or management of a chronic disease or condition;

(B) The in-kind item or service has a reasonable connection to the Beneficiary's health care;

(C) 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.

(D) The in-kind item or service is furnished to a Beneficiary directly by the Participant Hospital, or by an agent of the Participant Hospital operating under the Participant Hospital's direction and control.

(E) The availability of the in-kind item or service is not advertised or promoted, except that a Beneficiary may be made aware of the availability of the in-kind item or service at the time the Beneficiary could reasonably benefit from it;

(F) The cost of the in-kind item or service is not shifted to another Federal healthcare program;

(G) The Participant Hospital or, as applicable, by an agent of the Participant Hospital operating under the Participant Hospital's direction and control must maintain documentation of in-kind items or services furnished as Beneficiary incentives that exceed $25 in retail value; and

(H) The in-kind item or service is furnished in a manner consistent with any other programmatic requirements set forth in this Agreement.

(ii) For each in-kind item or service provided under this paragraph (c), the Participant Hospital shall maintain and make available to the government upon request all materials and records sufficient to establish whether such in-kind item or service was furnished in a manner that meets the conditions of this paragraph (c)(ii). Such materials and records must be maintained in accordance with Section 11.5 and include, without limitation, documentation of the following:

(A) The nature of the in-kind item or service;

(B) The identity of each Beneficiary that received the in-kind item or service;

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

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

SECTION 9 – PARTICIPATION IN EVALUATION AND SITE VISITS

Section 9.1 Evaluation Requirement

(a) General. The Participant Hospital shall participate and cooperate in any evaluation activities conducted by or on behalf of CMS aimed at assessing the impact of the Model on the goals of improving quality of care, population health, and reducing expenditures. The Participant Hospital shall require its Preferred Providers to participate and cooperate in any such evaluation activities conducted by or on behalf of CMS. Termination or expiration of this Agreement shall not affect the right of CMS to evaluate the Model.

(b) Primary Data. In its evaluation activities, CMS or its designee(s) may collect qualitative and quantitative data. These data may include, but are not limited to, the following sources:

(i) Site visits with the Participant Hospital;

(ii) Interviews with Beneficiaries and their caregivers;

(iii) Focus groups of Beneficiaries and their caregivers;

(iv) Interviews with the Participant Hospital, its Preferred Providers, and their staff;

(v) Focus groups with the Participant Hospital, its Preferred Providers, and their staff;

(vi) Direct observation of Beneficiary interactions with the Preferred Providers and their staff, care management meetings among Preferred Providers and their staff, and other activities related to the Participant Hospital's participation in the Model; and

(vii) Surveys.

(c) Secondary Data. In its evaluation activities, CMS may use data or information submitted by the Participant Hospital as well as claims submitted to CMS for items and services furnished to Beneficiaries. These data may include, but are not limited to:

(i) Claims data;

(ii) Survey data from Patient Experience surveys;

(iii) Medical records;

(iv) Clinical data such as lab values;

(v) Quality and clinical data submitted to the AHEAD Portal; and

(vi) Care delivery requirements reporting data submitted to the AHEAD Portal.

(d) Pursuant to 42 C.F.R. § 403.1110, CMS may use health data submitted by the Participant Hospital pursuant to Section 3.4 for the purpose of monitoring and evaluating the Model.

(e) Reporting Requirements. CMS may add or modify evaluation-related reporting requirements during the Agreement Term. CMS will notify the Participant Hospital of any additions or modifications at least 30 Days prior to the start of the PY or Transition Year in which such change would take effect.

Section 9.2 Site Visits

(a) The Participant Hospital shall cooperate and require its Preferred Providers to cooperate in any site visits conducted by or on behalf of CMS.

(b) CMS or its designee(s) shall, to the extent practicable, schedule any site visits to Participant Hospital and its Preferred Providers no fewer than 15 Days in advance. To the extent practicable, CMS will attempt to accommodate the Participant Hospital's request for particular dates in scheduling site visits. However, the Participant Hospital may not request a date that is more than 60 Days after the date of the initial site visit notice from CMS.

(c) The Participant Hospital shall ensure that personnel with the appropriate responsibilities and knowledge associated with the purpose of the site visit are available during site visits.

(d) Notwithstanding the foregoing, CMS or its designee(s) may perform unannounced site visits at any of the Participant Hospital's office locations at any time to investigate concerns about the health or safety of Beneficiaries or other program integrity issues.

(e) Nothing in this Agreement shall be construed to limit or otherwise prevent CMS from performing site visits permitted by applicable law or regulations.

Section 9.3 Participant Hospital Public Release of Information

(a) The Participant Hospital and its Preferred Provider shall obtain prior approval from CMS during the Agreement Term and for 6 months thereafter for the publication or release of

any press release, external report or statistical/analytical material that materially and substantially references the Participant Hospital's participation in the Model. External reports and statistical/analytical material may include, but are not limited to, papers, articles, professional publications, speeches, and testimony.

(b) All external reports and statistical/analytical material that are subject to this Section 9.3 must include the following statement on the first page: "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."

SECTION 10 – DATA SHARING AND REPORTING

Section 10.1 General Data Sharing and Reporting

(a) Beginning in PY1 and throughout the Implementation Period and Transition Period, CMS will offer the Participant Hospital the opportunity to request certain reports and access data dashboards as described in Section 10.2.

(b) The Participant Hospital shall have processes in place to submit data to CMS and the State to comply with Section 3, Section 8, and Section 10 of this Agreement.

Section 10.2 Provision of Certain Data to the Participant Hospital.

(a) The Participant Hospital may request from CMS certain individually-identifiable data and certain individually de-identified data regarding those Beneficiaries who are treated at the Participant Hospital or reside in the Participant Hospital geographic service area in the form of an aggregated data dashboard ("**Aggregated Data Dashboard**").

(b) In offering this individually-identifiable data, CMS does not represent that the Participant Hospital or any Preferred Provider has met all applicable HIPAA requirements for requesting data under 45 C.F.R. § 164.506(c)(4). The Participant Hospital and its Preferred Provider should consult with their own counsel to make those determinations prior to requesting this data from CMS.

(c) Subject to the limitations discussed in this Agreement, and in accordance with applicable law including HIPAA regulations and the regulations in 42 C.F.R. Part 2 regarding the confidentiality of substance use disorder patient records, after the Effective Date, CMS will offer the Participant Hospital the opportunity to request access to the Aggregated Data Dashboard by completing a data request form ("**HIPAA-Covered Data Disclosure Request Attestation**"). All such requests will be granted or denied at CMS' sole discretion, and may be based on CMS's available resources, the terms and conditions in this Agreement, and applicable law.

(d) The individually identifiable data and reports that CMS provides to the Participant Hospital under the preceding paragraph will omit individually identifiable data for

Beneficiaries who have opted out of data sharing with the Participant Hospital. Furthermore, such data and reports will also omit substance use disorder data for any Beneficiaries who have not opted into substance use disorder data sharing.

(e) The Participant Hospital must update its CMS Data Request Form if the assertions therein become inaccurate over the course of the Agreement PY or Transition Period through changes to the Participant Hospital's information, data needs, or otherwise. Furthermore, to ensure periodic confirmation of continued accuracy, CMS will require the Participant Hospital to review and attest to the accuracy of the assertions in the Participant Hospital's current CMS Data Request Form on at least an annual basis in a form and manner specified by CMS. The Participant Hospital must attest to the continued accuracy of the CMS Data Request Form or submit a new or updated CMS Data Request Form, as applicable, as a condition of the Participant Hospital's continued receipt of the data specified on such form.

(f) The Aggregated Data Dashboard may include, but is not limited to, the following individually-identifiable data: quarterly and annual utilization reports, monthly expenditure reports, and attributed beneficiary lists.

(g) CMS and the Participant Hospital agree that CMS retains all ownership rights to the data files described in the HIPAA-Covered Data Disclosure Request Attestation, and the Participant Hospital does not obtain any right, title, or interest in any of the data furnished by CMS.

(h) The Participant Hospital represents, and in furnishing any data files requested via the HIPAA-Covered Data Disclosure Request Attestation, CMS relies upon such representation, that any data files requested using the HIPAA-Covered Data Disclosure Request Attestation will be requested solely for the purposes described in the HIPAA-Covered Data Disclosure Request Attestation. Furthermore, the Participant Hospital agrees not to disclose, use, or reuse any of the requested data or any individually identifiable derivative data except as specified in this Agreement, or as CMS may authorize in writing outside of this Agreement, or as required by law. The Participant Hospital further agrees not to sell, rent, lease, loan or otherwise grant access to the data covered by this Agreement without the express authorization of the subject of such data and agrees to contractually bind all downstream data recipients to this limitation.

(i) Notwithstanding any other provision of this Agreement, but only in accordance with applicable law, the Participant Hospital may reuse and further disclose original or derivative data received under this Agreement without prior authorization from CMS if such use or disclosure is to enable the provision of clinical treatment, care management and coordination, to enable quality improvement activities, or to design or effectuate provider incentives under the Model. Any reuse or disclosure described in this paragraph is further limited to activities that do not result in the disclosure of individually identifiable original or derived information from the data files specified in the CMS Data Request Form to anyone who is not a HIPAA Covered Entity ("**CE**") or Business

Associate ("**BA**") of a HIPAA CE in a treatment relationship with the subject Beneficiary(ies). Furthermore, when using or disclosing protected health information (PHI) or personally identifiable information (PII) obtained from data files specified in the CMS Data Request Form, the Participant Hospital must make "reasonable efforts to limit" the information to the "minimum necessary," as these terms are used in 45 C.F.R. § 164.502(b), to accomplish the intended purpose of the use, disclosure or request. The Participant Hospital shall further limit its use and disclosure of such information to the types of disclosures that CMS itself would be permitted to make under the "routine uses" in the applicable systems of records listed in the CMS Data Request Form.

(j) Subject to the limits specified above and elsewhere in this Agreement and applicable law, the Participant Hospital may link information specified in the HIPAA-Covered Data Disclosure Request Attestation or derivative data to other sources of individually-identifiable health information, such as other medical records available to the Participant Hospital. The Participant Hospital may disseminate data obtained through the linking of the data specified in the HIPAA-Covered Data Disclosure Request Attestation to other sources of individually identifiable health information if such resulting data has been de-identified in accordance with HIPAA requirements in 45 C.F.R. § 164.514(b).

(k) The Participant Hospital agrees to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the CMS data requested in the HIPAA-Covered Data Disclosure Request Attestation, and to prevent unauthorized use or disclosure of such data or any individually identifiable derivative data files. 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 G--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" (nvlpubs.nist.gov/nistpubs/SpecialPublications/ NIST.SP.800-53r4.pdf). The Participant Hospital is prohibited from using unsecured telecommunications, including the Internet, to transmit directly or indirectly identifiable information from the files specified in the HIPAA-Covered Data Disclosure Request Attestation or any such derivative data files is strictly prohibited. Further, the Participant Hospital agrees that the data specified in the HIPAA-Covered Data Disclosure Request Attestation must not be physically moved, transmitted or disclosed in any way from or by the site of the custodian indicated in the HIPAA-Covered Data Disclosure Request Attestation other than as provided in the Agreement without approval from CMS, unless such movement, transmission or disclosure is required by law. Information derived from the CMS data files specified in the HIPAA-Covered Data Disclosure Request Attestation may only be used within the legal confines of the Participant Hospital.

(l) The Participant Hospital shall grant access to the data or the facility, or both, in which the data is maintained to the authorized designees of CMS or HHS Office of Inspector General, including at the site of the custodian indicated in the HIPAA-Covered Data Disclosure Request Attestation, for the purpose of inspecting to confirm compliance with the terms of this Agreement, and to contractually bind downstream data recipients to the same requirements as a condition of receiving such data.

(m) The Participant Hospital agrees that any publication or dissemination of purportedly "de-identified" data that is derived from the CMS data listed in the HIPAA-Covered Data Disclosure Request 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.

(n) The Participant Hospital agrees to report any breach of protected health information (PHI) or personally identifiable information (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 Hospital agrees to cooperate fully in any federal incident security process that results from such improper use or disclosure, and to contractually bind downstream data recipients to the same requirements as a condition of receiving such data.

(o) The Parties agree that the individual named in the HIPAA-Covered Data Disclosure Request Attestation is designated as custodian of the CMS data files on behalf of the Participant Hospital and will be responsible for the observance of all conditions of use and disclosure of such data and any derivative data files, and for the establishment and maintenance of security arrangements as specified in this Agreement to prevent unauthorized use or disclosure. The Participant Hospital agrees to notify CMS within 30 Days of any change of custodianship. The Parties agree that CMS may disapprove the appointment of a custodian or may require the appointment of a new custodian at any time.

(p) Data disclosed to the Participant Hospital pursuant to the HIPAA-Covered Data Disclosure Request Attestation may be retained by the Participant Hospital until the termination of the Agreement Term. The Participant Hospital may retain any individually identifiable health information from such data files or derivative data files after the termination of the Agreement if the Participant Hospital 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 or BA to whom the Participant Hospital provides such data in the course of carrying out the Model 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 Hospital shall destroy all other data, and ensure all other

downstream entities' destruction of their copies of the data, and send certification of the destruction of the Participant Hospital's and applicable downstream entities' data files and/or any derivative data files to CMS within 30 Days following the termination of the Agreement Term. These retention and destruction provisions survive termination of the Agreement Term.

Section 10.3 Rights in Data and Intellectual Property.

(a) CMS may use any data obtained pursuant to the Model to evaluate the Model and to disseminate quantitative results and successful care management techniques to other providers and suppliers and to the public. Data to be disseminated may include results of patient experience of care and quality of life surveys as well as measures based upon claims, medical records, and other data sources. The Participant Hospital will be permitted to comment on evaluation reports when the Participant Hospital has been specifically cited to ensure factual accuracy but may not edit conclusions or control the dissemination of reports.

(b) Notwithstanding any other provision in the Agreement, all proprietary trade secret information and technology of the Participant Hospital is and shall remain the sole property of the Participant Hospital, and, except as required by federal law, shall not be released by CMS without express written consent. The regulation at 48 C.F.R. § 52.227-14, "Rights in Data-General" is hereby incorporated by reference into the Agreement. CMS does not acquire by license or otherwise, whether express or implied, any intellectual property right or other rights to the Participant Hospital's proprietary information or technology.

(c) If the Participant Hospital maintains any information that should not be publicly disclosed because the Participant Hospital considers such information to be proprietary and confidential, the Participant Hospital acknowledges that it may submit to CMS a form, using either the template attached as Appendix A, or a form substantially the same as Appendix A, identifying specific examples of information the Participant Hospital considers to be proprietary and confidential. The Participant Hospital must notify CMS, in a form and manner to be specified by CMS, of any updates to this form. If the Participant Hospital does not submit such a form, the Participant Hospital will be deemed to have confirmed that it has no information it considers proprietary and confidential.

Section 10.4 Beneficiary Right to Opt Out of Data Sharing.

(a) In a form and manner to be determined by CMS, the Participant Hospital shall provide Beneficiaries who inquire about and wish to modify their preferences regarding claims data sharing for care coordination, care delivery transformation and quality improvement purposes with information about how to modify their data sharing preferences. The Participant Hospital shall inform them that they may modify their data sharing preferences by calling 1-800-MEDICARE. Such communications shall note that, even if a Beneficiary has elected to decline claims data sharing, CMS may still engage in certain limited data sharing for quality improvement purposes.

(b) The Participant Hospital shall allow Beneficiaries to reverse a data sharing preference at any time by calling 1-888-734-6433, option 8.

(c) CMS will maintain the data sharing preferences of Beneficiaries who elect to decline data sharing in the Model.

(d) The Participant Hospital may affirmatively contact a Beneficiary who has elected to decline claims data sharing no more than one time in a given PY to provide information regarding data sharing. Such contact includes mailings, phone calls, electronic communications, or other methods of communicating with Beneficiaries outside of a clinical setting.

(e) Notwithstanding the foregoing, the Participant Hospital shall receive claims data regarding substance use disorder treatment only if the Beneficiary has not elected to decline data sharing or otherwise been opted out of data sharing and has also submitted a CMS-approved form pursuant to Section 10.5.

(f) CMS will administratively opt an Beneficiary back into claims data sharing if the Beneficiary was administratively opted out of data sharing solely due to the termination of a different Participant Hospital. That is, the Beneficiary will be included in the Participant Hospital's data if he or she lives in the Participant Hospital's geographic service area, unless the Beneficiary affirmatively opts out of data sharing in accordance with this Section 10.4.

Section 10.5 Beneficiary Substance Use Disorder Data Opt In.

(a) The Participant Hospital may inform each Beneficiary, in compliance with applicable law:

(i) That he or she may elect to allow the Participant Hospital to receive individually-identifiable data regarding his or her utilization of substance use disorder treatment services;

(ii) Of the mechanism by which the Beneficiary can make this election; and

(iii) That 1-800-MEDICARE will answer any questions regarding data sharing of substance use disorder services.

(b) A Beneficiary may opt in to substance use disorder data sharing only by submitting a CMS-approved substance use disorder opt in form to the Participant Hospital. The Participant Hospital shall promptly send the opt-in form to CMS.

