



Health and Human Services
Centers for Medicare and Medicaid Services
Centers for Medicare and Medicaid Innovation
Patient Care Models Group
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**Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model
Participation Agreement**

June 2026

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Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model Participation Agreement

This Participation Agreement (“**Agreement**”) is between *[PARTICIPANT NAME]* (the “**Participant**”) and the Centers for Medicare & Medicaid Services (“**CMS**”).

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

The Participant is a Medicare Part B-enrolled organization identified by a single Taxpayer Identification Number (“**TIN**”) that is eligible to bill under the Medicare Physician Fee Schedule—excluding providers or suppliers enrolled in the Medicare Provider Enrollment, Chain, and Ownership System (“**PECOS**”) as Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (“**DMEPOS**”) suppliers, or enrolled as laboratory suppliers—and provides care services to Medicare beneficiaries with chronic conditions. The Participant delivers coordinated care which may include innovative technologies, including digital therapeutics, remote patient monitoring, and other technology-enabled interventions, with the goal of improving health outcomes.

Under Section 1115A of the Social Security Act (the “**Act**”), the CMS Center for Medicare and Medicaid Innovation (“**Innovation Center**”) is authorized to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) expenditures while maintaining or improving the quality of care for Medicare, Medicaid, or CHIP beneficiaries. Through the Advancing Chronic Care with Effective, Scalable Solutions Model (“**ACCESS**” or “**Model**”), the Innovation Center will test an outcome-aligned payment approach for technology-enabled care organizations to expand Beneficiary access to high-value coordinated care in Original Medicare that preserves or enhances quality while reducing spending.

The Participant submitted an application to participate in the Model, and CMS has approved the Participant for participation in the Model.

The parties therefore agree as follows:

Article 1. Agreement Term

Section 1.01 Effective Date

The date of this Agreement (“**Effective Date**”) will be the date this Agreement is signed by the last party to sign it as indicated by the date associated with that party’s signature.

Section 1.02 Agreement Term

The term of the Agreement begins on the Effective Date and expires two years following the last Day of the Agreement Performance Period (“**Agreement Term**”), unless the Agreement is sooner terminated by CMS in accordance with Section 17.01, in which case the Agreement Term ends on the effective date of termination.

Section 1.03 Agreement Performance Period

The performance period of this Agreement (“**Agreement Performance Period**”) begins on July 5, 2026, or such later date as CMS may specify in writing, and ends at 11:59 p.m. Eastern Time on June 30, 2036, unless the Agreement Performance Period or the Agreement is sooner terminated earlier under Article 17 by either party in accordance with Section 17.01 or 17.02, in which case the Agreement Performance Period ends on the Day specified by CMS in writing.

Section 1.04 Amended and Restated Agreements

A. At times specified by CMS throughout the Agreement Performance Period, CMS may offer the Participant the opportunity to sign an amendment to this Agreement, which may be in the form of an amended and restated version of this Agreement.

B. If the Participant fails to sign an amendment to this Agreement offered by CMS pursuant to Section 1.04(A) by a date specified by CMS, CMS may immediately or with advance notice terminate this Agreement pursuant to Section 17.01.

Article 2. Definitions

In this Agreement and Appendices, the following definitions apply:

“ACCESS Beneficiary” means an individual who is aligned to the Participant.

“ACCESS Clinician Roster” means an up-to-date roster of all Medicare-enrolled practitioners, including their NPIs, who have reassigned billing rights in PECOS to the Participant, and are furnishing or supervising Model Activities under the Participant’s TIN.

“ACCESS Participant” refers to a Medicare Part B-enrolled provider or supplier that is participating in the ACCESS Model, including but not limited to the Participant.

“ACCESS Participant Directory” means the CMS-maintained public-facing directory of all ACCESS Participants, as specified at Section 5.03.

“Active Care Delivery” refers to ongoing provision of services consistent with Model requirements specified in this Agreement, including patient engagement, monitoring, and timely collection and reporting of applicable OAP Measures. Patient engagement refers to clinically appropriate interaction with or support of the Beneficiary to advance the Care Delivery Plan, and monitoring means ongoing assessment of the Beneficiary’s clinical status or progress using available OAP Measure data. Patient engagement and monitoring do not require a specific modality, frequency, or intensity beyond what is clinically appropriate.

“Adjustment Percentage” means the larger of either the COA or SSA.

“Agreement Performance Period” means the period identified at Section 1.03 of this Agreement.

“Agreement Term” means the period identified at Section 1.02 of this Agreement.

“Align” or “Alignment” means the process by which the Participant assumes clinical responsibility for an Eligible ACCESS Beneficiary for a given Clinical Track, as described at Section 7.02

“API” stands for **“Application Programming Interface.”**

“ASCVD” stands for **“Atherosclerotic Cardiovascular Disease.”**

“Assessment Cohort” means the Reconciliation Cohort excluding ACCESS Beneficiaries who were unaligned due to Required Clinical Exclusions, loss of Medicare coverage, geographic relocation, or switching from the eCKM to CKM track with the same Participant.

“Beneficiary” means an individual who is enrolled in Medicare FFS.

“Beneficiary Cost-Sharing Support” means the Participant’s election to forego collection of beneficiary coinsurance for OAPs, if applicable.

“BH Track” stands for Behavioral Health Track and means the Clinical Track selection to address BH Qualifying Conditions, as described at Appendix C.

“Care Delivery Plan” means a written document that describes the ACCESS Participant’s care delivery approach specific to the selected Clinical Track(s) that is reasonably designed, safe, high-quality, and consistent with nationally recognized clinical guidelines and standards of care.

“Care Period” means the duration during which the Participant is responsible for furnishing Model Activities for the aligned ACCESS Beneficiaries in their respective Clinical Track and achieving specified clinical outcomes. The Care Period is defined as 12 months for all Clinical Tracks, unless a Beneficiary is unaligned earlier, in which case that Beneficiary’s Care Period ends on the date of unalignment.

“Care Updates” means the clinical informational updates shared between the Participant and an ACCESS Beneficiary’s Identified Care Team, if applicable, at specified milestones (including, but not limited to, treatment initiation and completion).

“Change in Control” means any of the following:

- A. 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 representing more than 50% of the Participant’s outstanding voting securities or rights to acquire such securities;
- B. The acquisition of the Participant by any other individual or entity;
- C. Any merger, division, dissolution, or expansion of the Participant;
- D. Any sale, lease, exchange or other transfer (in one transaction or a series of transactions) of all or substantially all the assets of the Participant; or
- E. The approval and completion of a plan of sale or liquidation of the Participant or an agreement for the sale or liquidation of the Participant.

“CKM Track” stands for Cardio-Kidney-Metabolic Track and means the Clinical Track selection to CKM Qualifying Conditions, as specified at Appendix E.

“Clinical Track” means one of the categories of clinically related conditions with shared interventions and care intensity for which the Participant may elect to tailor their participation in the Model.

“Clinical Validity Window” means the maximum allowable time between an OAP Measure’s collection date and submission date to CMS for each OAP Measure.

“Clinician” has the same meaning as “eligible professional” as defined in section 1848(k)(3) of the Act, as identified by a unique TIN and NPI combination, and who has reassigned billing rights to the Participant, is listed on the ACCESS Clinician Roster, and furnishes Model Activities for ACCESS Beneficiaries.

“CMS ACCESS Eligibility API” means the API that the Participant shall query to check whether a Prospective ACCESS Beneficiary is eligible for alignment.

“CMS ACCESS Alignment API” means the API that the Participant shall query to align an Eligible ACCESS Beneficiary.

“CMS ACCESS Unalignment API” means the API that the Participant shall query to unalign an ACCESS Beneficiary.

“CMS ACCESS Data Reporting API” means the API that the Participant must use to report clinical outcomes data for ACCESS Beneficiaries.

“CMS Beneficiary Claims Data API” refers to the CMS system that the Participant must use to securely request and obtain access to certain Beneficiary-identifiable Medicare Parts A, B, and D claims data.

“COA” stands for **“Clinical Outcome Adjustment”** and means the value calculated as described in Article 6.

“Compliant Claims” means claims submitted in compliance with the requirements at Section 6.03.

“Control” means the guideline-directed target within the Model that indicates a greater improvement in or maintenance of the Qualifying Condition, as specified in Section C of the applicable Appendices C through F.

“Control Group” means the comparison group to which Beneficiaries may be randomly assigned.

“Control Group Assigned Beneficiary” has the meaning set forth at Section 7.02(B).

“Covered Services” has the same meaning set forth in 42 C.F.R. § 512.110.

“Day(s)” means calendar days, unless otherwise specified.

“Day 365” means 365 days from the date of alignment.

“Descriptive Model Materials and Activities” has the same definition as 42 C.F.R. § 512.110.

“Designated Official” means the individual the Participant authorizes to act on the Participant's behalf for purposes of submitting and updating banking and Electronic Funds Transfer information for CMS to route payments to the Participant. The Designated Official must be an officer, director, or other individual with legal authority to bind the ACCESS Participant with respect to financial transactions and must be identified in the Electronic Funds Transfer Authorization Agreement (Form CMS-588) submitted pursuant to Section 3.01(C).

“Date of Service” means the earliest date within each calendar month in which the Participant or its Clinicians furnishes medical services to an ACCESS Beneficiary.

“Early Success Reporting” means OAP Measure data that the Participant may submit before the end of the Care Period, as described at Appendices C through F for each Clinical Track. The Participant may submit Early Success Reporting submitted up to 90 days prior to Day 365 for the eCKM and CKM Clinical Tracks and up to 180 days prior to Day 365 for the BH and MSK Clinical Tracks.

“eCKM Track” stands for Early Cardio-Kidney-Metabolic Track and means the Clinical Track selection to address eCKM risk factors, as described at Appendix D.

“Eligible ACCESS Beneficiary” has the meaning set forth at Section 7.02(B).

“Eligible Service Area” means the States, U.S. territories, or the District of Columbia that the Participant identifies to CMS where the Participant and its Clinicians can furnish services to ACCESS Beneficiaries consistent with the Care Delivery Plan in accordance with applicable federal and state laws.

“Excess Monthly OAPs” means Monthly OAPs previously paid for an ACCESS Beneficiary for which the Participant failed to submit valid baseline OAP Measure data before the end of the Care Period.

“FDA” stands for **“Food and Drug Administration.”**

“FFS” stands for **“Fee-For-Service.”**

“Financial Affiliate” means an individual or entity that has met any of the following criteria with respect to another organization (including a sole proprietorship):

A. A five percent or greater direct or indirect ownership interest that an individual or entity has in another organization.

B. An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization, either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W-2 employee of the organization.

C. Any reassignment relationship under 42 C.F.R. § 424.80. In the case of reassignment relationships, the billing prohibitions identified at Section 6.07(A) apply only to organizations, not to individual clinicians. An individual clinician who reassigns billing rights to an organization does not, by that reassignment alone, become an affiliate for purposes of the billing prohibitions identified at Section 6.07(A).

An individual or entity may be a Financial Affiliate through a direct or indirect relationship, including through another Financial Affiliate. However, two organizations shall not be deemed Financial Affiliates of each other solely by reason of a third party's ownership interest in both, unless that third party exercises operational or managerial control over either organization per paragraph (B) of this definition. For example, two organizations that are portfolio companies of the same investment firm are not Financial Affiliates of each other solely because of that shared investment, unless the investment firm exercises operational or managerial control over either organization.

“Follow-On Period” means a Care Period for which the conditions described in Section 6.02(A)(2) are met.

“Formerly-Aligned ACCESS Beneficiary” means an ACCESS Beneficiary who is unaligned from the Participant’s Clinical Track(s) for any reason during a Care Period, whether driven by the Participant or by the ACCESS Beneficiary.