SECTION 11 – MONITORING AND COMPLIANCE

Section 11.1 Monitoring Activities

(a) The Participant Hospital shall comply with, and shall require its Preferred Providers to comply with, all State and CMS monitoring and oversight requests and activities described in this Section 11.

(b) Monitoring Activities.

(i) CMS shall conduct monitoring activities to evaluate compliance by the Participant Hospital and its Preferred Providers with the terms of the Agreement. Such monitoring activities may include, without limitation:

(A) Claims analyses to identify fraudulent behavior or program integrity risks, such as inappropriate reductions in care (e.g., through claims-based utilization, inappropriate changes in case-mix or quality measures), efforts to manipulate risk scores or attributed populations, and overutilization;

(B) Review of documents from the Participant Hospital and its Preferred Providers, including surveys and questionnaires;

(C) Interviews with the Participant Hospital, its Preferred Providers, any individual or entity participating in Descriptive AHEAD Materials and Activities, and any individual or entity participating in activities related to promoting accountability for the quality, cost, and overall care for a population of Beneficiaries;

(D) Interviews with Beneficiaries and their caregivers;

(E) Audits of charts, medical records, Participant Hospital's PHAPs, Implementation Plans, Descriptive AHEAD Materials and Activities, and other data from the Participant Hospital and Preferred Providers; and

(F) Site visits to the Participant Hospital and its Preferred Providers.

(ii) If the Participant Hospital is a CAH, the Participant Hospital shall procure a CMS-approved vendor to conduct the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) or other patient experience surveys. The Participant Hospital is responsible for paying for the surveys and for ensuring that the survey results are transmitted to CMS by a date and in a form and manner specified by CMS.

(iii) In conducting monitoring activities, CMS or its designees may use any relevant data or information including, without limitation, all Medicare claims submitted for items or services furnished to Beneficiaries to monitor, among other things, any potential Unintended Negative Consequences.

(iv) Nothing in this Agreement shall be construed to limit or otherwise prevent CMS from monitoring as permitted by applicable law or regulations.

(v) CMS may monitor the Participant Hospital and the Participant Hospital's Preferred Providers pursuant to this Section 11 for up to two calendar year after the effective date of termination or expiration of this Agreement.

(c) Participant Hospital Compliance with Monitoring and Oversight Activities.

(i) The Participant Hospital shall contribute to monitoring activities and reports coordinated by the State pursuant to the State Agreement.

(ii) The Participant Hospital shall ensure it has sufficient access to all records, data, and other information necessary to comply with the monitoring activities described herein.

(iii) If the Participant Hospital fails to comply with any monitoring request or activity, CMS may take remedial action or terminate this Agreement in accordance with Section 12.

(d) Participant Hospital Compliance Plan. The Participant Hospital shall have a compliance plan that addresses the prevention, detection, and correction of noncompliance with the terms of this Agreement. The Participant Hospital shall update its compliance plan as may be needed to reflect changes in applicable statutes and regulations and the terms of this Agreement. CMS may request information from the Participant Hospital about its compliance plan at any time.

Section 11.2 Compliance with Laws

(a) Agreement to Comply

(i) The Participant Hospital shall comply with, and shall require its Preferred Providers to comply with, all applicable statutes, regulations, and guidance, including, without limitation: federal criminal laws; the federal False Claims Act (31 U.S.C. § 3729 et seq.); the federal anti-kickback statute (42 U.S.C. § 1320a-7b(b)); the federal civil monetary penalties law (42 U.S.C. § 1320a-7a); and the federal physician self-referral law (42 U.S.C. § 1395nn).

(ii) This Agreement does not waive any obligation of the Participant Hospital or its Preferred Providers to comply with the terms of any other CMS contract, agreement, model, or demonstration.

(b) Reservation of Rights

(i) Nothing contained in this Agreement or in the application process for AHEAD is intended to or can be construed as a waiver by the United States Department of Justice, the Internal Revenue Service, the Federal Trade Commission, HHS Office of the Inspector General, or CMS of any right to institute any proceeding or action for violations of any statutes, rules, or regulations administered by the government, or to prevent or limit the rights of the government to obtain relief under any other federal statutes or regulations, or on account of any violation of

the Agreement or any other provision of law. This Agreement does not bind any government agency except CMS and the Agreement binds CMS only to the extent provided in this Agreement.

(ii) The failure by CMS to require performance of any provision of this Agreement does not affect CMS' right to require performance at any time thereafter, nor does a waiver of any breach or default of the Agreement constitute a waiver of any subsequent breach or default or a waiver of the provision itself.

(c) Office of Inspector General of the Department of Health and Human Services (OIG) Authority. None of the provisions of this Agreement limit or restrict the OIG's authority to audit, evaluate, investigate, or inspect the Participant Hospital or its Preferred Providers.

(d) Other Government Authority. None of the provisions of this Agreement limit or restrict any other government authority that is permitted by law to audit, evaluate, investigate, or inspect the Participant Hospital or its Preferred Providers.

Section 11.3 Certification of Data and Information

(a) With respect to data and information generated or submitted to CMS or the State by the Participant Hospital or its Preferred Providers, the Participant Hospital shall ensure that an individual with the authority to legally bind the individual or entity submitting such data or information certifies the accuracy, completeness, and truthfulness of that data and information to the best of his or her knowledge, information, and belief.

(b) At the end of each PY and Transition Year, an individual with the legal authority to bind the Participant Hospital must certify to the best of his or her knowledge, information, and belief:

(i) That the Participant Hospital and its Preferred Providers are in compliance with Model requirements; and

(ii) The accuracy, completeness, and truthfulness of all data and information that are generated or submitted by the Participant Hospital and its Preferred Providers, including any quality data or other information or data relied upon by CMS.

Section 11.4 Audits and Inspection

(a) The Participant Hospital agrees, and shall require its Preferred Providers to agree that the federal government (including without limitation CMS, HHS, and the Comptroller General) or its designees, has the right to audit, inspect, investigate and evaluate any books, contracts, records, documents, and other evidence of the Participant Hospital and its Preferred Providers that pertain to the following:

(i) The Participant Hospital's compliance with the terms of this Agreement, including provisions that require the Participant Hospital to impose duties or requirements on its Preferred Providers;

(ii) Whether the Preferred Providers complied with the duties and requirements imposed on them by the Participant Hospital pursuant to the terms of this Agreement;

(iii) The quality of services performed under this Agreement;

(iv) The Participant Hospital's compliance with applicable laws, regulations and Medicare Program requirements;

(v) Any activity by the Participant Hospital or its Preferred Providers that may pose a potential risk of harm to Beneficiaries or a vulnerability to the integrity of the Model test;

(vi) The ability of the Participant Hospital to repay amounts owed to CMS under this Agreement.

Section 11.5 Maintenance of Records

(a) The Participant Hospital shall maintain and shall give the government (including CMS, HHS, and the Comptroller General or their designees) access to, and shall require all its Preferred Providers to maintain and give the government access to, all books, contracts, records, documents, and other evidence (including data related to Medicare utilization and costs, quality performance measures, and financial arrangements) sufficient to enable the audit, evaluation, inspection, or investigation of the Model, including the subjects identified in Section 11.4. The Participation Hospital shall maintain, and shall require all its Preferred Providers to maintain, such books, contracts, records, documents, and other evidence for a period of seven years after the expiration or termination of the Agreement Term, or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later, unless:

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

(ii) There has been a termination, dispute, or allegation of fraud or similar fault against the Participant Hospital, in which case the records must 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.

SECTION 12 – REMEDIAL ACTION AND TERMINATION

Section 12.1 Remedial Action

(a) Grounds for Remedial Action.

(i) CMS may take one or more of the remedial actions described in Section 12.2 if CMS determines that:

(ii) The Participant Hospital or any of its Preferred Providers has failed to comply with any provision of this Agreement (including terms that survive the expiration or termination of this Agreement);

(iii) The Participant Hospital or any of its Preferred Providers has failed to demonstrate improved performance following any remedial action imposed by CMS;

(iv) The Participant Hospital or any of its Preferred Providers has failed to comply with any applicable Medicare program laws or regulations;

(v) The Participant Hospital or any of its Preferred Providers has taken any action that threatens the health or safety of a Beneficiary or other patient;

(vi) The Participant Hospital or any of its Preferred Providers has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the Model, this Agreement, or any requirement of the Medicare, Medicaid, or CHIP programs;

(vii) The Participant Hospital or any of its Preferred Providers poses a significant program integrity risk, including the following:

(A) 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, Medicare or Medicaid program exclusion, or debarment; or

(B) Is subject to investigation or action by HHS (including the HHS Office of the 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;

(viii) The Participant Hospital or any of its Preferred Providers experiences or is expected to experience any Unintended Negative Consequences.

(ix) The Participant Hospital or any of its Preferred Providers has undergone a Change in Control or Change in Hospital Type;

(x) The volume of services previously delivered by the Participant Hospital has shifted to facilities not participating in the Participant Hospital's Medicare FFS Hospital Global Budget.

(xi) Medicare FFS claims for Eligible Hospital Services included under the Participant Hospital's Medicare FFS Hospital Global Budget do not amount to at least eighty

(80) percent of the Medicare FFS Hospital Global Budget amount for each PY or TY, as described in the Financial Specifications Document.

(xii) The Participant Hospital has failed to comply with the Corrective Action Plan (CAP), the monitoring or auditing plan, or both, developed by CMS for the Participant Hospital, or other remedial action imposed by CMS, if applicable.

(b) Remedial Action. If CMS determines that one or more grounds for remedial action described in Section 12.1(a) exist, CMS may immediately or with advance notice take one or more of the following remedial actions:

(i) Notify the Participant Hospital and, if appropriate, the Preferred Provider of the violation;

(ii) Require the Participant Hospital to provide additional information to CMS, the State, or their respective designees;

(iii) Conduct site visits in accordance with Section 9.3, interview the Participant Hospital's personnel and staff, interview Beneficiaries and other patients, or take other actions to gather information;

(iv) Place the Participant Hospital on a monitoring and/or auditing plan developed by CMS;

(v) Require the Participant Hospital to implement a corrective action plan ("**CAP**"), developed in accordance with Section 12.2 on a timeline specified by CMS;

(vi) Amend this Agreement without the consent of the Participant Hospital or the State to limit or deny the applicability of any or all waivers made pursuant to section 1115A(d)(1) of the Act or take other action to limit or deny the applicability of such waivers;

(vii) Discontinue the provision of data sharing and reports to the Participant Hospital;

(viii) Deny, suspend, recalculate, or recoup the Medicare FFS Hospital Global Budget for amounts owed to Medicare by the Participant Hospital;

(ix) Prohibit the Participant Hospital from furnishing any in-kind items and services under Section 8.9;

(x) Amend the Agreement without the consent of the Participant Hospital or the State to deny the use of one or more Beneficiary Engagement Incentives or Benefit Enhancements by the Participant Hospital or its Preferred Providers and to require the Participant Hospital to terminate any agreement effectuating such Beneficiary Engagement Incentives or Benefit Enhancements by a date specified by CMS;

(xi) Require the Participant Hospital to remove individuals or entities from the Preferred Provider List; or

(xii) Impose additional remedial actions if CMS determines that the remedial actions enumerated in this Section 12.1(b) are insufficient to correct noncompliance with the terms of this Agreement or that any previously imposed remedial actions were insufficient to correct noncompliance with the terms of this Agreement.

Section 12.2 CAP Requirements

(a) If CMS requires the Participant Hospital to implement a CAP pursuant to Section 12.1(b)(v), the Participant Hospital shall submit a proposed CAP for CMS approval by a deadline and in a form and manner specified by CMS ("Proposed CAP"). The Proposed CAP must:

(i) Outline the actions the Participant Hospital will take, or will require any of its Preferred Providers to take, within a specified time period to ensure that all deficiencies will be corrected in the timeframe approved by CMS, and that the Participant Hospital will be in compliance with the terms of this Agreement, together with supporting documentation;

(ii) Indicates how the Participant Hospital will measure, track, and report implementation of the CAP; and

(iii) Address such other issues as specified by CMS.

(b) To the extent practicable, CMS will provide a response to the Participant Hospital on the Proposed CAP within 30 Days after receipt. If CMS provides feedback on the Proposed CAP, the Participant Hospital shall incorporate and address any such feedback and shall submit a revised CAP ("**Revised Proposed CAP**") to CMS for CMS approval or rejection by a deadline specified by CMS. A Proposed CAP or Revised Proposed CAP will become effective on the date provided by CMS in CMS' notice of approval of the CAP. The Participant Hospital shall implement the CAP beginning on the effective date of the CAP.

(c) The Participant Hospital shall provide a PY of the Proposed CAP, Revised Proposed CAP, and approved CAP to the State.

(d) CMS will monitor and evaluate Participant Hospital's performance during and after the CAP process.

(e) CMS may take additional remedial action or terminate the Agreement, Agreement Performance Period, Implementation Period, or Transition Period, if the Participant Hospital does not implement the CAP within the specified timeframe.

Section 12.3 Termination by CMS

(a) CMS may immediately or with advance notice terminate the Agreement , Agreement Performance Period, Implementation Period, or Transition Period if:

(i) CMS determines that any of the grounds for remedial action set forth in Section 12.1(b) exist;

(ii) CMS determines that any of the grounds for remedial action set forth in Section 12.1(a) continue to exist after remedial action has been imposed pursuant to Section 12.1(b);

(iii) CMS determines that the Participant Hospital has failed to submit, obtain approval for, implement, or fully comply with the terms of a CAP;

(iv) CMS determines that the Participant Hospital has failed to demonstrate improved performance following any remedial action imposed by CMS;

(v) The Participant Hospital undergoes a Change in Control or Change in Hospital Type;

(vi) The Participant Hospital assigns or purports to assign any of the rights or obligations under the Agreement, voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or any other manner, without the written consent of CMS;

(vii) The Cooperative Agreement or State Agreement between CMS and the State is terminated prior to the end of the Implementation Period or Transition Period.

(viii) CMS determines that the agency no longer has the funds to support the Model.

(ix) CMS terminates or modifies the Model pursuant to section 1115A(b)(3)(B) of the Act.

(x) CMS determines that it is no longer in the public interest to test the Model.

(xi) The Participant Hospital fails to sign an amended and restated version of the Agreement offered by CMS in accordance with Section 1.4(a).

(b) CMS will make reasonable efforts to consult with the State and Participant Hospital before terminating the Implementation Period, Transition Period, Agreement Performance Period or the Agreement pursuant to this Section 12.3. If CMS terminates the Implementation Period, Transition Period, Agreement Performance Period or Agreement , CMS will provide a written notice to the Participant Hospital and the State that sets forth the effective date of, and reason for such termination.

Section 12.4 Termination by Participant Hospital

(a) Implementation Period Termination for Extraordinary Circumstance.

(i) Except as described in Section 12.4(b), the Participant Hospital may, in accordance with the requirements of this Section 12, terminate the Implementation Period of this Agreement if the Participant Hospital determines that its continued participation in the Model is no longer feasible or appropriate as the result of a circumstance that was unintended on the Effective Date, including

financial hardship or deterioration of quality of care. ("**Extraordinary Circumstance**").

(ii) If the Participant Hospital wishes to terminate the Implementation Period, the Participant Hospital shall provide written notice to CMS and the State alerting CMS and the State of the potential Extraordinary Circumstance(s). Such notice must specify the following:

(A) The potential Extraordinary Circumstance(s);

(B) A recommendation describing the actions the Participant Hospital propose to take to address the potential Extraordinary Circumstance(s);

(C) Any non-monetary resources or technical assistance, or both, the Participant Hospital requests from CMS or the State to address the potential Extraordinary Circumstance(s); and

(D) Any other content specified by CMS and the State.

(iii) After receiving the Participant Hospital's notice described in Section 12.4(a)(ii), CMS will determine, in consultation with the State, the following:

(A) Whether an Extraordinary Circumstance exists;

(B) If CMS determines an Extraordinary Circumstance exists, whether the actions recommended by the Participant Hospital to address the Extraordinary Circumstance may be taken;

(C) If CMS determines an Extraordinary Circumstance exists, whether CMS or the State will provide any non-monetary requested resources or technical assistance as related the Model; and

(D) If CMS determines an Extraordinary Circumstance exists, the deadline by which one or more of the parties must complete such actions.

(iv) If the Participant Hospital implements the actions approved by CMS in accordance with Section 12.4(a)(iii), and the Participant Hospital determines that such actions have not addressed the Extraordinary Circumstance(s), the Participant Hospital may terminate its participation in the Implementation Period and Transition Period by providing at least 60 Days advanced written notice of such termination to CMS, the State, and its Preferred Providers after the applicable deadline described in Section 12.5(a)(iii)(D).

(b) PY3 through PY10 and Transition Period Termination. Between June 1, 2027 and September 30, 2027, the Participant Hospital may terminate PY3 and each subsequent PY, and Transition Year, in accordance with Section 12.5(b)(i). If the Participant Hospital terminates under this paragraph (b), the Participant Hospital is terminating the remainder of the Implementation Period and Transition Period, specifically January 1, 2028 through December 31, 3035.