“HIE” stands for **“Health Information Exchange”** and has the same meaning as **“Health Information Network”** at 45 C.F.R. § 171.102.

“HIPAA” stands for **“Health Insurance Portability and Accountability Act of 1996.”**

“HIPAA Covered Entity” has the same meaning set forth in 45 C.F.R. § 160.103.

“Identified Care Team” means the ACCESS Beneficiary’s PCP, coordinating or referring clinician or entity meeting the requirements described in Section 4.05 if any, and any other coordinating clinician or entity identified by CMS.

“Initial Period” means a Care Period for which the conditions described in Section 6.02(A)(1) are met.

“MAC” stands for **“Medicare Administrative Contractor.”**

“Medical Director” means a Physician who meets the requirements set forth at Section 4.04.

“Medically Necessary” has the same meaning as “reasonable and necessary” as determined in accordance with Section 1862(a) of the Act.

“Medicare FFS Claim” means a Part A, B, or D claim.

“Minimum Improvement” means a minimum change that is clinically meaningful, but not the ACCESS Beneficiary’s ultimate clinical goal, as specified in Section C of the applicable Appendices C through F.

“Model Activities” means all services and related care delivery activities furnished by the Participant and its Clinicians to ACCESS Beneficiaries for the treatment and management of Qualifying Conditions, including activities designed to achieve applicable OAP Measure targets, including but not limited to the requirements described at Article 3, Article 4, and Article 5.

“Model Year 1” means the time period spanning July 5, 2026, to December 31, 2027.

“Monthly OAP” means one-twelfth of the Medicare portion of the OAP Allowed Amount.

“MSK Track” stands for Musculoskeletal Track and means the Clinical Track selection to address MSK Qualifying Conditions, as described at Appendix F.

“NPI” stands for **“National Provider Identifier.”**

“OAP” stands for **“Outcome-Aligned Payment”** and means the fixed payments made by CMS to the Participant for managing all Qualifying Conditions of an aligned ACCESS Beneficiary within a given Clinical Track over a Care Period, with full payment contingent on achieving track-specific OAP Measure targets as described in Section 6.05.

“OAP Allowed Amount” means the total Medicare-approved payment rate established by CMS for a given Clinical Track and Performance Year, representing the maximum annual payment per ACCESS Beneficiary. It includes both the Medicare program payment at 80% and beneficiary coinsurance at 20%. Allowed amounts do not reflect potential downward payment adjustments resulting from the Clinical Outcome Adjustment or Substitute Spend Adjustment applied to the Medicare paid amount.

“OAP Measure” means Clinical Track- and Qualifying Condition-specific biomarkers and PROMs, as applicable, that ACCESS Participants must report to CMS.

“OAP Measure Success” means that, for an applicable OAP Measure, the Participant has submitted Valid OAP Measure data within the required reporting frequency for the Care Period and has achieved Target, as described in Section 5.01(A)(2).

“OAR” stands for **“Outcome Attainment Rate”** and means the percentage of the ACCESS Beneficiaries within a specific Clinical Track whose Care Period ended and who met all required OAP Measure Targets and reporting requirements for the Reconciliation Cohort, described in Article 6.

“OAT” stands for **“Outcome Attainment Threshold”** and means the minimum percentage of ACCESS Beneficiaries meeting all required OAP Measure Targets and reporting requirements for a specific Clinical Track that must be attained to be eligible for the full OAP Unadjusted Annual Paid Amount.

“PCP” stands for **“Primary Care Practitioner.”**

“PFS” stands for **“Physician Fee Schedule.”**

“PHI” stands for **“Protected Health Information”** and has the same meaning as 45 C.F.R. § 160.103.

“PII” stands for **“Personally Identifiable Information”** and has the same meaning as “individually identifiable health information” at 45 C.F.R. § 160.103.

“Physician” has the same meaning as “physician” in Section 1861(r) of the Act.

“Program Integrity Screening” means a review of an individual’s or entity’s program integrity history and current status, including, but not limited to, the provisions at Section 3.04(A).

“PROM” stands for **“Patient-Reported Outcomes Measures.”**

“Qualifying Condition” means one or multiple health care condition(s) in a given Clinical Track with which an ACCESS Beneficiary must be diagnosed and have validated and documented before receiving services from the Participant.

“Reconciliation” means the process by which CMS reviews the Participant's OAR and SSR, across the Reconciliation Cohort to determine the Reconciliation Payment, as described in Article 6.

“Reconciliation Cohort” means all ACCESS Beneficiaries whose Care Initiation is within the applicable Reconciliation Round, as defined in Appendix I, and for whom the Participant submitted at least one Compliant Claim and all baseline OAP Measures for the applicable Clinical Track during the Care Period.

“Reconciliation Payment” means the amount paid by CMS to the Participant following Reconciliation for the applicable Reconciliation Cohort, as described in Article 6.

“Reconciliation Report” means the report that CMS issues to the Participant after the Reconciliation Round.

“Reconciliation Round” means the semi-annual process in which CMS performs Reconciliation for the ACCESS Beneficiaries in the applicable Reconciliation Cohort.

“Required Clinical Exclusions” means the clinical conditions specified and described in Section D of the applicable Clinical Track at Appendices C through F for which alignment is not permitted.

“Rural Adjustment” means the payment adjustment applied to ACCESS Beneficiaries in either the eCKM or CKM Clinical Track(s) whose residence is in a rural area, as defined by the Health Resources and Services Administration’s Federal Office of Rural Health Policy as described at Appendices D and E.

“Substitute Spend Services” means services billed on claims submitted by a Medicare-enrolled provider or supplier other than the Participant, as identified at Section D in Appendices C through F, with a principal diagnosis code on the claim matches any Qualifying Condition in the applicable Clinical Track.

“SSA” stands for **“Substitute Spend Adjustment”** and means the value calculated as described in Article 6.

“SSR” stands for **“Substitute Spend Rate”** and means the share of the Participant’s aligned ACCESS Beneficiaries who did not receive any listed substitute services for the same condition during the Care Period, as described in Article 6.