(i) If the Participant Hospital wishes to terminate the remainder of the Implementation Period (i.e. PY3 - PY10) and the Transition Period, the Participant Hospital must provide written notice of such termination to CMS and the State between June 1, 2027, and September 30, 2027.

(ii) The Participant Hospital must provide at least 60 days advance written notice of such termination to its Preferred Providers.

(c) Transition Period. The Participant Hospital may terminate the Transition Period of this Agreement by providing at least 60 days advanced written notice of such termination to CMS, the State, and its Preferred Providers.

Section 12.5 Notifications upon Termination

(a) If CMS terminates the Agreement, Agreement Performance Period, Implementation Period or Transition Period under Section 12.3, the Participant Hospital shall provide written notice of the termination to all its Preferred Providers. The Participant Hospital shall deliver such written notice no later than 60 Days before the effective date of termination unless a different date is specified by CMS. The Participant Hospital shall include in such notices any content specified by CMS, including, but not limited to, information regarding data retention and data destruction and the discontinuation of Beneficiary Engagement Incentives and Benefit Enhancements.

(b) If the Participant Hospital terminates the Implementation Period or Transition Period under Section 12.4, the Participant Hospital shall provide written notice in accordance with Section 12.5(d). The Participant Hospital shall include in such notices any content specified by CMS, including, but not limited to, information regarding data retention and data destruction and the discontinuation of Beneficiary Engagement Incentives and Benefit Enhancements.

Section 12.6 Financial Settlement Upon Termination

If the Agreement , Agreement Performance Period, Implementation Period or Transition Period is terminated pursuant to Section 12.3 or 12.4, CMS shall conduct settlement for the entire Performance Year or Transition Year in which the date of such termination occurs.

SECTION 13 – LIMITATION ON REVIEW AND DISPUTE RESOLUTION

Section 13.1 Limitations on Review

(a) There is no administrative or judicial review under sections 1869 or 1878 of the Act or otherwise for the following:

(i) The selection of organizations, sites, or participants to test models selected for testing or expansion under section 1115A of the Act, including the decision by CMS to terminate the Agreement or Implementation Period or Transition Period,

or to require the termination of any individual's or entity's status as a Preferred Provider;

(ii) The elements, parameters, scope, and duration of such models for testing or dissemination, including the methodology for calculating the Medicare FFS Hospital Global Budget;

(iii) Determinations regarding budget neutrality under section 1115A(b)(3);

(iv) The termination or modification of the design and implementation of a model under section 1115A(b)(3)(B);

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

(vi) A final financial settlement report issued pursuant to Section 5.6, including without limitation the determination by CMS of—

(A) The historical baseline expenditures;

(B) The Participant Hospital's Medicare FFS Hospital Global Budget;

(C) The liability and amounts of any monies owed.

(vii) The assessment of the quality of care furnished by the Participant Hospital or its Preferred Providers by CMS;

(viii) The methodology applied to calculate the Medicare FFS Hospital Global Budget; and

(ix) The alignment of Beneficiaries to the Participant Hospital by CMS for purposes of performance adjustments;

Section 13.2 Reconsideration Process

(a) Right to Reconsideration. The Participant Hospital may request reconsideration of a determination made by CMS pursuant to the Agreement only if such reconsideration is not precluded by section 1115A(d)(2) of the Act or the Agreement.

(i) Such a request for reconsideration by the Participant Hospital must satisfy the following criteria:

(A) The request must be submitted to a designee of CMS ("**Reconsideration Official**") who—

(1) Is authorized to receive such requests; and

(2) Did not participate in the determination that is the subject of the reconsideration request.

(B) The request must include a copy of the initial determination issued by CMS and contain a detailed, written explanation of the basis for the dispute, including supporting documentation and documentation of the Participant Hospital's prior attempts to resolve the Hospital Global Budget dispute with CMS.

(C) The request must be made within 30 Days of the date of the initial determination for which reconsideration is being requested via email to InnovationModelsReconsiderations@cms.hhs.gov or such other email address as may be specified by CMS.

(ii) Requests that do not meet the requirements of Section 13.2(a)(i) will be denied.

(iii) Within 10 business days of receiving a request for reconsideration, the Reconsideration Official will send to the Participant Hospital and to CMS a written acknowledgement of receipt of the reconsideration request. Such an acknowledgement will set forth:

(A) The review procedures; and

(B) A schedule that permits each Party to submit documentation in support of the Party's position for consideration by the Reconsideration Official.

(b) Standards for Reconsideration.

(i) The Parties shall proceed diligently with the performance of this Agreement during the course of any dispute arising under this Agreement.

(ii) The reconsideration will consist of a review of documentation that is submitted timely and in accordance with the standards specified by the Reconsideration Official.

(iii) The burden of proof is on the Participant Hospital to demonstrate to the Reconsideration Official with clear and convincing evidence that the determination is inconsistent with the terms of this Agreement.

(c) Reconsideration Determination.

(i) The Reconsideration Determination will be based only upon:

(A) Position papers and supporting documentation that are timely submitted to the Reconsideration Official and meet the standards for submission under Section 13.2(a)(i); and

(B) Documents and data that were timely submitted to CMS in the required format before the agency made the determination that is the subject of the reconsideration request.

(ii) The Reconsideration Official will issue to CMS and to the Participant Hospital a written notification of the determination ("**Reconsideration Determination**"). Absent unusual circumstances, the Reconsideration Determination will be issued within 60 Days of receipt of timely filed position papers and supporting documentation.

(iii) The Reconsideration Determination is final and binding 30 Days after its issuance, unless the Participant Hospital or CMS timely requests review of the Reconsideration Determination in accordance with Section 12.2(d)(i) and (ii).

(d) CMS Administrator Review. The Participant Hospital or CMS may request CMS Administrator review of the Reconsideration Determination.

(i) The request must be made via email to CMS at the email address specified in Section 13.2(a)(i)(C) (or such other email address as specified by CMS) within 30 Days after the date of the Reconsideration Determination.

(ii) The request must include a copy of the Reconsideration Determination and a detailed, written explanation of why the Participant Hospital or CMS disagrees with the Reconsideration Determination.

(iii) Within 30 business days after receiving a request for review, the CMS Administrator (or a delegate acting on behalf of the CMS Administrator) will determine whether the request for review is granted or denied. The Administrator will promptly send the parties a written acknowledgement of receipt of the request for review. Such an acknowledgement will set forth:

(A) Whether the request for review is granted or denied; and

(B) If the request for review is granted, the review procedures and a schedule that permits each Party to submit a brief in support of the Party's position for consideration by the CMS Administrator.

(iv) If the request for review is denied, the Reconsideration Determination is final and binding as of the date the request for review is denied.

(v) If the request for review is granted:

(A) The record for review will consist of timely submitted briefs and the evidence contained in the record of the proceedings before the Reconsideration Official. The CMS Administrator will not consider documentation submitted for review other than the documents and data described in Section 13.2(c)(i).

(B) The CMS Administrator will review the record and issue to CMS and to the Participant Hospital a written determination.

(C) The written determination of the CMS Administrator is final and binding.

(e) Effect of Dispute Resolution. The dispute resolution process under this Agreement shall not be construed to negate, diminish, or otherwise alter the applicability of existing laws, rules, and regulations or determinations made by other government agencies.

SECTION 14 – MISCELLANEOUS

Section 14.1 Agency Notifications and Submission of Reports

(a) Unless otherwise stated in writing after the Effective Date, all notifications and reports required under this Agreement shall be submitted to the parties at the addresses set forth below.

CMS:
AHEAD Model
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mailstop: AR-21-55
Baltimore, MD 21244
Email: AHEAD@cms.hhs.gov

State: (Will be provided by the State)_____

Address: _____

_____

_____

_____

Email: _____

In a form and manner and by a date specified by CMS, the Participant Hospital shall provide the following information to CMS as applicable:

Participant Hospital: _____

Address: _____

_____

_____

_____

Email: _____

(b) Unless otherwise stated in writing after the Effective Date, all notices, approvals, authorizations and communications required or permitted to be given under the Agreement shall be communicated in the following manner:

(i) Given in writing (including, but not limited to, Microsoft Word document, Microsoft Excel spreadsheet, or PDF); and

(ii) Transmitted in a form and manner specified by CMS.

(c) In the event that the notice, approval, authorization or communication cannot be given by electronic mail, the Parties shall personally deliver or mail, by prepaid, certified mail or overnight courier such notice, approval, authorization or communication to the addresses set forth in Section 13.1(a).

For the purposes of the Agreement, a Party may change its address, fax number, email address or the person to whom a notice or other communication is marked to the attention of, by giving notice of such change to the other Parties.

Section 14.2 Notice of Bankruptcy

(a) If the Participant Hospital has filed a bankruptcy petition, whether voluntary or involuntary, the Participant Hospital must provide written notice of the bankruptcy to CMS and to the U.S. Attorney's Office in the district where the bankruptcy was filed, unless final payment has been made by either CMS or the Participant Hospital under the terms of each model tested under section 1115A of the Act in which the Participant Hospital is participating or has participated and all administrative or judicial review proceedings relating to any payments under such models have been fully and finally resolved.

(b) The Participant Hospital must send the notice of bankruptcy by certified mail no later than 5 Days after the Participant Hospital has filed a petition. The notice must contain a copy of the filed bankruptcy petition (including its docket number) and a list of all models tested under section 1115A of the Act in which the Participant Hospital is participating or has participated. This list need not identify a model tested under section 1115A of the Act in which the Participant Hospital participated if final payment has been made under the terms of the model and all administrative or judicial review proceedings regarding model-specific payments between the Participant Hospital and CMS have been fully and finally resolved with respect to that model.

(c) The notice to CMS must be addressed to the CMS Office of Financial Management, Mailstop C3-01-24, 7500 Security Boulevard, Baltimore, Maryland 21244 or to such

other address as may be specified on the CMS website for purposes of receiving such notices.

Section 14.3 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, and 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.

Section 14.4 Entire Agreement; Amendment

(a) The Agreement, including all appendices, constitutes the entire agreement between the Parties for the Agreement Term . In the event of any inconsistency between the Agreement and any agreement previously executed by the Parties governing participation in the Model, the terms of the Agreement shall control.

(b) The Parties may amend the Agreement or any Appendix hereto at any time by mutual written agreement; provided, however, that CMS may amend the Agreement or any Appendix hereto without the consent of the Participant Hospital as specified Section 1.4(b) of this Agreement.

Section 14.5 Survival

(a) Expiration or termination of this Agreement by any Party shall not affect the rights and obligations of the Parties accrued prior to the effective date of the expiration or termination of this Agreement, except as provided in this Agreement. The rights and duties under the following sections of this Agreement shall also survive termination of this Agreement and apply thereafter:

(i) Section 3.6. Change in Control and Change in Hospital Type

(ii) Section 5.3 Hospital Global Budgets for PY 3 and subsequent PYs;

(iii) Section 9.1. Evaluation Requirements (for a one-year period following expiration or termination of the Agreement Term);

(iv) Section 9.2. Site Visits (for a one-year period following expiration or termination of the Agreement Term);

(v) Section 10 Data Sharing and Reporting

(vi) Section 11.1. Monitoring Activities (for a one-year period following expiration or termination of the Agreement Term);

(vii) Section 11.2 Compliance with Laws

(viii) Section 11.3 Certification of Data and Information;

(ix) Section 11.4. Audits and Inspection

(x) Section 11.5 Maintenance of Records;

(xi) Section 12.5 Notifications upon Termination

(xii) Section 12.6 Financial Settlement Upon Termination

(xiii) Section 13.1 Limitation on Review

(xiv) Section 14.2. Notice of Bankruptcy

(xv) Section 14.5. Survival

(xvi) Appendix D – Telehealth Benefit Enhancement

(xvii) Appendix E – Nurse Practitioner and Physician Assistant Services Benefit Enhancement

Section 14.6 Precedence

If any provision of this Agreement conflicts with a provision of any document incorporated herein by reference, the provision of this Agreement shall prevail.

Section 14.7 Prohibition on Assignment

Except with the prior written consent of CMS, the Participant Hospital shall not transfer, including by merger (whether the Participant Hospital is the surviving or disappearing entity), consolidation, dissolution, or otherwise: (1) any discretion granted it under this Agreement; (2) any right that it has to satisfy a condition under this Agreement; (3) any remedy that it has under this Agreement; or (4) any obligation imposed on it under this Agreement. The Participant Hospital shall provide CMS 90 Days' advance written notice of any such proposed transfer. This obligation remains in effect until final payment by or to the Participant Hospital has been made under this Agreement. CMS may condition its consent to such transfer on full payment of any amounts owed by the Participant Hospital under this Agreement or owed to CMS by the proposed assignee. Any purported transfer in violation of this Section is voidable at the discretion of CMS

Section 14.8 Certification

The Participant Hospital executive signing this Agreement certifies to the best of his or her knowledge, information, and belief that the information submitted to CMS and contained in this Agreement (inclusive of appendices), is accurate, complete, and truthful, and that he or she is authorized by the Participant Hospital to execute this Agreement and to legally bind the Participant Hospital on whose behalf he or she is executing this Agreement to its terms and conditions.

Section 14.9 Execution in Counterpart

This Agreement and any amendments hereto may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement. This Agreement and any amendments hereto may be signed by autopen or electronic signature (e.g., DocuSign or similar electronic signature technology) and may be transmitted by electronic means. Copies of this Agreement and any amendments hereto that are so executed and delivered have the same force and effect as if executed with handwritten signatures and physically delivered.

Participant Hospital

Date: _____

By: _____

Name of Authorized Signatory

Title: _____

Centers for Medicare and Medicaid Services

Date: _____

By: _____

Maryland Department of Health

Date: _____

By: _____

Health Services Cost Review Commission

Date: _____

By: _____

APPENDIX A – PARTICIPANT HOSPITAL PROPRIETARY AND FINANCIAL INFORMATION

In a form and manner and by a date specified by CMS, the Participant Hospital shall provide the following information to CMS as applicable:

The following are specific examples, without limitation, of what the Participant Hospital considers proprietary and confidential information currently maintained by the Participant Hospital that should not be publicly disclosed:

1)

2)

3)

4)

In accordance with Section 10.3 of the Agreement, this information shall remain the sole property of the Participant Hospital and, except as required by federal law, shall not be released by CMS without the express written consent of the Participant Hospital.

APPENDIX B – MEDICARE PAYMENT WAIVERS

In accordance with section 1115A(d)(1) of the Act, CMS finds that it is necessary solely for the purposes of testing the Model and operationalizing Medicare FFS Hospital Global Budget payments to waive the following requirements:

(a) IPPS. Sections 1886(d), 1886(g), and 1886(b)(l) of the Act and implementing regulations at 42 CFR 412, subparts A through M.

(b) OPPS. Section 1833(t) of the Act and implementing regulations at 42 CFR Part 419.

(c) Medicare Hospital Readmissions Reduction Program. Section 1886(q) of the Act, and implementing regulations at 42 C.F.R. §§ 412.152 and 412.154. Notwithstanding this waiver, the Participant Hospital will continue to be subject to applicable reporting requirements under the Act.

(d) Medicare Hospital Value Based Purchasing (VBP) Program. Section 1886(o) of the Act, and implementing regulations at 42 C.F.R. § 412.160, et seq. Notwithstanding this waiver, the Participant Hospital will continue to be subject to applicable reporting requirements under the Act.

(e) Hospital Inpatient Quality Reporting Program. Section 1886(b)(3)(B)(viii) of the Act. Notwithstanding this waiver, the Participant Hospital will continue to be subject to applicable reporting requirements under the Act.

(f) Hospital Outpatient Quality Reporting (OQR) Program. Section 1833(t)(17)(A) of the Act. Notwithstanding this waiver, the Participant Hospital will continue to be subject to applicable reporting requirements under the Act.

(g) Medicare Hospital Acquired Conditions Program. Section 1886(p) of the Act, and implementing regulations at 42 C.F.R. § 412.172. Notwithstanding this waiver, the Participant Hospital will continue to be subject to applicable reporting requirements under the Act.

(h) Medicare Promoting Interoperability Program. Section 1886(b)(3)(B)(ix) of the Act, and implementing regulations at 42 C.F.R. § 412.64. Notwithstanding this waiver, the Participant Hospital will continue to be subject to applicable reporting requirements under the Act.

(i) REH Services. Sections 1861(kkk)(1) and 1834(x)(1) of the Act as pertains to facilities REH services paid under OPPS with a 5% payment increase, and Sections 1834(x)(2), 1834(x)(5)(B) and 1817 of the Act as pertains to additional monthly facility payment to REH facilities from Federal Hospital Insurance Trust Fund.

(j) Rural Emergency Hospital Quality Reporting (REHQR) Program. Section 1861(kkk)(7) of the Act.

(k) Payment for Post-Hospital SNF Care Furnished by a Critical Access Hospital with Swing-bed Approval. Section 1883(a)(3) of the Act and 42 C.F.R. § 413.114(a).

(l) Periodic Interim Payments Made to CAHs**.** Section 1815(e)(2) of the Act and 42 C.F.R. § 413.64(h)(2)(vi).

(m) Conditions of Payment for Inpatient Services Furnished at CAHs (CAH 96-Hour Certification). Section 1814(a)(8) of the Act and 42 C.F.R. § 424.15.

APPENDIX C - CAH QUALITY PROGRAM MEASURES

If the Participant Hospital is a CAH, CMS will use the following measures to assess quality performance.

CMS may amend this Agreement without the consent of the Participant Hospital or the State to modify the CAH quality program measures at CMS' sole discretion. To the extent practicable, CMS will notify the Participant Hospital regarding any such modification at least 90 Days prior to the date such modification would take effect.

Domain	Measure	Identifier	Steward	CMS Program Alignment	Data Sources
Health Care Quality and Utilization	CMS Hybrid Hospital-Wide Readmission (Hybrid HWR)	NQF 2879 CMIT 529	CMS	IQR	Claims; Electronic Health Data; Administrative Data
Health Care Quality and Utilization	Emergency Transfer Communication Measure	NQF 0291 CMIT N/A	University of Minnesota	N/A (MBQIP)	Claims, Electronic Health Data, Paper Medical Records
Health Care Quality and Utilization	Outpatient ED Arrival to Discharge (OP-18b)	CMIT 427	CMS	OQR	Electronic Health Data
Health Care Quality and Utilization	OPI-01 Safe Use of Opioids - Concurrent Prescribing	NQF 3316e CMIT 506	CMS	IQR; Promoting Interoperability Program	Electronic Health Data
Patient Safety	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital onset Clostridium difficile Infection (CDI)	NQF 1717 CMIT 462	CDC	HACRP HIQR HVBP	Electronic Health Data, Other, Paper Medical Records
Patient Safety	VTE-1 Venous Thromboembolism Prophylaxis	NQF 0371 CMIT 758	Joint Commission	IQR; Promoting Interoperability Program	Electronic Health Data

Patient Safety	Sepsis Bundle (SEP-1)	CMIT 678	CMS	IQR; VBP	Electronic Health Data
Patient Safety	Severe Obstetrics Complications (PC-07)	NQF N/A CMIT 1028	The Joint Commission	Promoting Interoperability Program	Electronic Health Data
Patient Experience	HCAHPS - Hospital Consumer Assessment of Healthcare Providers and Systems	NQF 0166 CMIT 338	CMS	IQR; HVBP	Instrument-Based Data

APPENDIX D – TELEHEALTH BENEFIT ENHANCEMENT

I. Waiver

a. CMS waives the following requirements with respect to otherwise covered telehealth services furnished by Participant Hospital or Preferred Provider in accordance with the terms and conditions set forth in this Appendix:

i. Waiver of Originating Site Requirements: CMS waives the requirements in Section 1834(m)(4)(C) of the Act and 42 CFR § 410.78(b)(3) and (4) with respect to telehealth services furnished in accordance with this Appendix.

ii. Waiver of Originating Site Requirement in the Eligible Telehealth Individual Provision: CMS waives the requirement in Section 1834(m)(4)(B) of the Act that telehealth services be "furnished at an originating site" when the services are furnished in accordance with this Appendix.

iii. Waiver of Originating Site Facility Fee Provision: CMS waives the requirement in Section 1834(m)(2)(B) of the Act and 42 CFR § 414.65(b) with respect to telehealth services furnished to a Beneficiary at his/her home or place of residence when furnished in accordance with this Appendix.

II. Beneficiary Eligibility Requirements

a. For telehealth services to be eligible for reimbursement under this Appendix, the Beneficiary must be:

i. Located at an originating site that is either one of the sites listed in section 1834(m)(4)(C)(ii) of the Act; or the Beneficiary's home or place of residence; and

ii. Receiving a CMS approved telehealth service. A list of these services can be found at https://www.cms.gov/medicare/coverage/telehealth/list-services.

b. All telehealth services must be furnished in accordance with all other applicable state and Federal laws and all other Medicare coverage and payment criteria, including the remaining requirements of Section 1834(m) of the Act and 42 CFR §§ 410.78 and 414.65.

c. The Participant Hospital shall not furnish telehealth services in lieu of in person services or encourage, coerce, or otherwise influence a Beneficiary to seek or receive telehealth services in lieu of in person services when the Participant Hospital or Preferred Provider knows or should know in person services are medically necessary.

II. Responsibility for Denied Claims

a. If a claim for any telehealth services furnished by Participant Hospital or Preferred Provider under the Telehealth Benefit Enhancement is denied as a result of a CMS error and the Participant Hospital or Preferred 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 of the Telehealth Benefit Enhancement as though the coverage denial had not occurred.

b. If a claim for any telehealth services furnished by Participant Hospital or Preferred Provider is denied for any reason other than a CMS error and CMS determines that the Participant Hospital or Preferred 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 of the Act: 1. CMS shall, notwithstanding such denial, pay for such telehealth services under the terms of the Telehealth Benefit Enhancement as though the coverage denial had not occurred, but CMS will recoup these payments from the Participant Hospital.

c. If a claim for any telehealth services furnished by the Participant Hospital or Preferred Provider is denied and Participant Hospital or Preferred 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 of the Act:

    i. CMS shall not make payment to the Participant Hospital or Preferred Provider for such services;

    ii. The Participant Hospital or Preferred Provider that provided the telehealth services must not charge the Beneficiary for the expenses incurred for such services; and

    iii. The Participant Hospital or Preferred Provider shall ensure that any monies collected from the Beneficiary related to such services are returned to the Beneficiary.

III. **Compliance and Enforcement**

a. CMS will monitor the Participant Hospital and Preferred Provider 's use of the Telehealth Benefit Enhancement to ensure that services furnished under the Benefit Enhancement are medically appropriate and consistent with the terms of the Benefit Enhancement.

B. CMS may terminate or suspend one or more of the waivers under this Appendix or take other remedial action if the Participant Hospital fails to comply with the terms and conditions of the Telehealth Benefit Enhancement.

APPENDIX E – NURSE PRACTITIONER AND PHYSICIAN ASSISTANT SERVICES BENEFIT ENHANCEMENT

I. Election of Nurse Practitioner and Physician Assistant Services Benefit Enhancement Election

If the Participant Hospital wishes to offer the Nurse Practitioner and Physician Assistant Services Benefit Enhancement during a PY, the Participant Hospital must timely submit to CMS its selection of the Nurse Practitioner and Physician Assistant Services Benefit Enhancement as described in Section 8 of the Agreement.

II. Waiver

a. CMS waives the following requirements with respect to services that would otherwise be Covered Services when furnished to an Beneficiary provided that either an Eligible Nurse Practitioner or an Eligible Physician Assistant makes such certification or referral or establishes such plan of care in accordance with the terms and conditions set forth in this Appendix ("Nurse Practitioner and Physician Assistant Services Benefit Enhancement"):

i. The requirement in section 1861(eee)(2)(C) of the Act that a physician must establish, review, and sign an individualized cardiac rehabilitation care plan;

ii. The requirements in section 1861(iii)(1)(B) of the Act and the implementing regulations at 42 CFR § 414.1515(c) that a plan of care for home infusion therapy must be established by a physician;

iii. The requirements in section 1861(vv)(1) of the Act and the implementing regulations at 42 CFR § 410.132(c) that a referral for medical nutrition therapy services must be made by a physician; and

iv. The requirement in section 1861(fff)(1) of the Act and the implementing regulations at 42 CFR § 410.47(b)(2)(v) that a physician must establish, review, and sign an individualized pulmonary rehabilitation care plan.

III. Responsibility for Denied Claims

a. If a claim based on a certification, plan of care, or referral made pursuant to the Nurse Practitioner and Physician Assistant Services Benefit Enhancement and submitted by a Medicare-enrolled provider (as defined at 42 CFR § 400.202) or supplier (as defined at 42 CFR § 400.202) who bills for items and services it furnishes to Beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations (a "Billing Provider") is denied for any reason other than a CMS error, including Eligible Nurse Practitioner or Eligible Physician Assistant error, and CMS determines that the Billing Provider did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

i. CMS shall, notwithstanding such determination, pay for such claims under the terms of the Nurse Practitioner and Physician Assistant Services Benefit Enhancement as though the coverage denial had not occurred, but CMS will recoup these payments from the Participant Hospital. The Participant Hospital shall owe CMS the amount of any such payments, for that PY;

ii. If the Billing Provider that provided the items or services is a Preferred Provider, the Participant Hospital shall ensure that the Billing Provider does not charge the Beneficiary for the expenses incurred for such items or services;

iii. If the Billing Provider that provided the items or services is a Preferred Provider, the Participant Hospital shall ensure that the Billing Provider returns to the Beneficiary any monies collected from the Beneficiary related to such items or services; and

iv. If the Billing Provider that provided the items or services is not a Preferred Provider, the Participant Hospital shall ensure that the Beneficiary is made whole for the expenses incurred for such items or services.

b. If a claim based on a certification, plan of care, or referral made pursuant to the Nurse Practitioner and Physician Assistant Services Benefit Enhancement and submitted by a Billing Provider is denied and the Billing 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:

i. CMS shall not make payment to the Billing Provider for such items or services;

ii. If the Billing Provider that provided the items or services is a Preferred Provider, the Participant Hospital shall ensure that the Billing Provider does not charge the Beneficiary for the expenses incurred for such items or services;

iii. If the Billing Provider that provided the items or services is a Preferred Provider, the Participant Hospital shall ensure that the Billing Provider returns to the Beneficiary any monies collected from the Beneficiary related to such items or services; and

iv. If the Billing Provider that provided the items or services is not a Preferred Provider, the Billing Provider is obligated under existing Medicare rules and regulations to not charge the Beneficiary for the expenses incurred for such items or services and to return to the Beneficiary any monies collected from the Beneficiary related to such items or services.

IV. Compliance and Enforcement

a. CMS may revoke its approval of a Preferred Provider to participate as either an Eligible Nurse Practitioner or an Eligible Physician Assistant under the Nurse Practitioner and Physician Assistant Services Benefit Enhancement at any time if the Preferred Provider's

continued participation in this Nurse Practitioner and Physician Assistant Services Benefit Enhancement might compromise the integrity of the Model.

b. CMS will monitor the Participant Hospital's use of the Nurse Practitioner and Physician Assistant Services Benefit Enhancement to ensure that services furnished pursuant to a certification, referral, or plan of care established by an Eligible Nurse Practitioner or an Eligible Physician Assistant under this Benefit Enhancement are medically appropriate and consistent with the terms of this Benefit Enhancement.

c. In accordance with Section 12 of the Agreement, CMS may terminate or suspend the waiver under Section II of this Appendix or take other remedial action, as appropriate, if the Participant Hospital or any of its Preferred Providers fails to comply with the terms and conditions of the Nurse Practitioner and Physician Assistant Services Benefit Enhancement.

APPENDIX F - PLANNED SERVICE LINE ADJUSTMENT REQUESTS

(a) The Participant Hospital shall submit a request for a Planned Service Line Adjustment and all supporting data for such a request to the State in accordance with the process described in this Appendix F and described in the Financial Specifications Document.

(b) The State shall submit to CMS a recommendation to approve or deny a Planned Service Line Adjustment Request, and all supporting data, no later than 120 Days prior to the PY for which the adjustment would first be applied.

(c) CMS shall approve or deny any such Planned Service Line Adjustment Request. When determining whether to approve or deny a Planned Service Line Adjustment Request, CMS may consider the following factors:

(i) alignment with the Statewide PHAP and Statewide Accountability Targets as set forth in the State Agreement;

(ii) the potential to achieve savings or budget neutrality for Medicare;

(iii) impact on beneficiary access to care;

(iv) fulfillment of existing obligations under Medicare and Medicaid; and

(v) recommendation from the State to approve or deny the Planned Service Line Adjustment Request, in accordance with Section 12.d. of the State Agreement.

(d) If CMS approves the Participant Hospital's Planned Service Line Adjustment Request, CMS will apply a Service Line Adjustment to the Participant Hospital's Medicare FFS Hospital Global Budget starting in the subsequent PY in accordance with the Financial Specifications Document.

APPENDIX G – CARE REDESIGN PROGRAM

If the Participant Hospital elects to participate in the Care Redesign Program, it must comply with the terms and conditions of this Appendix G, and other requirements of this Agreement and State Agreement, as applicable.

ARTICLE I CRP

1.1 CRP. The Participant Hospital may participate in the Care Redesign Program (CRP) during PY1 or PY2 ("CRP Implementation Period") .

ARTICLE II Definitions

"Allowable CRP Interventions" means the CRP Interventions set forth in the Participant Hospital's Approved Track Implementation Protocol.

"Approved Track Implementation Protocol" means a Track Implementation Protocol that has been completed by the Participant Hospital and approved by the State and CMS in accordance with section 3.5 of this Appendix G.

"Care Partner" means a provider or supplier who (1) is enrolled in Medicare; (2) provides items and services to CRP Beneficiaries; (3) satisfies any applicable CRP Care Partner Qualifications; (4) is identified on the CRP Care Partner List; and (5) has a written CRP Care Partner Arrangement with the Participant Hospital.

"CRP Care Partner Arrangement" means a financial arrangement between the Participant Hospital and a CRP Care Partner pursuant to which the CRP Care Partner participates in a CRP Track and may receive Incentive Payments, Intervention Resources, or both, in exchange for performing Allowable CRP Interventions.

"CRP Care Partner List" means the list, as may be updated in accordance with section 5.3 of this Appendix G, of CRP Care Partners and CRP Downstream Care Partners approved by CMS to participate in the CRP.

"**CRP Care Partner Qualifications**" means additional criteria, as set forth in the relevant Track Implementation Protocol, with which a CRP Care Partner must comply in order to participate in CRP Track and receive Incentive Payments, Intervention Resources, or both and with which a CRP Downstream Care Partner must comply in order to participate in a CRP Track and receive Downstream Incentive Payments.

"CRP Beneficiary" means a Medicare FFS Beneficiary who either resides within the Service Area of the Participant Hospital or receives items or services at the Participant Hospital.

"CRP Intervention" means an activity or process, available under a CRP Track and set forth in the relevant Track Implementation Protocol, that is designed to improve or support one or more of the following: (1) care management and care coordination; (2) population health; (3) access to care; (4) risk stratification; (5) evidence-based care; (6) patient experience; (7) shared-decision making; (8) the reduction of medical error rates; or (9) operational efficiency.

"CRP Report" means the report the Participant Hospital submits to the State and CMS, in accordance with Article IX of this Appendix G.

"CRP Track" means a care redesign initiative developed by the State and CMS, and implemented by the Participant Hospital with the assistance of CRP Care Partners.

"CRP Downstream Care Partner" means an individual who is a PGP Member of a PGP Care Partner and who (1) is enrolled in Medicare; (2) provides items and services to CRP Beneficiaries; (3) satisfies any applicable CRP Care Partner Qualifications; (4) is identified on the CRP Care Partner List; and (5) has a CRP Downstream Care Partner Arrangement with its PGP Care Partner.

"CRP Downstream Care Partner Arrangement" means a financial arrangement between a PGP Care Partner and a CRP Downstream Care Partner pursuant to which the CRP Downstream Care Partner participates in a CRP Track and receives Downstream Incentive Payments in exchange for performing Allowable CRP Interventions.

"Downstream Incentive Payment" means a monetary payment made by the PGP Care Partner to a CRP Downstream Care Partner solely for Allowable CRP Interventions performed on a Medicare FFS Beneficiary by the CRP Downstream Care Partner during a PY.

"Incentive Payment" means a monetary payment made by the Participant Hospital directly to a CRP Care Partner solely for Allowable CRP Interventions actually performed on a Medicare FFS Beneficiary by the CRP Care Partner.

"Incentive Payment Methodology" means the methodology, as determined in accordance with the State Agreement for calculating Incentive Payments and Downstream Incentive Payments for a CRP Track.

"Incentive Payment Pool" means the aggregate amount of Incentive Payments, as determined by the State in accordance with the State Agreement, which the Participant Hospital may pay to all of its CRP Care Partners in a CRP Track for PY1 or PY2.

"Intervention Resource" means nonmonetary remuneration furnished by the Participant Hospital directly to a CRP Care Partner for the purpose of assisting the CRP Care Partner(or, in the case of a CRP Care Partner that is a PGP, its PGP Members) in performing care management and the CRP Interventions for Medicare FFS Beneficiaries.

"**Intervention Resource Allocation"** means a monetary amount, as determined by the State in accordance with the State Agreement and specified in the relevant Approved Track Implementation Protocol that the Participant Hospital may use to fund Intervention Resources during the PY1 or PY2.

"IP Failure" stands for "implementation protocol failure" and means the failure of the Participant Hospital as determined by the State, to comply with one or more of the Participant Hospital's Approved Track Implementation Protocols.

"NPI" stands for "national provider identifier."

"NPP" stands for "non-physician practitioner."

"PAU" stands for "potentially avoidable utilization" and means the utilization of heath care items and services, including care furnished to treat complications during the Participant Hospital admission, which may be unnecessary or is avoidable through improved efficiency, care coordination, or effective community-based care.