“SST” stands for **“Substitute Spend Threshold”** and means the minimum percentage of ACCESS Beneficiaries who did not receive any services listed on the Substitute Spend List for the specified Clinical Track during the Care Period, as described at Appendices C through F, that must be attained to meet one of the criteria to be eligible for the full OAP Unadjusted Annual Paid Amount.

“Target” means the Minimum Improvement or Control values specified by CMS via posted guidelines for each OAP Measure.

“Timely Error Notice” means a written notice of an error in the mathematical calculations in the Reconciliation Report within 30 Days after the Reconciliation Report is issued.

“Total Paid Amount” means the aggregate of Monthly OAPs already disbursed to the Participant for Beneficiaries in the Reconciliation Cohort, excluding all withheld OAPs retained by CMS pursuant to Section 6.04.

“Unalign” or “Unalignment” means any process by which the alignment relationship between the ACCESS Beneficiary and the ACCESS Participant is terminated.

“Valid” means OAP Measure data that were collected in the manner required by CMS via posted guidelines and electronic communication and submitted via the CMS ACCESS Data Reporting API within the applicable clinical validity windows, and at the required reporting frequencies for each OAP Measure.

“Withheld OAPs” means the Monthly OAPs retained by CMS and not paid to the Participant pending Reconciliation, as described in Section 6.05.

Article 3. General Requirements

Section 3.01 Participant Requirements

A. During the Agreement Performance Period, the Participant shall:

1. Be a legal entity formed under applicable state, federal, or tribal law and authorized to conduct business in one or more of the 50 States, U.S. territories, and/or the District of Columbia in which it operates for the purpose of carrying out the activities required by this Agreement;
2. Be a Medicare Part B-enrolled provider or supplier that is eligible to bill under the Medicare Physician Fee Schedule—excluding providers or suppliers enrolled in PECOS as DMEPOS supplier or laboratory suppliers— identified by a single organizational TIN; and
3. Meet the requirements outlined in Section 4.02 and Section 4.03, including but not limited to those specified therein.

B. If the Participant fails to meet any requirements set forth in Sections 3.01(A), then the Participant shall provide written notice to CMS—

1. At least 30 Days before failing to satisfy any such requirements, or
2. Within five Days of becoming aware that the Participant has failed to satisfy any such requirements.

C. Information for Electronic Funds Transfer (EFT).

1. The Participant shall submit an EFT Authorization Agreement (Form CMS-588) to CMS in a manner and by a deadline specified by CMS.
2. The Participant shall promptly update its EFT Authorization Agreement if there are account or bank changes, or any change to the Participant set forth in Section 3.03. CMS may withhold amounts owed to the Participant until the Participant has submitted, and CMS has processed, an Electronic Funds Transfer Authorization Agreement with updated and correct information.
3. If the Participant fails to submit or accurately complete the EFT Authorization Agreement, CMS will withhold all payment amounts owed to the Participant until the Participant has submitted, and CMS has processed, an EFT Agreement with the correct information.

Section 3.02 Participant Engagement with CMS

A. The Participant shall designate at least one representative authorized to receive and respond to CMS communications regarding Model participation, including but not limited to inquiries relating to monitoring and compliance activities, audits, Beneficiary alignment and outreach, and other requests for information. The Participant shall notify CMS of this designation and ensure any changes to the representative's information is conveyed via the ACCESS participant portal.

B. The Participant shall respond to CMS inquiries and requests for information within the timeframes specified by CMS in the communication, or if no timeframe is specified, then within a reasonable period not to exceed 10 business days.

C. Failure to timely respond to CMS communications may be considered by CMS when evaluating the Participant's compliance with this Agreement and may constitute grounds for remedial action pursuant to Article 16.

Section 3.03 Changes to the Participant

A. In addition to the provisions provided in Section 3.02, the Participant must comply with the following requirements if one of the following changes occurs:

1. Change of Participant Name. The Participant shall provide advance written notice to CMS of any change in its legal name. Such notice must be furnished at least 60 Days before the change in legal name becomes effective and must include any legal document effectuating the name change, authenticated by the appropriate state, federal, or tribal official (if applicable). The parties shall execute an agreement reflecting the change of the Participant'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 has been made under this Agreement.

2. Change in Participant TIN. The Participant shall provide at least 90 Days' advance written notice to CMS before the effective date of any change in the Participant's TIN. Such notice must be submitted in the form and manner specified by CMS. In response to a change in the Participant's TIN, 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 has been made under this Agreement.

3. Change in Control.

i. The Participant shall provide written notice to CMS at least 90 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 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 this Agreement by the new controlling entity and may require the new controlling entity to execute a novation agreement with CMS or require the new controlling entity to execute a new agreement with CMS.

iii. If the Participant 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 immediately conduct Reconciliation.

4. Change in Primary Point of Contact. The Participant shall report to CMS through the ACCESS participant portal any changes to the contact information for the Participant's primary point of contact, as identified in Section 19.01, no later than 15 Days following the change.

5. Change in Financial Affiliate Status. Unless the change in Financial Affiliate status is due to a change in control, the Participant shall notify CMS in a form and manner specified by CMS no later than 30 Days after any addition or change in the identity or status of any Financial Affiliate of the Participant.

Section 3.04 Program Integrity Screening

A. In addition to any Program Integrity Screening(s) performed during the Model application process, CMS may perform a Program Integrity Screening(s) on the Participant and its Clinicians during the performance period, in a form and manner, and at a time or frequency, to be determined by CMS. The Program Integrity Screening may include, but is not limited to, the following:

1. Confirmation of current Part B Medicare enrollment status;
2. 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;
3. History of failure to pay Medicare debts in a timely manner;
4. Current or prior law enforcement investigations or administrative actions;
5. Affiliations with individuals or entities that have a history of program integrity issues;

6. Review of performance in, and compliance with the terms of, other CMS models, demonstration programs, and initiatives;
7. Review of compliance with Medicare and Medicaid program requirements;
8. Review of billing history and any administrative audits, investigations, or other activities conducted regarding suspicious billing or other potential program fraud and abuse;
9. Review of any administrative, criminal, or civil violations, including but not limited to the laws specified at Section 9.01(A), and actions related to program integrity or other factors relevant to participation in an initiative involving Federal funds; and
10. Other information pertaining to the trustworthiness of the individual or entity.