"PAU Savings" means the Medicare cost savings the Participant Hospital is deemed to have achieved for a CRP Track through the reduction of PAU and other savings that the Participant Hospital achieved as a result of the reduced PAU, as determined by the State in accordance with section 3.8.

"PFS" means the Medicare Physician Fee Schedule.

"PGP" stands for "physician group practice."

"PGP Care Partner" means a CRP Care Partner that is a PGP.

"PGP Member" or **"Member of the PGP"** means a physician or NPP who is an owner or employee of a PGP or has entered into a contract with a PGP, and who has reassigned to the PGP his or her right to receive Medicare payment.

"Physician Incentive Payment Cap" means the maximum amount of Incentive Payments that a CRP Care Partner who is an individual physician or NPP or a CRP Downstream Care Partner may receive during a PY, as calculated in accordance with section 6.6(f) of this Appendix G.

"PIP" stands for "performance improvement plan" and means a plan that the Participant Hospital must implement, as required by the State or CMS, to address an IP Failure of the Participant Hospital or one of its CRP Care Partners or CRP Downstream Care Partners under an Approved Track Implementation Protocol.

"Track Implementation Protocol" means a form that has been approved by CMS, in accordance with the State Agreement, that is designed to be completed by the Participant

Hospital and to set forth the Participant Hospital's plan for implementing a CRP Track.

ARTICLE III CRP Requirements

3.1 **General.** The Participant Hospital is eligible to participate in the CRP in PY1 or PY2.

3.2 **CRP Tracks.** If the Participant Hospital participates in a CRP Track during PY1 or PY2, the Participant Hospital shall engage one or more Care Partners to perform Allowable CRP Interventions.

3.3 **CRP Calendar.** CMS shall maintain a calendar setting forth the deadlines for various activities to be conducted by the parties in implementing the CRP ("**CRP Calendar**"). Each party shall comply with the deadlines specified in the CRP Calendar that correspond to its obligations under this Appendix G. CMS may update the CRP Calendar without the consent of the Participant Hospital or the State.

(a) The State shall ensure that the CRP Calendar is available to the Participant Hospital electronically at all times.

(b) The State shall notify the Participant Hospital in writing within 7 days of any changes made to the CRP Calendar.

(c) CMS shall not update the CRP Calendar in a manner that changes a deadline to a date that is less than 30 days before the effective date of such change.

3.4 CRP Committee

(a) The Participant Hospital shall establish and maintain a committee to oversee and monitor its implementation of the CRP ("**CRP Committee**"). The Participant Hospital shall require the CRP Committee to comply with all applicable terms of this Appendix G.

(b) During PY1 and PY2, at least one CRP Committee member must be a CRP Beneficiary.

(c) The CRP Committee shall monitor the Participant Hospital's implementation of the CRP, in accordance with section 11.2 of this Appendix as applicable, to ensure compliance with this Appendix G and each of the Participant Hospital's Approved Track Implementation Protocols.

(d) The CRP Committee shall oversee the Participant Hospital's implementation of the CRP by conducting at least the following activities:

(i) For each CRP Track in which the Participant Hospital is participating, assisting the Participant Hospital in selecting the Allowable CRP Interventions;

(ii) Providing a forum for sharing ideas, identifying problems, and developing solutions between the Participant Hospital and the Participant Hospital's CRP Care Partners and CRP Downstream Care Partners;

(iii) Offering the internal leadership to ensure the integrity of and opportunity for success of the CRP and each CRP Track in which the Participant Hospital is participating; and

(iv) Conducting a qualitative analysis by the CRP Committee on the status of the Allowable CRP Interventions and offering suggestions to the Participant Hospital on how implementing the Allowable CRP Interventions could be improved.

(e) The CRP Committee shall report annually to the Participant Hospital's governing body on the status of the implementation of each CRP Track and the Participant Hospital's adherence to and implementation of its compliance program, as described in section 11.2 of this Appendix G.

(f) Notwithstanding anything to the contrary in this Appendix G, the CRP Committee shall not have any role in governing the Participant Hospital or its medical staff, which remain under the control of the Participant Hospital.

(g) By the deadlines specified in the CRP Calendar and in a form and manner determined by CMS, the Participant Hospital must notify CMS and the State of the initial composition of its CRP Committee and any changes to the composition of its CRP Committee. Upon receiving any such notice, CMS or the State may take one or more of the actions set forth in section 15.4 of this Appendix G if CMS or the State determines the change compromises the integrity of the CRP, the AHEAD model, the Medicare program or other federal health programs, or the safety of Medicare beneficiaries.

3.5 Submission and Review of Track Implementation Protocols

(a) The Participant Hospital may participate in a CRP Track only if it has an Approved Track Implementation Protocol for that CRP Track. The Participant Hospital shall implement each CRP Track in accordance with this Appendix G and the relevant Approved Track Implementation Protocol.

(b) By the deadlines specified in the CRP Calendar, the State shall make a Track Implementation Protocol available to the Participant Hospital for each of the CRP Tracks available for the PY.

(c) The Participant Hospital shall complete a Track Implementation Protocol for each CRP Track in which it intends to participate during the PY. The Track Implementation Protocol completed by the Participant Hospital must be the Track Implementation Protocol most recently approved by CMS for the CRP Track in accordance with section 9.b of the State Agreement. When completing a Track Implementation Protocol, the Participant Hospital shall follow all instructions in that document.

(d) By the deadlines specified in the CRP Calendar, the Participant Hospital shall submit

each of its completed Track Implementation Protocols to the State for review. The Participant Hospital shall promptly submit to the State any additional information that the State determines is necessary to complete its review.

(e) The State shall review each of the Participant Hospital's completed Track Implementation Protocols for compliance with the terms of the State Agreement. The State may approve, reject, or request modifications to a Track Implementation Protocol submitted by the Participant Hospital, and the State may deny funding, in whole or in part, for one or more Intervention Resources specified in the Participant Hospital's Track Implementation Protocol.

(i) If the State approves a completed Track Implementation Protocol, it shall submit the document to CMS for review by the deadlines specified in the CRP Calendar. The State shall ensure that the Track Implementation Protocol submitted for CMS review specifies the Participant Hospital's Intervention Resource Allocation and all other required information.

(ii) If the State rejects a completed Track Implementation Protocol, the Participant Hospital will not participate in the relevant CRP Track during the PY.

(f) CMS shall promptly review each completed Track Implementation Protocol submitted for its review by the State.

(i) If CMS does not reject the Track Implementation Protocol by the deadlines specified in the CRP Calendar, the Track Implementation Protocol is deemed approved by CMS and constitutes an "Approved Track Implementation Protocol," as defined in Article II of this Appendix G. The effective date of the Approved Track Implementation Protocol will be the first day of the relevant PY.

(ii) If CMS rejects the Track Implementation Protocol, the Participant Hospital will not participate in the relevant CRP Track during the PY. CMS may reject a Track Implementation Protocol that has been approved by the State only if it determines that:

(A) The Track Implementation Protocol does not include the PAU Savings methodology (as determined in accordance with the State Agreement), the Incentive Payment Methodology, and the CRP Care Partner set forth in the relevant, most recently CMS approved Track Implementation Protocol;

(B) The Track Implementation Protocol does not include the Intervention Resource Allocation, if any; or

(C) The Track Implementation Protocol compromises the integrity of the CRP Track, the CRP, the AHEAD Model, the Medicare program, other federal health care programs, or the safety of Medicare beneficiaries.

(g) The State shall provide to the Participant Hospital a copy of the Approved Track Implementation Protocol for each CRP Track in which the Participant Hospital will participate during each PY, by the deadlines specified in the CRP Calendar.

3.6 Amendment of Approved Track Implementation Protocols

(a) If the Participant Hospital wishes to or is required to amend an Approved Track Implementation Protocol effective on a date other than the first day of the relevant PY, it must complete and submit to the State the Track Implementation Protocol most recently approved by CMS for the CRP Track in accordance with the State Agreement.

(b) The State shall promptly review the completed Track Implementation Protocol. The State may approve, reject or request modifications to the completed Track Implementation Protocol.

(i) If the State approves the completed Track Implementation Protocol, it shall submit the document to CMS for review. The State shall ensure that the completed Track Implementation Protocol submitted for CMS review specifies the Participant Hospital's Intervention Resource Allocation, if any, and all other required information.

(ii) If the State rejects the completed Track Implementation Protocol, the Participant Hospital shall continue to implement the CRP Track in accordance with the Approved Track Implementation Protocol that the Participant Hospital sought to amend, unless the State notifies the Participant Hospital otherwise.

(c) CMS shall promptly review the completed Track Implementation Protocol submitted for its review by the State.

(d) If CMS does not reject the completed Track Implementation Protocol within 30 days after receipt, it is deemed approved by CMS and constitutes an "Approved Track Implementation Protocol." Such Approved Track Implementation Protocol is effective on the date it is approved or deemed approved by CMS unless a different effective date is specified in the document, and the Approved Track Implementation Protocol that was previously in effect ceases to be effective.

(e) If CMS rejects the completed Track Implementation Protocol, the Participant Hospital shall continue to implement the CRP Track in accordance with the Approved Track Implementation Protocol that the Participant Hospital sought to amend, unless CMS notifies the Participant Hospital otherwise. CMS may reject the completed Track Implementation Protocol only for the reasons set forth in section 3.5(f)(ii) of this Appendix G.

3.7 Retention of Track Implementation Protocols. In accordance with section 11.4 of this Appendix G, the Participant Hospital shall retain the Approved Track Implementation Protocol for each CRP Track in which it is participating. The Participant Hospital shall ensure the CRP Committee has access to all of its Approved Track Implementation Protocols for the full

duration of the Appendix G Term, in order for the CRP Committee to fulfill its responsibilities under this Appendix G.

3.8 Incentive Payment Pool and PAU Savings

(a) The Participant Hospital may make Incentive Payments for each PY to one or more Care Partners for a CRP Track only if –

(i) The State has determined an Incentive Payment Pool for the CRP Track; and

(ii) The Incentive Payment is made pursuant to a CRP Care Partner Arrangement that complies with section 6.3 of this Appendix G.

(b) The State shall calculate PAU Savings using a methodology that has been approved by CMS in accordance with the State Agreement, which set forth in the CRP Participant Hospital's Approved Track Implementation Protocol. In a form and manner determined by the State and by the deadline specified in the CRP Calendar, the State shall notify the Participant Hospital of its PAU Savings and Incentive Payment Pool for the relevant CRP Track and PY.

(c) The Participant Hospital shall not distribute an Incentive Payment to a CRP Care Partner participating in a CRP Track until the State has notified the Participant Hospital of the relevant Incentive Payment Pool. If the Participant Hospital contests the Incentive Payment Pool in accordance with paragraph (f) of this section 3.8 of the Appendix the Participant Hospital shall not distribute any Incentive Payments to any Care Partner participating in the relevant CRP Track until the Incentive Payment Pool is deemed final in accordance with paragraph (f)(iii) of this section 3.8 of this Appendix G.

(d) The Participant Hospital shall not distribute an Incentive Payment to a CRP Care Partner until the CRP Care Partner has reported the number of Allowable CRP Interventions it performed during the PY, or portion thereof, for which the Incentive Payment is calculated.

(e) For any CRP Track, the aggregate amount of Incentive Payments distributed by the Participant Hospital in the PY must not exceed the Incentive Payment Pool for that CRP Track.

(f) Contestation of Errors. The Participant Hospital may contest the State's calculation of PAU Savings and the Incentive Payment Pool in accordance with the following:

(i) The Participant Hospital may contest mathematical errors in the calculation of PAU Savings and the Incentive Payment Pool, but the methodology used to determine PAU Savings and the Incentive Payment Pool is not subject to review.

(ii) If the Participant Hospital wishes to contest errors in the calculation of PAU Savings or the Incentive Payment Pool, it must provide a written

notice of error and supporting documentation to the State no later than 30 days after the date on which the State notified the Participant Hospital of the amount of its PAU Savings and Incentive Payment Pool.

(iii) If the State receives a timely notice of error for either or both calculations, the State shall respond in writing within 30 days to either confirm or reject the notice of error.

(A) If the State confirms the error, the State shall revise the relevant calculation(s) and notify the Participant Hospital in writing of the revised PAU Savings and/or Incentive Payment Pool. The revised amount(s) are deemed final on the date of the State's written response.

(B) If the State rejects the notice of error, the State shall notify the Participant Hospital in writing that the relevant calculation(s) are correct and are deemed final on the date of the State's written response.

3.9 Physician Incentive Payment Cap. The Participant Hospital shall not distribute an Incentive Payment to a PGP Care Partner or to a CRP Care Partner that is a physician or NPP until CMS has notified the Participant Hospital of the Physician Incentive Payment Cap for the relevant PY.

3.10 Interaction with Other Medicare Initiatives.

(a) The Participant Hospital, CRP Care Partners, and CRP Downstream Care Partners may participate in other Medicare initiatives, including the Medicare Shared Savings Program, if the terms of such initiatives do not prohibit their participation in the CRP.

(b) CMS will inform the State in writing no later than 30 days prior to the start of each PY of any CRP Tracks in which dual participation by Care Partners in the CRP Track and AHEAD is prohibited. CMS will also inform the State in writing no later than 30 days prior to the implementation date of any CRP Tracks with an implementation date that is mid-PY as to whether dual participation by Care Partners in the new CRP Track and AHEAD is prohibited.

(c) CMS may amend this Appendix G without the consent of the State or the Participant Hospital as may be necessary to avoid duplicative accounting for items and services furnished by a provider or supplier, or by any other participant in an existing or future Medicare program, demonstration, or model other than the CRP. CMS shall provide at least 90 days written notice of any such amendment to Appendix G.

3.11 Notice of Certain Events.

(a) The Participant Hospital shall notify CMS and the State within 60 days after discovering that the Participant Hospital or any CRP Care Partner or Downstream Care

Partner:

(i) Is excluded from participating in a Federal healthcare program, including Medicare;

(ii) Has had its Medicare billing privileges revoked; or

(iii) Has had its licensure or accreditation status terminated or suspended by a health licensing authority or accrediting organization.

(b) The Participant Hospital shall notify CMS and each State Party within 60 days after discovering that the Participant Hospital or any CRP Care Partner or Downstream CRP Care Partner is under investigation or action by HHS (including HHS Office of Inspector General and CMS) or the Department of Justice due to an allegation of fraud or significant misconduct, including without limitation 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 is a party.

ARTICLE IV Track Termination and Participant Hospital Withdrawal From a Track

4.1 **Track Termination.** A CRP Track may be terminated only by CMS or the State in accordance with the State Agreement. If CMS or the State terminates a CRP Track, the terminating party shall provide written notice of termination to each of the other parties. Such notice shall specify the reason for termination of the CRP Track, the effective date of such termination, and if applicable, whether the Participant Hospital will be prohibited after such effective date from distributing Incentive Payments. No later than 5 business days after the date of such termination notice, the Participant Hospital shall provide written notice of the effective date of such termination to each CRP Care Partner participating in the relevant CRP Track.

4.2 **Track Withdrawal.** The Participant Hospital may withdraw from a CRP Track only by providing written notice to CMS and each State Party at least 90 days prior to the effective date of withdrawal. Such notice shall specify the reason for withdrawal and the effective date of withdrawal. The Participant Hospital shall provide at least 60 days advance written notice of withdrawal from a CRP Track to each CRP Care Partner participating in the relevant CRP Track.

4.3 Consequences of Track Termination and Withdrawal

(a) If CMS or a State Party terminates a CRP Track, or if the Participant Hospital withdraws from a CRP Track, and such track is the only CRP Track in which the Participant Hospital is participating, this Appendix G will terminate in accordance with section 16.1.c.

(b) If CMS or a State Party terminates a CRP Track, or the Participant Hospital withdraws from a CRP Track, and such CRP Track is not the only CRP Track in which the Participant Hospital is participating --

(i) The Participant Hospital shall distribute any Incentive Payments owed to Care Partners for Allowable CRP Interventions performed by the CRP Care Partner prior to the termination or withdrawal, unless CMS or the State prohibits the Participant Hospital from distributing an Incentive Payment to one or more Care Partners;

(ii) The Participant Hospital shall not distribute any new Intervention Resources to its CRP Care Partners;

(iii) If, after the effective date of termination or withdrawal, the Participant Hospital continues to make available any Intervention Resource already distributed to its CRP Care Partners, the Participant Hospital shall charge the CRP Care Partner fair market value for the use of the Intervention Resource as of the effective date of termination or withdrawal.

ARTICLE V Care Partners

5.1 General

(a) The Participant Hospital shall enter into a CRP Care Partner Arrangement with each CRP Care Partner identified on the CRP Care Partner List. The Participant Hospital shall not enter into a CRP Care Partner Arrangement with any individual who is a PGP Member of a PGP Care Partner.

(b) The Participant Hospital shall require a PGP Care Partner to have a Downstream CRP Care Partner Arrangement that requires each Downstream CRP Care Partner identified on the CRP Care Partner List to comply with the applicable terms of this Appendix G.