B. CMS may deny or terminate participation in the Model based on the results of a Program Integrity Screening or other information regarding the Participant's or its Clinicians' history of program integrity issues obtained at any point during or after the application and selection processes and throughout the Agreement Performance Period.

Section 3.05 Use of Devices Participating in the FDA TEMPO Pilot

If the Participant furnishes, deploys, or uses any medical device participating in the U.S. Food and Drug Administration (“FDA”) Technology-Enabled Meaningful Patient Outcomes for Digital Health Devices Pilot (“**TEMPO Pilot**”), the Participant:

- A. Acknowledges that the FDA retains sole authority over the participation of the device in the TEMPO Pilot (except where the device manufacturer chooses to cease participation in the TEMPO Pilot) and the regulatory oversight of such device;
- B. Shall furnish, deploy, or use the device solely in accordance with the plan for collection, monitoring, analysis, and reporting of real-world performance data associated with the device's selection for participation in the TEMPO Pilot, including any changes to such plan as discussed between the device manufacturer and FDA, and including, without limitation, all aspects of such plan related to the intended use of the device, patient eligibility, monitoring, data collection, reporting, and documentation;
- C. Shall include the following disclosures as part of the Participant's disclosure obligations under Section 7.02(D) for any device(s) participating in the TEMPO Pilot, including use of any reference language provided by CMS for such disclosures:
 1. That the device is part of an FDA pilot;

2. That use of the device is subject to a plan for collection, monitoring, analysis, and reporting of real-world performance data associated with the device's participation in that pilot;
3. That the effectiveness of the device for the intended use for which the device is participating in the pilot has not yet been evaluated by FDA; and
4. That relevant data may be shared with FDA, consistent with applicable federal privacy and security requirements.

D. Shall permit CMS to share applicable Model data with FDA as it relates to the devices participating in the TEMPO Pilot, to the extent permitted by law;

E. Shall undertake any additional data submission or reporting specified by CMS or FDA; and

F. Shall immediately discontinue furnishing, deploying, or using the device within the Model if the FDA terminates the device's participation in the TEMPO Pilot and the device has not received FDA premarket authorization for the intended use for which the device was participating in the TEMPO Pilot.

G. Shall immediately discontinue furnishing, deploying, or using the device within the Model if CMS makes a determination that the device (regardless of whether it participates in the TEMPO Pilot) presents, based on a review of clinical data, a risk of harm that outweighs the potential clinical benefits for individuals entitled to benefits under Medicare Part A or enrolled under Part B.

Article 4. ACCESS Care Delivery Approach

Section 4.01 Care Delivery Plan

A. The Participant shall require and ensure its Clinicians, and other individuals or entities (including any technology vendors, subcontractors, or care coordinators) providing ACCESS Model services on behalf of the Participant, implement the ACCESS care delivery approach in accordance with the provisions of this Article 4.

B. The Participant shall maintain a “**Care Delivery Plan**” in accordance with this Section 4.01(B). In developing the Care Delivery Plan, the Participant shall use reasonable clinical judgment to incorporate applicable clinical guidelines into Model Activities, recognizing that guidelines may conflict, evolve during the Model, and require individualized application to specific patient circumstances based on current clinical evidence.

C. Upon request, the Participant shall make the Care Delivery Plan available to CMS to determine whether the Care Delivery Plan is inconsistent with the terms of the Agreement or likely to result in program integrity concerns. If CMS determines that the Care Delivery Plan is inconsistent with the terms of the Agreement or is likely to result in program integrity concerns, CMS may require the Participant to amend the Care Delivery Plan.

D. The Participant shall monitor for circumstances when an ACCESS Beneficiary’s clinical needs exceed the scope of Active Care Delivery or its Care Delivery Plan and facilitate transition to an appropriate clinician and care setting to support continuity and patient safety.

1. The Participant’s obligations are limited to documenting the ACCESS Beneficiary’s clinical needs and conditions that exceed the scope of the Participant’s Active Care Delivery and Care Delivery Plan; directing the ACCESS Beneficiary to an appropriate clinician, care setting, emergency services, or other care resources as clinically appropriate; and provisioning relevant clinical data as requested to the extent exchangeable through existing systems under Participant’s control. For the purposes of the Model, the Participant shall not be responsible for subsequent prescribing or treatment.

2. Pursuant to Section 9.03 and Section 9.04, CMS shall evaluate the Participant’s compliance with the requirement in this Section 4.01(D) to effectively monitor for escalation of an ACCESS Beneficiary’s condition, and that any referrals are appropriate and consistent with clinical guidelines. If the Participant fails to comply, CMS shall take remedial actions pursuant to Article 16 and may pursue termination pursuant to Section 17.01.

E. The Participant shall, or shall ensure a Financial Affiliate, retain primary responsibility for, and participate in, the furnishing of Model Activities and shall not function primarily as a billing or administrative intermediary or primarily as a referral or conduit to other Medicare-enrolled providers.

Section 4.02 Participant Conditions of Participation

In addition to the requirements identified at Section 3.01, during the Agreement Performance Period, the Participant shall:

- A. Designate a Medicare-enrolled Physician as Medical Director, who is responsible for oversight of care delivery and model performance, as described at Section 4.04;
- B. Ensure that all Clinicians furnishing or supervising services for which individual Medicare enrollment is required are individually active Medicare-enrolled providers or suppliers in good standing who are participating in Medicare and, as participating providers or suppliers, have agreed to accept assignment of the Medicare Part B payment for all covered services furnished to the Participant's ACCESS Beneficiaries, and have reassigned their billing rights to the Participant's TIN;
- C. Submit and maintain an up-to-date ACCESS Clinician Roster via the ACCESS participant portal, which will be linked on the ACCESS Model CMS webpage, with additions and/or removals submitted within 15 Days of the change, unless CMS determines that such submissions are no longer required and notifies the Participant of this change in a form and manner to be specified by CMS; and
- D. Successfully pass Program Integrity Screenings.

Section 4.03 Required Participant Model Activities

As a condition of ongoing participation in the Model, during the Agreement Performance Period, the Participant must comply with the following requirements:

- A. Submit Compliant Claims for each calendar month of services provided to ACCESS Beneficiaries using CMS-defined G-codes;
- B. Transmit electronic clinical updates to ACCESS Beneficiaries' other health care providers (including the Identified Care Team, as applicable), as described in Section 4.05, and support other healthcare technology requirements, as described in Section 4.07;
- C. Submit timely OAP Measure data, as described in Section 5.01;
- D. Comply with all applicable federal and state laws and regulatory requirements, including but not limited to:

1. Licensure and scope-of-practice standards under 42 C.F.R. § 424.516;
2. HIPAA requirements governing the privacy and security of Protected Health Information (“**PHI**”), in accordance with 45 CFR § 164.530(c) and the terms set forth in Section 8.02(I) of this Agreement; and
3. FDA requirements for any digital health devices used that qualify as medical devices under section 201(h)(1) of the Federal Food, Drug, and Cosmetic Act (or otherwise be subject to FDA enforcement discretion).

E. Attest to Active Care Delivery and ongoing compliance with Agreement requirements through monthly claims submission;

F. In addition to the requirements at Section 3.03, disclose to CMS any material changes in ownership, licensure, or exclusion status;

G. Meet minimum clinical outcome performance, as described at Section 5.01; and

H. Comply with the terms of this Agreement, with failure subjecting the Participant to remedial action or termination as described at Article 16 and Article 17, respectively.

Section 4.04 Medical Director

A. The Participant shall designate a Medical Director.

B. The Medical Director shall be a Physician with active Medicare Part B enrollment in good standing, who is subject to an employment arrangement with the Participant, or has an arrangement with the Participant wherein the Medical Director is either a self-employed Physician or a Physician employed by a professional entity or physicians’ group to serve as the Participant’s Medical Director.

C. The arrangement between the Participant and the Medical Director shall:

1. Specify the name of the Physician who will assume the responsibilities and obligations of the Medical Director position; and
2. Enumerate the responsibilities of the Medical Director for overseeing and ensuring the quality of Model Activities. Such responsibilities shall include, but are not limited to, the following:
 - i. Participating in the development, periodic review, and approval of the Participant’s Care Delivery Plan, including an established, written patient safety plan that sets forth protocols for identifying, and addressing patient safety concerns, including care escalation pathways and management of adverse events

associated with the Participant's treatment plans, consistent with the terms of this Agreement;

ii. Ensuring that all policies and procedures related to patient care, data reporting, and safety, consistent with the terms of this Agreement, are adhered to by all its Clinicians;

iii. Monitor patient outcomes, validate standardized protocols for OAP Measure data collection, and if applicable, address Corrective Action Plans (CAP) as described at Section 16.03, to improve clinical results and compliance; and

iv. Ensure adherence to all applicable federal and state laws related to Model Activities, including licensure, scope-of-practice, and laws identified at Section 9.01(A).

D. Notwithstanding the provisions at Section 4.04(E)(2)(iv), the Participant shall execute the Medical Director Acknowledgment and Attestation ("**Medical Director Attestation**") at Appendix J with the Medical Director before the beginning of the Agreement Performance Period.

E. Contact Information Required in ACCESS Participant Portal.

1. The Participant shall maintain accurate and up-to-date contact information for the Medical Director within the ACCESS participant portal.

2. In the event the Medical Director position becomes vacant, the Participant shall:

i. Notify CMS through the ACCESS participant portal of the vacancy within five business days of the Medical Director's removal or resignation;

ii. Designate a qualified replacement within 30 Days; and

iii. Provide CMS with all required contact information for the new Medical Director in a form and manner as specified by CMS.

iv. Ensure that any replacement Medical Director executes the Medical Director Acknowledgment and Attestation at Appendix J within 30 Days of designation.

Section 4.05 Care Coordination Activities

A. Identifying the Care Team.

1. The Participant shall determine annually whether each ACCESS Beneficiary has an existing Primary Care Provider ("**PCP**"), coordinating or referring clinician or entity meeting the requirements described in Section 4.05(A)(2)(ii), and any other coordinating

clinician or entity identified by CMS (collectively referred to as the “**Identified Care Team**”).

2. This requirement is met when the Participant:

- i. Reviews any CMS-supplied information, if made available by CMS at the time the Participant submits an alignment or realignment request, which may include Medicare providers or suppliers associated with the ACCESS Beneficiary;
- ii. Asks the ACCESS Beneficiary during alignment to provide or confirm the name and contact information of their current PCP and any other clinicians or entities that have referred the beneficiary for ACCESS services or are furnishing or reasonably expected to furnish care related to the ACCESS Beneficiary’s Qualifying Condition(s), provided that such clinicians or entities are of a type that furnishes items or services payable by Medicare, if any, and documents the results of such inquiry; and

3. If, upon completion of the requirements at Section 4.05(A)(2), the ACCESS Beneficiary does not identify or confirm a current Identified Care Team, then CMS shall consider the Participant’s obligation under Section 4.05(A)(1) satisfied.

B. Consent to Share Updates with Identified Care Team. The Participant shall obtain the ACCESS Beneficiary’s consent to proactively share Care Updates with the ACCESS Beneficiary’s Identified Care Team. The Participant may obtain consent from the ACCESS Beneficiary verbally or in writing; and must document consent in the ACCESS Beneficiary’s record. If the ACCESS Beneficiary declines to provide consent, then CMS shall consider the Participant’s obligation to share updates under Section 4.05 satisfied.