(c) An individual or entity will be included on the CRP Care Partner List as a CRP Care Partner or CRP Downstream Care Partner only upon the prior written approval of CMS.

(d) CMS may periodically monitor the program integrity history of the Participant Hospital, CRP Care Partners, and CRP Downstream Care Partners.

(e) CMS may remove an individual or entity from the CRP Care Partner List pursuant to section 15.4(b) of this Appendix G. If CMS removes an individual or entity from the CRP Care Partner List, it shall notify the Participant Hospital and the State in writing of the effective date of removal.

(f) The inclusion of an individual or entity on a CRP Care Partner List does not imply or constitute a determination that the CRP Care Partner or CRP Downstream Care Partner has no program integrity issues and does not preclude CMS or any other government authority from enforcing any and all applicable laws, rules and regulations or from initiating or continuing any audit, investigation, evaluation, or inspection of a CRP Care Partner or CRP Downstream Care Partner.

5.2 CRP Care Partner List

(a) By the deadlines specified in the CRP Calendar, and at such other times as mutually agreed to by the State and CMS, the Participant Hospital must submit to CMS a proposed CRP Care Partner List for each PY. The proposed CRP Care Partner List must identify each proposed CRP Care Partner by name, NPI, billing TIN, and such other information as may be specified by CMS, and must specify each CRP Track in which the proposed CRP Care Partner is expected to participate. If any proposed CRP Care Partner is a PGP, the proposed CRP Care Partner List must identify each proposed CRP Downstream Care Partner by the PGP name, billing TIN of the PGP, and the name and NPI of each proposed CRP Downstream Care Partner who is a PGP Member of that PGP.

(b) CMS shall conduct a Program Integrity Screening on each individual or entity identified on the proposed CRP Care Partner List. CMS may reject any proposed CRP Care Partner or CRP Downstream Care Partner, or remove an individual or entity identified on the CRP

Care Partner List. After reviewing the Program Integrity Screening results, CMS shall submit to the Participant Hospital, by the deadlines specified in the CRP Calendar, an approved CRP Care Partner List identifying the individuals and entities that CMS has approved to be CRP Care Partners and CRP Downstream Care Partners for the PY.

(c) The Participant Hospital shall review the CMS-approved CRP Care Partner List and make any necessary corrections to it, including the removal of any individuals or entities that are not enrolled in Medicare, do not provide items and services to CRP Beneficiaries, do not satisfy the relevant CRP Care Partner Qualifications, or with whom the Participant Hospital does not yet have a fully executed written CRP Care Partner Arrangement. The Participant Hospital shall not make any additions to this list at this time. The Participant Hospital shall certify that the list (as corrected, if applicable) is a true, accurate, and complete list of all individuals and entities that CMS has approved to be CRP Care Partners or CRP Downstream Care Partners, and that the list identifies all individuals and entities with whom, in the case of CRP Care Partners, the Participant Hospital has a fully executed CRP Care Partner Arrangement.

(d) The Participant Hospital shall submit the certified CRP Care Partner List to CMS by the deadlines specified in the CRP Calendar and shall update the list in accordance with section 5.3 of this Appendix G.

5.3 Changes to the CRP Care Partner List

(a) Additions. Except at such times and in such manner as CMS may permit, the Participant Hospital shall not request the addition of any individual or entity to the CRP Care Partner List or increase the number of CRP Tracks in which a CRP Care Partner participates. Any such requests shall be made in accordance with the procedures set forth in section 5.2 of this Appendix G, except that CMS need not conduct a Program Integrity Screening in the case of a request to make a late addition to the certified CRP Care Partner List or a request to increase the number of CRP Tracks in which a CRP Care Partner or CRP Downstream Care Partner is participating. For purposes of this paragraph, a request to make a "late addition" to the certified CRP Care Partner List is a request to add an individual or entity that appeared on the CMS-approved CRP Care Partner List submitted to the Participant Hospital by CMS pursuant to section 5.2(b) of this Appendix G but did not appear on the CRP Care Partner List that was certified by the Participant Hospital pursuant to section 5.2(c) of this Appendix G. Any late addition to a certified CRP Care Partner List will become effective on the date the request is approved by CMS.

(b) Removals. In a form and manner specified by CMS, the Participant Hospital shall notify CMS no later than 30 days after an individual or entity has ceased to be a CRP Care Partner or CRP Downstream Care Partner, or ceased participation in one or more CRP Tracks. The Participant Hospital shall include in the notice the date on which the individual or entity ceased to be a CRP Care Partner or CRP Downstream Care Partner, or ceased to participate in one or more CRP Tracks. The removal of the individual

or entity from the CRP Care Partner List or from the relevant CRP Track will be effective on the date the individual or entity ceased to be a CRP Care Partner or CRP Downstream Care Partner, or ceased to participate in the relevant CRP Track. For purposes of this Appendix G, an individual or entity ceases to be a CRP Care Partner or CRP Downstream Care Partner when they no longer satisfy the definition of "CRP Care Partner" or "CRP Downstream Care Partner" in Article II of this Appendix G.

(c) Effect of Exclusion. If a CRP Care Partner or CRP Downstream Care Partner is excluded from participation in Medicare, Medicaid, or any other federal health care program, the CRP Care Partner or CRP Downstream Care Partner is removed from the CRP Care Partner List effective no later than the effective date of exclusion.

5.4 CRP Care Partner List Access and Retention

(a) CMS shall maintain all CRP Care Partner Lists in a manner that permits the State and the Participant Hospital to review and access the lists during the PY.

(b) The Participant Hospital shall maintain copies of its current and historical CRP Care Partner Lists in accordance with section 11.4 of this Appendix G.

ARTICLE VI CRP Care Partner Arrangements

6.1 General

(a) The Participant Hospital shall not distribute any Incentive Payments or Intervention Resources to an individual or entity other than a CRP Care Partner with whom the Participant Hospital has a fully executed written CRP Care Partner Arrangement.

(b) The Participant Hospital shall provide all Intervention Resources and make all Incentive Payments in accordance with a CRP Care Partner Arrangement that complies with all of the criteria set forth in this Article VI of Appendix G.

(c) The Participant Hospital shall ensure that its compliance program includes oversight of its own compliance with its CRP Care Partner Arrangements and its compliance with the terms of this Appendix G.

(d) **CRP Care Partner Selection Criteria.** The Participant Hospital shall develop, maintain, and use written policies for selecting individuals and entities to be Care Partners. The policies must reflect the CRP Care Partner Qualifications, if any, for the CRP Track and must contain criteria related to the quality of care delivered by the potential CRP Care Partner(including PGP Members, if applicable) and must not be based directly on the volume or value of past or anticipated referrals or other business generated by, between, or among the Participant Hospital, potential Care Partner, or any individual or entity affiliated with the Participant Hospital or potential CRP Care Partner(including a PGP Member in the case of a CRP Care Partner that is a PGP).

6.2 CRP Care Partner Arrangement Requirements. The Participant Hospital shall

ensure that each CRP Care Partner Arrangement complies with the following criteria:

(a) The arrangement is in writing, legally binds the parties to comply with the terms of the arrangement, and is in existence before Allowable CRP Interventions are performed by the CRP Care Partner.

(b) The arrangement specifies the following:

i. Each CRP Track in which the CRP Care Partner will participate and the Allowable CRP Interventions, as set forth in the relevant Approved Track Implementation Protocol, that the CRP Care Partner may perform;

ii. The CRP Care Partner Qualifications;

iii. The mechanism through which the CRP Care Partner must report to the Participant Hospital the number of Allowable CRP Interventions it has performed (or, in the case of a PGP Care Partner, its CRP Downstream Care Partners have performed) and the frequency of such reporting; and

iv. The financial or economic terms of the CRP Care Partner Arrangement for each CRP Track in which the CRP Care Partner is participating, including the frequency and Incentive Payment Methodology for Incentive Payments and the nature and amount of Intervention Resources.

(c) The arrangement complies with all relevant laws and regulations, including all applicable fraud and abuse laws and all applicable payment and coverage requirements.

(d) The arrangement requires the CRP Care Partner and its employees and contractors, if any, to comply with the applicable terms of this Appendix G (including requirements regarding PIPs, access to records, record retention, and participation in any evaluation, monitoring, compliance, and enforcement activities performed by CMS, the State, or their designees) and all other applicable laws and regulations, including fraud and abuse laws. The Participant Hospital shall provide a copy of this Participation Agreement and the Participant Hospital's relevant Approved Track Implementation Protocols to each Care Partner.

(e) The arrangement requires the CRP Care Partner to use Certified Electronic Health Record Technology, as defined at 42 CFR 414.1305, to create a summary record of care formatted according the standard adopted at 45 CFR 170.205(a)(3) that includes, where applicable, the Common Clinical Data Set as defined by 45 CFR 170.102. The arrangement shall also require the CRP Care Partner to electronically transmit such summary to a state-designated health information exchange in more than 10 percent of the instances when the CRP Care Partner transitions or refers a patient to another setting of care.

(f) The arrangement requires the Care Partners to comply with the requirements set forth

in Article VIII of the Appendix G, except that references to "Participant Hospital" are replaced with "CRP Care Partner."

(g) The arrangement requires the CRP Care Partner to be in compliance with all Medicare provider enrollment requirements at 42 CFR 424.500 et seq., including having a valid and active TIN, NPI, or other identifier and reporting all changes to enrollment information to CMS consistent with 42 CFR 424.516.

(h) The arrangement requires the CRP Care Partner to use, as defined by the implementing regulations at 42 CFR part 412 and 42 CFR part 495, a state-designated health information exchange.

(i) The individual's or entity's participation as a CRP Care Partner in the relevant CRP Track must be voluntary and without penalty for nonparticipation.

(j) The arrangement does not induce the Participant Hospital or a CRP Care Partner to reduce or limit Medically Necessary services to any Medicare beneficiary.

(k) The arrangement complies with the requirements set forth in sections 6.5 and 6.6, regarding Incentive Payment and Intervention Resource requirements, and section 6.4 regarding PGP Care Partners, of this Appendix G, if applicable.

(l) The arrangement requires the Participant Hospital to comply with the notification requirements in sections 4.1, 4.2, and 16.5(b) of this Appendix G. and to provide prompt written notice to the CRP Care Partner of the effective date of termination of the Participant Hospital's relevant Approved Track Implementation Protocol.

6.3 Additional CRP Care Partner Arrangement Requirements for PGP Care Partners. If the CRP Care Partner is a PGP Care Partner, the Participant Hospital shall ensure the CRP Care Partner Arrangement complies with the following additional criteria:

(a) The arrangement prohibits the PGP Care Partner from distributing a Downstream Incentive Payment to an individual or entity other than a CRP Downstream Care Partner with whom the PGP Care Partner has a CRP Downstream Care Partner Arrangement.

(b) The arrangement requires the PGP Care Partner to distribute all Downstream Incentive Payments in accordance with a CRP Downstream Care Partner Arrangement that complies with all of the criteria set forth in Article VII of this Appendix G.

(c) The arrangement requires the PGP Care Partner to maintain records of the information specified in section 7.3(f) in accordance with section 11.4, except that references to "Participant Hospital" are replaced with "PGP Care Partner."

(d) The arrangement requires the PGP Care Partner to terminate any CRP Downstream Care Partner Arrangement pursuant to remedial action imposed by CMS or a State Party under section 15.4 of Appendix G.

(e) The arrangement prohibits or suspends the PGP Care Partner's ability to distribute a Downstream Incentive Payment to a CRP Downstream Care Partner pursuant to remedial action imposed by CMS or a State Party under section 15.4 of Appendix G and requires the Participant Hospital to recalculate Incentive Payments to account for any Downstream Incentive Payments that were improperly distributed during such a prohibition or suspension.

(f) The arrangement requires the PGP Care Partner to have a CRP Downstream Care Partner Arrangement with each CRP Downstream Care Partner that complies with Article VII and requires the CRP Downstream Care Partner to comply with Article VIII, except that references to "Participant Hospital" are replaced with "CRP Downstream Care Partner."

6.4 Intervention Resource Requirements

(a) If the Participant Hospital provides Intervention Resources, it shall provide Intervention Resources only to an individual or entity that is identified on the CRP Care Partner List for the relevant CRP Track during the PY, except that the Participant Hospital shall not provide Intervention Resources to a CRP Care Partner that is a PGP Member.

(b) The Participant Hospital shall provide only the Intervention Resources specified in the Participant Hospital's relevant Approved Track Implementation Protocol.

(c) For each PY and for each CRP Track in which the Participant Hospital is participating, the Participant Hospital shall not provide an Intervention Resource to any CRP Care Partner unless the Participant Hospital's relevant Approved Track Implementation Protocol sets forth an Intervention Resource Allocation.

(d) For each PY and for each CRP Track in which the Participant Hospital is participating, the Participant Hospital shall not expend, in the aggregate, more funding on Intervention Resources than the Intervention Resource Allocation set forth in the Participant Hospital's relevant Approved Track Implementation Protocol.

(e) Neither the Participant Hospital nor the CRP Care Partner may condition the opportunity to provide or receive Intervention Resources on the volume or value of referrals or business otherwise generated by, between, or among the Participant Hospital, the Care Partner, or any individual or entity affiliated with the Participant Hospital or CRP Care Partner(including a PGP Member in the case of a CRP Care Partner that is a PGP).

(f) The amount and nature of Intervention Resources provided to a CRP Care Partner must be determined in a manner substantially based on criteria related to quality of care and the performance of Allowable CRP Interventions. The Participant Hospital may take into account –

(i) The Care Partner's need to improve the quality of care it furnishes relative to other

Care Partners; and

(ii) The Care Partner's opportunity to perform Allowable CRP Interventions and care management related to Allowable CRP Interventions, relative to other Care Partners.

(g) The Participant Hospital shall require the CRP Care Partner to use Intervention Resources to perform Allowable CRP Interventions and care management related to Allowable CRP Interventions.

(h) The Participant Hospital shall maintain records of the following in accordance with section 11.4:

(i) The identity of each CRP Care Partner to whom an Intervention Resource was provided;

(ii) The date the Intervention Resource was provided;

(iii) The date the Participant Hospital ceased to provide the Intervention Resource;

(iv) The date, if any, on which the Participant Hospital retrieved the Intervention Resource from the Care Partner;

(v) The documentation establishing whether the CRP Care Partner paid for use of Intervention Resources after the effective date of the Participant Hospital's withdrawal from the relevant CRP Track, or the effective date of termination of the CRP Care Partner Arrangement, the relevant CRP Track, or this Appendix G.

(vi) The nature of the Intervention Resource furnished to each Care Partner;

(vii) The amount actually spent by the Participant Hospital to fund the Intervention Resource; and,

(viii) The CRP Track for which the Intervention Resource was provided.

(i) The Participant Hospital shall require the CRP Care Partner to maintain records of the information specified in section 6.5(h)(ii), (iii), and (v) of this Appendix G.

6.5 Incentive Payment Requirements

(a) To be eligible to receive an Incentive Payment, a CRP Care Partner that is not a PGP Care Partner must:

(i) Be identified on the Participant Hospital's CRP Care Partner List for the relevant CRP Track during the relevant PY; and

(ii) Have performed at least one Allowable CRP Intervention for the relevant CRP Track during the relevant PY or portion thereof.

(c) The Participant Hospital may pay a PGP Care Partner an Incentive Payment only if:

(i) The PGP Care Partner is identified on the Participant Hospital's CRP Care Partner List for the relevant CRP Track during the relevant PY;

(ii) The Incentive Payment is for Allowable CRP Interventions actually performed by the PGP CRP Care Partner or its Downstream Care Partners, as applicable, during the relevant PY or portion thereof;

(iii) The Participant Hospital designates the portion of each Incentive Payment that the PGP Care Partner must pay, as a Downstream Incentive Payment, to each CRP Downstream Care Partner; and

(iv) The Participant Hospital prohibits a PGP Care Partner from retaining any portion of an Incentive Payment that is allocated as a Downstream Incentive Payment to one of its CRP Downstream Care Partners.

(d) For each PY and for each CRP Track in which the Participant Hospital is participating, the Participant Hospital shall not distribute an Incentive Payment to any Care Partner, unless the Participant Hospital satisfies the PAU Savings and Incentive Payment Pool requirements set forth in section 3.8 of this Appendix G.

(e) For each PY or portion thereof, and for each CRP Track in which the Participant Hospital is participating, an Incentive Payment distributed by the Participant Hospital to a CRP Care Partner must be calculated using the Incentive Payment Methodology set forth in the relevant Approved Track Implementation Protocol.

(f) For each PY and for each CRP Track in which the Participant Hospital is participating, the sum of all Incentive Payments distributed by the Participant Hospital to its Care Partners must not exceed the Incentive Payment Pool for that CRP Track, as calculated by the State in accordance with the State Agreement.