C. Proactive Updates with Identified Care Team.

1. The Participant shall establish coordination processes to proactively share Care Updates with each ACCESS Beneficiary’s Identified Care Team using secure, nationally recognized exchange methods as defined below, to the extent permitted by law.

2. This requirement is met when the Participant:

- i. Makes a reasonable effort to determine how to contact the Identified Care Team, including but not limited to—
 - a. Checking at least one trusted source for valid contact or routing information, such as a Health Information Exchange (“**HIE**”), a directory of health care providers and their contact or routing information within a defined geographic area, a DirectTrust directory, or National Plan and Provider Enumeration System (NPPES) endpoint listing; or

b. Accessing valid contact or routing information through a Health Information Service Provider, an entity that facilitates the secure electronic exchange of health information, including routing and delivery of Direct Secure Messages. CMS will not consider the Participant's use of query-only exchange (i.e., connecting to an HIE without "pushing" the Care Update to the Identified Care Team) to satisfy this requirement.

ii. Ensure that the information is sent only to the intended recipient, consistent with requirements under federal and state law, which may include confirming the identity and secure endpoint of the receiving Identified Care Team by verifying the provider's or supplier's name, NPI, and practice affiliation in a trusted exchange directory such as an HIE, DirectTrust, or NPPES listing. If the Participant cannot confirm the Identified Care Team's identity or secure endpoint or no valid contact information is available after making a reasonable effort to do so, then CMS shall consider the Participant's obligation under Section 4.05 to be satisfied;

iii. Proactively sends or attempts to send required Care Updates through a HIPAA-compliant secure electronic method, including, but not limited to, Direct Secure Messaging, a HIE-supported push mechanism, a subscription-based mechanism, or an electronic fax solution. If the Participant sends the Care Update to a HIPAA-compliant portal maintained by the Participant, CMS will not deem this requirement fulfilled unless the portal is part of an established data-sharing relationship or technical integration with the Identified Care Team, that ensures the Care Update is delivered to and accessible by that Identified Care Team;

iv. Documents the outcome of the attempt; and

v. Makes the contents of each Care Update shared with the Identified Care Team reasonably accessible to the ACCESS Beneficiary for viewing.

D. Schedule for Required Care Updates with Identified Care Team.

1. CMS shall provide the Participant with a template form for the purpose of providing required Care Updates to Identified Care Teams. The Participant must use the template form provided by CMS, or a substantially equivalent format that includes all required elements and information contained in the CMS template. The Participant shall ensure that Care Updates provided to Identified Care Teams are also maintained in the ACCESS Beneficiary's record. Upon request, the Participant shall make the Care Update template available to CMS to ensure any substantially equivalent format is consistent with the template form provided by CMS.

2. The Participant shall transmit Care Updates to the Identified Care Team within the following timeframes:

- i. Baseline Data Submission. Within 10 Days of submission of all baseline OAP Measures.
- ii. Care Completion. Within 30 Days after the end of the Care Period.
- iii. Care Escalation. Within 10 Days of any transition of the ACCESS Beneficiary to another practitioner or care setting due to clinical needs exceeding the scope of ACCESS services.

3. If the Participant voluntarily submits additional updates, as clinically appropriate, then such additional updates are not required to conform to the template form.

Section 4.06 Clinical Tracks

A. Clinical Tracks. The Participant shall provide care to treat all Qualifying Conditions within the Clinical Track(s) that are selected in the ACCESS participant portal, in accordance with this Section 4.06(A).

1. The parties acknowledge that the Participant selected its initial Clinical Track(s) selection and Eligible Service Area during the application process via the ACCESS participant portal. The Participant may update their selected Clinical Track(s) and Eligible Service Areas at any time in the ACCESS participant portal. If the Participant elects to remove a Clinical Track or narrow its Eligible Service Area, then the Participant shall comply with the notice requirements set forth in Section 17.03 with respect to all ACCESS Beneficiaries aligned to the affected Clinical Track, as if such removal constituted a termination under that section.
2. The Participant agrees to all requirements, obligations, and payment amounts identified in this Agreement's Appendices C through F applicable to any Clinical Track the Participant selects.
3. CMS may modify the Clinical Tracks at any time, including the types of Clinical Tracks available for selection, Qualifying Conditions for each Clinical Track, or any other requirements therein, as described in this Agreement's Appendices C through F. CMS will provide advance written notice of any such modification in a time, form, and manner to be determined by CMS.

B. The Participant shall be responsible for managing all Qualifying Conditions within the Clinical Track(s) to which the Participant attributes the ACCESS Beneficiary.

Section 4.07 Health Information Technology Requirements

A. Participation in the Model shall not require the Participant to utilize Certified Electronic Health Record Technology (CEHRT) as defined in 42 C.F.R. § 414.1305. The Participant acknowledges that this provision does not waive any obligation the Participant may have to utilize CEHRT under applicable laws, regulations, or other CMS program requirements independent of this Agreement. However, the Participant must utilize, where applicable, health information technology that meets standards and implementation specifications adopted under 45 C.F.R. Part 170, Subpart B, and applicable certification criteria adopted under 45 CFR Part 170, Subpart C, by the Office of the National Coordinator for Health Information Technology (ONC) under the ONC Health IT Certification Program, and to meet the following minimum Health Information Technology (HIT) requirement.