(g) If the CRP Care Partner is a physician or NPP, the total amount of Incentive Payments distributed to the CRP Care Partner for the relevant PY must not exceed the Physician Incentive Payment Cap. The Physician Incentive Payment Cap is twenty-five percent (25%) of the Average CRP Care Partner PFS Expenditures for the preceding calendar year. The Average CRP Care Partner PFS Expenditures are calculated by CMS by dividing A by B and multiplying the result by .25, where "A" equals the sum of all Medicare PFS payments made during the preceding calendar year for Part B covered services to all of the Participant Hospital's CRP Downstream Care Partners and CRP Care Partners who are physicians or NPPs, and "B" equals the total number of the Participant Hospital's CRP Downstream Care Partners and CRP Care Partners who are physicians or NPPs during the relevant PY. For example, if the Participant Hospital has three Care Partners, and the three Care Partners had PFS expenditures the previous year totaling $100, $200, and $300, respectively, then the maximum Physician Incentive Payment for each CRP Care Partner in the PY would be $50 ((100 + 200 + 300) ÷ 3 x

.25). CMS shall notify the Participant Hospital of the Physician Incentive Payment Cap for the PY by the deadline specified in the CRP Calendar.

(h) Neither the Participant Hospital nor a CRP Care Partner may condition the opportunity to provide or receive Incentive Payments on the volume or value of referrals or business otherwise generated by, between, or among the Participant Hospital, a Care Partner, a CRP Downstream Care Partner, or any individual or entity affiliated with the Participant Hospital, CRP Care Partner(including a PGP Member), or CRP Downstream Care Partner.

(i) All Incentive Payments must be made by check, electronic funds transfer, or another traceable cash transaction.

(j) The Participant Hospital shall maintain records of the following in accordance with section 11.4:

(i) The identity of each CRP Care Partner to whom an Incentive Payment was made;

(ii) The date the Incentive Payment was made;

(iii) The amount of the Incentive Payment made to each CRP Care Partner;

(iv) In the case of a PGP Care Partner, the portion of each Incentive Payment designated to be paid to a CRP Downstream Care Partner as a Downstream Incentive Payment; and

(v) The CRP Track and PY (or portion thereof) for which the Incentive Payment was calculated.

(k) The Participant Hospital shall require each CRP Care Partner to maintain records of the information specified in section 6.6(i)(ii)-(v) of this Appendix G.

ARTICLE VII Downstream CRP Care Partner Arrangements

7.1 General. The requirements of this Article VII survive 150 days after the termination of this Appendix G or for such longer period of time as CMS may specify in advance written notice to the Participant Hospital.

7.2 CRP Downstream Care Partner Arrangement Requirements. The CRP Downstream Care Partner Arrangement must comply with the following criteria:

(a) The arrangement is in writing, legally binds the parties to comply with the terms of the arrangement, and is in existence before Allowable CRP Interventions are performed by the CRP Downstream Care Partner.

(b) The arrangement specifies the following:

(i) Each CRP Track in which the CRP Downstream Care Partner will participate

and the Allowable CRP Interventions, as set forth in the relevant Approved Track Implementation Protocol, that the CRP Downstream Care Partner may perform;

(ii) The CRP Downstream Care Partner's obligation to report to the PGP CRP Care Partner the number of Allowable CRP Interventions it has performed; and

(iii) The financial or economic terms of the CRP Downstream Care Partner Arrangement for each CRP Track in which the CRP Downstream Care Partner is participating, including the frequency and Incentive Payment Methodology for Downstream Incentive Payments.

(c) The arrangement complies with all relevant laws and regulations, including all applicable fraud and abuse laws and all applicable payment and coverage requirements.

(d) The arrangement requires the CRP Downstream Care Partner to comply with the applicable terms of this Appendix G (including requirements regarding PIPs, access to records, record retention, and participation in any evaluation, monitoring, compliance, and enforcement activities performed by CMS, the State, or their designees) and all other applicable laws and regulations, including fraud and abuse laws. The Participant Hospital shall require the PGP Care Partner to provide a copy of this Agreement and the Participant Hospital's relevant Approved Track Implementation Protocols to each CRP Downstream Care Partner.

(e) The arrangement requires the CRP Downstream Care Partner to comply with Article VIII, except that references to "Participant Hospital" are replaced with "CRP Downstream Care Partner."

(f) The arrangement requires the CRP Downstream Care Partner to be in compliance with all Medicare provider enrollment requirements at 42 CFR 424.400 et seq., including having a valid and active TIN, NPI, or other identifier and reporting all changes to enrollment information to CMS consistent with 42 CFR 424.516.

(g) The arrangement requires the CRP Downstream Care Partner to use a Certified Electronic Health Record Technology to create a summary record of care formatted according to the standard adopted at 45 CFR 170.205(a)(3) that includes, where applicable, the Common Clinical Data Set as defined by 45 CFR 170.102. The arrangement shall also require the CRP Downstream Care Partner to electronically transmit such summary to a state-designated health information exchange in more than 10 percent of the instances when the CRP Care Partner transitions or refers a patient to another setting of care.

(h) The CRP Downstream Care Partner's participation in the relevant CRP Track must be voluntary and without penalty for nonparticipation.

(i) The arrangement does not induce the Participant Hospital or a CRP Care Partner to reduce or limit Medically Necessary services to any Medicare beneficiary.

(j) The arrangement complies with the requirements set forth in section 7.3 of this Appendix G regarding Downstream Incentive Payment requirements.

7.3 Downstream Incentive Payment Requirements.

(a) To be eligible to receive a Downstream Incentive Payment, the CRP Downstream Care Partner must:

(i) Be identified on the Participant Hospital's CRP Care Partner List for the relevant CRP Track during the relevant PY; and

(ii) Have performed at least one Allowable CRP Intervention for the relevant CRP Track during the relevant PY.

(b) The total amount of Downstream Incentive Payments distributed to a CRP Downstream Care Partner for the relevant PY must not exceed the Physician Incentive Payment Cap.

(c) Neither the PGP Care Partner nor a CRP Downstream Care Partner may condition the opportunity to make or receive Downstream Incentive Payments on the volume or value of referrals or business otherwise generated by, between, or among the Participant Hospital, the PGP Care Partner, the CRP Downstream Care Partner, or any individual or entity affiliated with the Participant Hospital, the PGP Care Partner(including other PGP Members of the PGP Care Partner), or the CRP Downstream Care Partner.

(d) All Downstream Incentive Payments must be made by check, electronic funds transfer, or another traceable cash transaction.

(e) The amount of Downstream Incentive Payments designated by the Participant Hospital to be provided to each CRP Downstream Care Partner must be included in the Participant Hospital's CRP Report and reported to CMS and the State in accordance with Article IX of this Appendix G.

(f) The PGP Care Partner shall maintain records of the following in accordance with section 11.4 of this Appendix G except that references to "Participant Hospital" are replaced with "PGP Care Partner":

(i) Documentation on a current and historical basis of the identity of its CRP Downstream Care Partners;

(ii) The identity of each CRP Downstream Care Partner to whom a Downstream Incentive Payment was made;

(iii) The date(s) the Downstream Incentive Payment was made;

(iv) The amount of the Downstream Incentive Payment(s) made to each CRP Downstream Care Partner; and

(v) The CRP Track and PY (or portion thereof) for which the Downstream Incentive Payment was calculated.

ARTICLE VIII Beneficiary Protections

8.1 Availability of Services

(a) The Participant Hospital shall make Medically Necessary services available to Medicare beneficiaries in accordance with applicable laws, regulations and guidance. Medicare beneficiaries and their assignees retain the right to appeal claims determinations in accordance with 42 CFR part 405.

(b) The Participant Hospital shall not take any action to avoid treating "at risk beneficiaries" (as defined at 42 CFR 425.20) or to target certain beneficiaries for any reason that could compromise the integrity of the CRP, the Maryland TCOC Model, the Medicare Program or other federal health programs, or the safety of Medicare beneficiaries.

(c) The Participant Hospital shall not take any action to reduce or limit medically necessary services for Medicare beneficiaries.

8.2 **Beneficiary Choice.** Consistent with section 1802(a) of the Act, the Participant Hospital shall not commit any act or omission, nor adopt any policy, that inhibits Medicare beneficiaries from exercising their freedom to obtain health services from providers and suppliers who are not the Participant Hospital or any of its Care Partners or Downstream Care Partners, or any individual or entity affiliated with the Participant Hospital, any of its CRP Care Partners or CRP Downstream Care Partners. This prohibition shall not apply to referrals made by employees or contractors who are operating within the scope of their employment or contractual arrangements with the employer or contracting entity, provided that the employees and contractors remain free to make referrals without restriction or limitation if a Medicare beneficiary expresses a preference for a different provider or supplier, or the referral is not in the Medicare beneficiary's best medical interests in the judgment of the referring party.

ARTICLE IX Reporting Obligations

9.1 **CRP Report.** The Participant Hospital shall submit CRP Reports to the State and CMS so that the State and CMS can determine the Participant Hospital's compliance with the relevant Approved Track Implementation Protocol.

(a) The Participant Hospital shall submit CRP Reports to the State and CMS, in a form and manner specified by CMS and by the deadlines specified in the CRP Calendar.

(b) The CRP Report must include the following information:

(i) If applicable, the type and total amount of Intervention Resources provided to each CRP Care Partner for each CRP Track in which it is participating and the amount actually spent by the Participant Hospital to fund such Intervention Resources, in comparison to the Participant Hospital's Intervention Resource

Allocation;

(ii) The total number of Allowable CRP Interventions performed by each CRP Care Partner and CRP Downstream Care Partner for each CRP Track in which the Participant Hospital is participating;

(iii) If applicable, the total amount of Incentive Payments made to each CRP Care Partner for each CRP Track in which the Participant Hospital is participating and for which Incentive Payments may be made at that time, and in the case of a PGP Care Partner, the portions of each Incentive Payment that the Participant Hospital designated pursuant to section 6.6(b)(iii) of this Appendix G for distribution as Downstream Incentive Payments;

(iv) A summary from the CRP Committee of its monitoring of the Participant Hospital's compliance with this Appendix G and each of its Approved Track Implementation Protocols;

(v) A qualitative analysis, completed by the CRP Committee, on the status of the Allowable CRP Interventions under each CRP Track in which the Participant Hospital is participating and suggestions from the CRP Committee on how implementing the Allowable CRP Interventions could be improved;

(vi) Each IP Failure identified by the State and the status of such IP Failure;

(vii) Any PIP or other remedial action taken by CMS or a State Party and the status of such PIP or action; and

(viii) Any obligations on the Participant Hospital, imposed by a Corrective Action Plan issued by CMS under the Agreement, and the status of such obligations.

(c) Upon submission of each CRP Report, the Participant Hospital shall certify the following:

(i) That the CRP Report is true, accurate and complete; and

(ii) That if the Participant Hospital learns that a submitted CRP Report is not true, accurate, or complete, it will promptly submit a revised CRP Report.

(d) The CRP Report must adhere to the Generally Accepted Accounting Principles and Generally Accepted Government Auditing Standards (the Yellow Book).

(e) The State shall review the Participant Hospital's CRP Report in accordance with section 11.3 of this Appendix G and the State Agreement.

(f) The requirements of this Article IX survive 135 days after the termination of this Appendix G, or for such longer period of time as CMS may specify in advance written notice to the Participant Hospital.

ARTICLE X Data Sharing and Reports

10.1 General

(a) Section 10 of this Agreement is incorporated to this Appendix G.

ARTICLE XI Compliance and Monitoring

11.1 Compliance with Law

(a) The Participant Hospital shall comply with all applicable statutes, regulations, and guidance, including without limitation, federal criminal laws, the federal False Claims Act (31 U.S.C. § 3729 et seq.), the federal anti-kickback statute (42 U.S.C. § 1320a-7b(b)), the federal civil monetary penalties law (42 U.S.C. § 1320a-7a), the federal physician self-referral law (42 U.S.C. § 1395nn), and applicable State laws, as enforced by the State.

(b) This Appendix G does not provide any waivers of laws, and the Participant Hospital, all Care Partners, and all CRP Downstream Care Partners must comply with all applicable laws and regulations, except as explicitly provided in any separate waiver that may be granted pursuant to section 1115A(d)(1) of the Act specifically for the AHEAD model and the CRP. Waivers granted under section 1115A(d)(1) may be amended or revoked at any time for any reason without the consent of the State or the Participant Hospital.

11.2 Participant Hospital Compliance and Monitoring Plan

(a) The Participant Hospital shall have a compliance program that addresses the prevention, detection, and correction of fraud and abuse and noncompliance with this Appendix G. The Participant Hospital shall update its compliance program as may be needed as a result of changes in applicable statutes and regulations, and the terms of this Appendix G. The Participant Hospital may modify, use and share its existing compliance programs or the compliance programs of its Care Partners to meet the requirements of this section.

(b) The Participant Hospital shall conduct monitoring activities to ensure that the implementation of the CRP, any of its Approved Track Implementation Protocols, any of its CRP Care Partner Arrangements, complies with this Appendix G.

11.3 CMS and State Monitoring Activities

(a) CMS and the State shall conduct monitoring activities to assess compliance by the Participant Hospital, its Care Partners, and its CPR Downstream Care Partners with this Appendix G.

(b) CMS and the State shall conduct monitoring activities to identify evidence of unintended consequences. Such monitoring activities may include without limitation:

(i) Examining trends and patterns in the settings of care where beneficiaries receive care;

(ii) Examining utilization rates; and

(iii) Analyzing resources expended on patient care and cost efficiency.

(c) The Participant Hospital shall cooperate with, and shall require its CRP Committee, its Care Partners, and its Downstream Care Partners to cooperate with, all State and CMS monitoring requests and activities.

(d) If the State determines, as a result of its monitoring activities or through other means, that the Participant Hospital has failed to comply with the terms of this Appendix G, it shall promptly notify CMS and the other State Party in writing in accordance with section 15.3(a).

11.4 Audits and Record Retention. The Participant Hospital shall comply with, and shall require all of its Care Partners to comply with, the following obligations:

(a) To give the State and federal government (including CMS, HHS, and the Comptroller General) or their designees, access to all books, contracts, records, documents, and other evidence (including data related to Medicare utilization and costs, quality performance measures, and financial arrangements) sufficient to enable the audit, evaluation, inspection, or investigation of the Model, including the Participant Hospital's compliance with this Appendix G; the quality of services furnished under the Model; the calculation, administration, allocation, and distribution of any Intervention Resources, Incentive Payments, or Downstream Incentive Payments; and the Participant Hospital's and its Care Partners' compliance with Approved Track Implementation Protocols, CRP Care Partner Arrangements, and Downstream CRP Care Partner Arrangements.

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

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

(ii) There has been a termination, dispute, or allegation of fraud or similar fault against the Participant Hospital, its Care Partners, or its Downstream Care Partners, in which case the 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.

11.5 Reservation of Rights

(a) Nothing contained in this Appendix G shall be construed as:

(i) Limiting the authority of the HHS Office of Inspector General or any other federal or state government authority to audit, evaluate, investigate, or inspect the Participant Hospital, its Care Partners, or its Downstream Care Partners;

(ii) Limiting the right of the federal government to obtain relief under any federal statutes or regulations for noncompliance with the terms of this Appendix G or any other provision of law; or

(iii) 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 Hospital, any of its Care Partners, or any of its Downstream Care Partners, for violations of any statutes, rules, or regulations administered by the federal government.

(b) This Appendix G shall not be construed to bind any federal government agency, except CMS.

(c) The failure by CMS or the State to require performance of any provision of this Appendix G shall not affect CMS's or the State's right to require performance at any time thereafter, nor shall a waiver of any breach or default of this Appendix G constitute a waiver of any subsequent breach or default or a waiver of the provision itself.

ARTICLE XII Training and Shared Learning Activities

12.1 Training Sessions. The Participant Hospital will make reasonable efforts to participate in CMS-sponsored training sessions related to the implementation and requirements of the CRP. CMS will, wherever possible, offer trainings in virtual or telephonic format, including recorded sessions, and will offer the Participant Hospital access to archived training materials to the extent feasible.

12.2 Shared Learning Activities. The Participant Hospital will make reasonable efforts to regularly participate in CMS-sponsored learning activities designed to strengthen results and share learning that emerges from participation in the CRP. Such learning activities may include periodic conference calls, site visits, virtual or in-person meetings, and other activities by which participants actively share resources, tools, and ideas.

ARTICLE XIII Evaluation

13.1 General. The Participant Hospital shall participate in an independent evaluation conducted by CMS and/or its designees, aimed at assessing the impact of the CRP on the goals of better health, better health care, and lower Medicare per capita costs for CRP Beneficiaries. Evaluation activities will include data collection before the Participant Hospital begins participating in the CRP. CMS or its designees shall, to the extent practicable, provide the Participant Hospital with no less than 30 days advance

notice of any site visits for purposes of evaluation, shared learning, and documentation of best practices.

(a) Primary Data. In its evaluation activities, CMS or its designee(s) may collect qualitative and quantitative data from data sources that may include, but are not limited to:

(i) Site visits with the Participant Hospital;

(ii) Interviews or focus groups with CRP Beneficiaries and their caregivers;

(iii) Interviews or focus groups with the Participant Hospital, its Care Partners, and its Downstream Care Partners;

(iv) Direct observation of patient interactions with the Participant Hospital's and Care Partners' staff; and

(v) Surveys.

(b) Secondary Data. In its evaluation activities, CMS or its designee(s) may use data or information submitted by the Participant Hospital for quality and monitoring purposes as well as claims submitted by practitioners, providers and suppliers to CMS for items and services furnished to CRP Beneficiaries. These data may include, but are not limited to:

(i) Claims data;

(ii) Survey data;

(iii) Medical records including clinical data such as lab values; and

(iv) Quality and clinical data submitted via the Participant Hospital's CRP Report.

(c) Reporting Requirements. CMS may add or modify evaluation-related reporting requirements during the Appendix G Term. CMS will notify the Participant Hospital of any additions or modifications at least 90 days prior to when such additions and modifications will take effect.

ARTICLE XIV Site Visits

14.1 Planned Visits. Except as provided in section 14.2 and 14.3 below, CMS, the State or their designee(s) shall, to the extent practicable, provide the Participant Hospital with no less than 15 days advance notice of a site visit to be conducted as part of compliance and monitoring activities. To the extent practicable, CMS and the State will attempt to accommodate the Participant Hospital's request for particular dates in scheduling site visits, but the Participant Hospital shall not request a date that is more than 30 days after the date of the initial site visit notice from CMS or the State.

14.2 Right to Visit. CMS, the State, or their designee(s) may perform unannounced site visits

at any office or physical location of the Participant Hospital or its Care Partners at any time to investigate concerns about the health or safety of Medicare beneficiaries, or other program integrity issues.

14.3 Authority to Visit. Nothing in this Appendix G limits the authority of CMS or the State to conduct a site visit permitted by applicable law or regulations.

ARTICLE XV Remedial Action

15.1 Grounds for Remedial Action Against the Participant Hospital.

(a) CMS or a State Party may impose one or more of the remedial actions described in section 15.4(a) of this Appendix G against the Participant Hospital if CMS makes a determination, including a determination pursuant to section 15.3 of this Appendix G, that the Participant Hospital:

(i) Has an IP Failure, or has otherwise failed to comply with any provision of this Appendix G, one or more of its Approved Track Implementation Protocols, one or more CRP Care Partner Arrangements, one or more CRP Downstream Care Partner Arrangements, any requirement under the AHEAD model, or any applicable Medicare program requirement, rule or regulation;

(ii) Has failed to demonstrate improved performance following any remedial action, including a PIP, or has failed to address an IP Failure by the deadlines specified in a PIP;

(iii) Has taken any action that threatens the health or safety of a beneficiary or other patient;

(iv) Has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the CRP, the AHEAD model or any requirement of the Medicare program;

(v) Is subject to sanctions or other actions of an accrediting organization or a federal, state or local government agency, including revocation of Medicare billing privileges, Medicare or Medicaid program exclusion, or debarment;

(vi) Except as specified in section 18.6 of this Appendix G, assign, or purport to assign, any of the rights or obligations under this Appendix G, voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or any other manner, without the written consent of CMS; or

(vii) Has past or present program integrity issues.

(b) CMS may impose one or more of the remedial actions described in section

15.4(b) of this Appendix G against the Participant Hospital if CMS makes a determination, including a determination pursuant to section 15.3 of this Appendix G, that a CRP Care Partner or CRP Downstream Care Partner:

(i) Has taken any action that threatens the health or safety of a beneficiary or other patient;

(ii) Has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the CRP, the AHEAD model, or any requirement of the Medicare program;

(iii) Is subject to sanctions or other actions of an accrediting organization or a federal, state or local government agency, including revocation of Medicare billing privileges, Medicare or Medicaid program exclusion, or debarment; or

(iv) Has any past or present program integrity issues.

15.2 Remedial Action Procedure

(a) If the State determines, as a result of its monitoring activities or through other means, that grounds for remedial action against the Participant Hospital exist, it shall promptly notify CMS and the State in writing. Such notice shall specify the grounds for remedial action, the relevant facts, whether it recommends that any remedial action should be imposed, and if applicable, the type of remedial action that should be imposed. CMS shall promptly review the notice and determine the appropriate response. CMS shall promptly inform the State of its determination in writing and shall specify the party or parties to this Appendix G that will be responsible for imposing and monitoring the remedial action.

(b) If CMS has not received a notice under paragraph (a) of this section 15.3 of the Appendix G, and it determines both that grounds for remedial action against the Participant Hospital exist and that remedial action should be imposed, it shall promptly notify the State in writing. Such notice shall specify the grounds for remedial action, the relevant facts, the plan for remedial action, and the party or parties to this Appendix G that will be responsible for imposing and monitoring the remedial action.

15.3 Types of Remedial Action

(a) If CMS determines that remedial action is warranted pursuant to sections 3.4(g), 3.12, or 15.1(a), one or more of the actions set forth in the following paragraphs (i) – (xii) may be taken by CMS or the State, and CMS may

take either or both of the actions set forth in the following paragraphs (xiii) and (xiv).

(i) Notify the Participant Hospital and, if appropriate, its CRP Care Partner and its CRP Downstream Care Partners, of the violation;

(ii) Require the Participant Hospital to provide additional information to CMS, the

State or their designees;

(iii) Conduct on-site visits, interview the Participant Hospital's and Care Partner's personnel and staff, or interview beneficiaries and patients to gather information;

(iv) Subject the Participant Hospital to additional monitoring, auditing, or both;

(v) Remove one or more individuals or entities from the Participant Hospital's CRP Care Partner List;

(vi) Require the Participant Hospital to terminate one or more of its CRP Care Partner Arrangements;

(vii) Prohibit or suspend the Participant Hospital's distribution of Incentive Payments or Intervention Resources to any of its CRP Care Partners;

(viii) Require the Participant Hospital to recalculate an Incentive Payment based on a prohibition or suspension of a PGP Care Partner's distribution of a Downstream Incentive Payment to any of its Downstream Care Partners;

(ix) Require the Participant Hospital to amend one or more of its Approved Track Implementation Protocols;

(x) Terminate the Participant Hospital's participation in one or more CRP Tracks;

(xi) Require the Participant Hospital to enter into a PIP, in accordance with section 15.6 of this Appendix G;

(xii) Require the Participant Hospital to comply with any applicable requirements under a Corrective Action Plan that CMS imposes upon the State, under the terms of the State Agreement;

(xiii) Amend this Appendix G without the consent of the Participant Hospital to limit or deny the applicability of any or all waivers of existing law made pursuant to section 1115A(d)(1) of the Act; or

(xiv) Discontinue the provision of data sharing and reports to the Participant Hospital, under section 10.2 of this Appendix G.

(b) If CMS determines that remedial action is warranted pursuant to section 15.1(b) of this Appendix G, CMS may take one or more of the following actions:

(i) Remove the CRP Care Partner or CRP Downstream Care Partner from the Participant Hospital's CRP Care Partner List;

(ii) Require the Participant Hospital to terminate its CRP Care Partner Arrangements with the CRP Care Partner;

(iii) If the CRP Care Partner remains on the CRP Care Partner List, prohibit or suspend the Participant Hospital's distribution of Incentive Payments or

Intervention Resources to that Care Partner; or

(iv) Require the Participant Hospital to recalculate an Incentive Payment based on a prohibition or suspension of a PGP Care Partner's distribution of a Downstream Incentive Payment to the CRP Downstream Care Partner.

15.4 IP Failure. If the State, after consultation with the Participant Hospital, determines the Participant Hospital has caused or suffered an IP Failure, the State must provide written notice (an "**IP Failure Notice**") to the Participant Hospital and CMS. The IP Failure Notice must identify and explain how the Participant Hospital failed to comply with the relevant Approved Track Implementation Protocol and may require the Participant Hospital to –

(a) Implement a PIP, in accordance with section 15.6 of this Appendix G; or

(b) Amend one or more Approved Track Implementation Protocols in accordance with section 3.6 of this Appendix G. If the State rejects the amended Approved Track Implementation Protocol in accordance with section 3.6(b)(ii) of this Appendix G., the State may require the Participant Hospital to implement a PIP.

15.5 Performance Improvement Plans

(a) If the Participant Hospital is required to implement a PIP, the Participant Hospital must, as instructed by CMS or the State, either:

(i) Submit to CMS or the State, as applicable, a proposed PIP for review by a deadline specified by CMS or the State, as applicable; or

(ii) Cooperate with CMS or the State, as applicable, in developing a PIP.

(b) The PIP must outline the actions the Participant Hospital will take within a specified time period to ensure that the IP Failure will be corrected and that the Participant Hospital will come into and remain in compliance with this Appendix G and all relevant Approved Track Implementation Protocols.

(c) If applicable, the State will promptly review the proposed PIP. If the State determines the proposed PIP will adequately address the IP Failure, the State will submit the PIP to CMS for review.

(d) CMS will promptly review the proposed PIP and will provide revisions to the proposed PIP, if any, to the State within 30 days of receipt. The State will incorporate CMS' revisions, if any, into the proposed PIP and will provide the Participant Hospital with the final PIP it must implement.

(e) If the State or CMS determines the proposed PIP will not address the IP Failure, the State or CMS may terminate the Participant Hospital's Approved Track Implementation Protocols for the relevant CRP Track(s) and, upon written notice to the Participant Hospital, the State or CMS may terminate any of the Participant Hospital's other Approved Track Implementation Protocols, or this Appendix G, in accordance with

section 16.3. If, as a result of terminating one or more Approved Track Implementation Protocols, the Participant Hospital is no longer participating in a CRP Track, this Appendix G will terminate in accordance with section 16.1(c) of this Appendix G.

(f) If the Participant Hospital does not comply with the PIP within the specified timeframe, CMS or the State may take one or more of the actions set forth in section 15.4(a) of this Appendix G.

(g) The Participant Hospital must ensure that all Care Partners and Downstream Care Partners comply with the terms of the PIP, if applicable.

(h) The Participant Hospital shall not distribute any Incentive Payments or distribute any new Intervention Resources after the receipt of an IP Failure Notice until:

(i) The Participant Hospital has implemented the PIP or the amended Approved Track Implementation Protocol, as required by the State; and

(j) The State has provided the Participant Hospital with written notice that the IP Failure is resolved and that the Participant Hospital may distribute Incentive Payments or new Intervention Resources to its Care Partners.

ARTICLE XVI Termination

16.1 Termination by the Participant Hospital. The Participant Hospital may terminate its participation in CRP for any reason by providing written notice to CMS and each State Party at least 90 days prior to the effective date of termination.

16.2 Termination by CMS.

(a) Except as set forth in paragraph (b) of this section, CMS may immediately or with advance notice terminate the Participant Hospital's participation in CRP if CMS determines that any of the grounds for remedial action set forth in sections 15.1 or 15.2 of this Appendix G continue to exist after remedial action has been taken.

(b) CMS may immediately or with advance notice terminate the Participant Hospital's participation in CRP if the Participant Hospital –

(i) Is subject to investigation or action by HHS (including 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; or

(ii) Has past or present program integrity issues.

16.3 Termination by the State

(a) A State Party must obtain prior written consent from CMS to terminate the Participant Hospital's participation in CRP for the Participant Hospital's failure to comply with the terms of this Appendix G. If a State Party so wishes to terminate the Participant Hospital's participation in CRP , it shall provide written notice to CMS specifying the grounds for termination, the proposed effective date of termination, whether the other State Party consents to the termination, and if applicable, the reasons why the other State Party does not consent to the termination. CMS shall promptly review the notice and either approve or reject the proposed termination.

16.4 Notice of Termination

(a) To Parties. A party that terminates participation in CRP pursuant to sections 16.2, 16.3, or 16.4 must provide written notice of termination to each of the other parties. Such notice shall specify the reason for termination, the effective date of such termination, and if applicable, whether the Participant Hospital

will be prohibited after such effective date from distributing Incentive Payments.

(b) To Care Partners. The Participant Hospital must provide written notice of termination to each of its Care Partners upon either receiving a notice of termination from the State or CMS, or providing a notice of termination to the State and CMS. Such notice shall specify the effective date of such termination and if applicable, whether the Participant Hospital is prohibited after such effective date from distributing Incentive Payments.

16.5 Consequences of Termination

(a) The Participant Hospital shall distribute any Incentive Payments owed to a CRP Care Partner for Allowable CRP Interventions performed by the CRP Care Partner prior to the effective date of termination of this Appendix G, unless the Participant Hospital's participation in CRP is terminated pursuant to sections 16.3 or 16.4(a) and CMS or the State prohibits the Participant Hospital from distributing an Incentive Payment to one or more Care Partners.

(b) The Participant Hospital shall not distribute any new Intervention Resources to its Care Partners after issuing or receiving notice of termination.

(c) If after the effective date of termination, the Participant Hospital continues to make available any Intervention Resource already distributed to its Care Partners, the Participant Hospital shall charge the CRP Care Partner fair market value for the use of the Intervention Resource after the effective date of termination.

ARTICLE XVII Limitations on Review and Dispute Resolution

17.1 Limitations on Review. Notwithstanding any other provision of this Appendix G, 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 Appendix G, or to require the Participant Hospital to terminate any CRP Care Partner Arrangement or Downstream CRP Care Partner Arrangement;

(c) The elements, parameters, scope, and duration of such models for testing or dissemination, including the addition or removal of a CRP Track and the methodologies used to calculate PAU Savings, and the Incentive Payment Pool;

(d) Determinations regarding budget neutrality under subsection 1115A(b)(3) of the Act;

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

(f) Decisions about expansion of the duration and scope of a model under subsection 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 subsection.

17.2 Dispute Resolution Process. The State will consider disputes by the Participant Hospital that are not precluded from review ("**Permitted Dispute**"), as determined by CMS, including disputes made in accordance with section 3.8(f). The State will only consider a dispute of PAU Savings and Incentive Payment Pool calculations if it has received a timely notice of error as specified in section3.8(f). The Participant Hospital must copy CMS on any such Permitted Dispute correspondence and submit by email to CMS. If the State and the Participant Hospital are unable to resolve a Permitted Dispute to mutual satisfaction, the Permitted Dispute will be subject to the following dispute resolution process, which process is limited solely to Permitted Disputes:

(a) The Participant Hospital must submit a request for reconsideration to a designee of CMS ("**Reconsideration Official**") who is authorized to receive such requests and did not participate in the determination that is the subject of the reconsideration request. The request must contain a detailed, written explanation of the basis for the dispute, including supporting documentation sufficient for CMS to evaluate the dispute. The request must be made within 30 days after the date of the determination for which reconsideration is being requested, and it must be submitted by email to CMS at the address specified in section 18.1 of this Appendix G or such other address as may be specified by CMS. Requests that do not meet these requirements will be denied by the reconsideration official.

(b) The Participant Hospital must submit the reconsideration request within 30 days of the date of its receipt of the calculation related to the Permitted Dispute, via email to CMS at the address specified in section 18.1 of this Appendix G or such other address as may be specified in writing by CMS.

(c) Within 15 days of receiving a reconsideration request satisfying the requirements under

paragraph (a) of this section 17.2 of Appendix G, the Reconsideration Official will send to the Participant Hospital, CMS and the State a written acknowledgement of receipt of the Reconsideration Request, which must set forth:

(i) The procedures under which the Reconsideration Official will review the reconsideration request (the "**Reconsideration Review**"), consistent with the procedures outlined in this section 17.2; and

(ii) A briefing schedule that permits each party to submit only one written brief, including any evidence, for consideration by the Reconsideration Official in support of the party's position. The submission of any additional briefs or supplemental evidence will be at the sole discretion of the Reconsideration Official.

(d) The Reconsideration Review will consist of a review of documentation that is submitted timely and in accordance with the procedures described in the Reconsideration Official's acknowledgment under paragraph (c) of this Section 17.2 of Appendix G.

(e) The burden of proof is on the Participant Hospital to demonstrate with clear and convincing evidence that the calculation is inconsistent with the terms of this Appendix G and any Approved Track Implementation Protocol.

(f) The Reconsideration Official will base its final determination (the "**Reconsideration Determination**") only upon:

(i) Position papers and supporting documentation that are timely submitted to the Reconsideration Official in accordance with the procedures described in the Reconsideration Official's acknowledgment under paragraph (d) of this section 17.2; and

(ii) Documents and data that the State or its designee considered prior to making the calculation related to the Permitted Dispute.

(g) The Reconsideration Determination is not subject to review under the terms of this Appendix G.

(h) The Reconsideration Official will send its written Reconsideration Determination to CMS, the State and the Participant Hospital within 60 days of receipt of timely filed position papers and supporting documentation.

(i) The Reconsideration Determination is final and binding.

(j) The Reconsideration Review process under this Appendix G shall not be construed to negate, diminish, or otherwise alter the applicability of existing laws, rules, and regulations or determinations made by government agencies, including State determinations made in accordance with its Appendix G with the Participant Hospital.

ARTICLE XVIII Miscellaneous

18.1 Survival. Termination of this Appendix G by any party will not affect the rights and obligations of the parties accrued prior to the effective date of the termination of this Appendix G, except as provided in this Appendix G. The data privacy and security requirements articulated in this Appendix G survive for the duration that CMS data remains in the possession of a Care Partner, the Participant Hospital, or any entities with which the Participant Hospital shared such data.