B. The Participant shall:

1. No later than July 6, 2027—or, if the Participant is entering the Model after such date, upon the start of the Participant’s Agreement Performance Period—the Participant must:
 - i. Establish or maintain connectivity to an HIE, CMS Aligned Network, or similar trusted network that enables bidirectional electronic exchange of health information across the geographic areas in which the Participant delivers services. Such connectivity must make the following information available for access and query by other health care providers involved in an ACCESS Beneficiary’s care: (1) OAP Measures, including for each measure the most recent value and collection date and time, baseline value, and outcome target, presented in a format that preserves clinical meaning and is reasonably usable by other treating providers; and (2) data for any medications managed under the Model, consistent with an unexpired version of the United States Core Data for Interoperability (USCDI) standard adopted in 45 CFR § 170.213; and
 - ii. Make available one or more APIs that meet the requirements of the Standardized API for patient and population services certification criterion in the ONC Health IT Certification Program at 45 CFR § 170.315(g)(10) (certification to 45 CFR § 170.315(g)(10) is not required), and that support at a minimum the most recent version of the USCDI adopted by ONC at 45 CFR § 170.213. This requirement helps ensure patients and authorized health care providers who participate in this Model can access and exchange electronic health information using FHIR®-based standards.
2. Have the capability to connect to and exchange data with the four ACCESS APIs (CMS ACCESS Eligibility API, CMS ACCESS Alignment API, CMS ACCESS Unalignment API, and CMS ACCESS Data Reporting API), including transmitting

required clinical data and patient-reported outcomes through the CMS ACCESS Data Reporting API, in accordance with CMS data collection processes and applicable technical specifications.

Article 5. Model Participation, Performance Measure(s) and Target(s), and Participant Reporting

Section 5.01 OAP Measure(s) and Target(s)

A. General.

1. CMS shall assess Qualifying Condition-specific performance using OAP Measure data reported by the Participant on the OAP Measures set forth in Appendices C through F for outcomes in each Clinical Track. CMS may amend Appendices C through F without the consent of the Participant at any time and shall notify the Participant of any such changes via written notice at least 90 days prior to the date such changes take effect. The Participant may decline to continue in the Model at any time, as described in Section 17.02.

2. CMS shall assess OAP Measure performance relative to each ACCESS Beneficiary's OAP Measure baseline data for each Clinical Track to which the Participant aligns the ACCESS Beneficiary.

i. The Participant's success for each OAP Measure shall be assessed based upon the following, as calculated out of the total number of ACCESS Beneficiaries aligned to the Clinical Track for the Reconciliation Cohort:

a. ACCESS Beneficiaries who achieve Minimum Improvement or Control during Active Care Delivery for all applicable OAP Measures; and

b. ACCESS Beneficiaries who have baseline OAP Measure data at or below the Control OAP Measure Target at alignment and maintain Control through the end of Active Care Delivery.

3. CMS shall use OAP Measure performance to determine the OAR and the OAP Reconciliation Payment, as described in Article 6 of this Agreement.

4. The Participant shall adhere to the Clinical Validity Windows for each selected Clinical Track(s) for each OAP Measure, as specified at each Section F in the Appendices C through F.

B. OAP Measure Reporting Requirements.

1. The Participant shall adhere to the Participant Data Reporting Requirements specified in Section F of Appendices C through F of this Agreement, and shall comply with the Data Collection Requirements specified in Appendix B of this Agreement.

2. If the Participant did not submit or re-submit baseline quality data as described in this section within 60 Days of the date of alignment, the Participant may attempt to re-align the same ACCESS Beneficiary in the applicable Clinical Track by resubmitting the ACCESS Beneficiary's information through the CMS ACCESS Alignment API as described in Section 7.02. If successful, and the Participant subsequently submits baseline data within 60 Days of the new date of alignment, then CMS shall treat the resubmission as a new alignment and issue payments accordingly for the new Care Period.

3. The Participant shall collect clinical biomarker and PROM data according to CMS-defined data collection requirements for each OAP Measure, as described in Appendix B of this Agreement.

i. The Participant shall retain documentation of the data source, date, and method of collection for all OAP Measures.

ii. CMS shall monitor suspicious patterns, as described in Article 9.03, and reserves the right to audit any submitted values and withhold or recover payment if data quality, measurement protocol, or provenance cannot be verified.

C. Clinical Track-Specific Requirements. The Participant must comply with all Clinical Track-specific performance and Data Reporting Requirements identified in Appendices C through F of this Agreement, as applicable.

1. Pursuant to Article 6 of this Agreement, CMS shall only make payments for the calendar months in which the Participant submits Compliant Claims.

Section 5.02 Performance Monitoring

In addition to the processes specified at Article 9, CMS may take remedial action or terminate the Participant from the Model, as specified at Section 17.01, if the Participant or its Clinicians demonstrate persistent or significant inappropriate treatment (e.g. excessive or insufficient) or treatment inconsistent with safe, evidence-based care.

Section 5.03 Public Reporting of Outcome Measures

Subject to Section 13.02(D), CMS shall maintain a public-facing directory of participants in the Model, and may make the same or similar information available through other CMS-designated platforms such as data.cms.gov, which may include—

A. The Participant's organization name;

B. The Participant's risk-adjusted outcome data which CMS may derive from Participant-submitted data and other data sources available to CMS; and

C. Any additional information regarding the Participant that CMS deems relevant to aid beneficiaries in selecting an ACCESS Participant with whom they wish to align, in accordance with Section 13.02 and applicable data privacy and security regulations, including the CMS Cell Size Suppression Policy to protect patient privacy.

Article 6. Payment

Section 6.01 Overview

A. CMS shall pay the Participant in accordance with the terms of this Article 6 and Appendices C through F of this Agreement, pursuant to the Participant's Clinical Track selection, and subject to Reconciliation as described at Section 6.05, financial settlement, and recoupment, as applicable.

B. CMS shall disburse Monthly OAPs in accordance with the EFT Authorization Agreement under Section 3.01.

C. If an ACCESS Beneficiary is aligned to more than one Clinical Track with the Participant, then the discount applied to the Monthly OAPs will be set to 0%. CMS may adjust this discount in subsequent years, and will provide advance written notice of any such adjustment in a time, form, and manner to be determined by CMS.

Section 6.02 Outcome-Aligned Payments (OAPs)

A. Initial and Follow-On Periods.

1. Initial Period.

i. The Participant is eligible to receive Monthly OAPs for the Care Period calculated based on the Initial Period OAP Allowed Amount, specified in the Appendices C through F for each Clinical Track, when:

a. The Participant has not submitted ACCESS-specific G-code claims in the two-year period preceding the alignment date of the ACCESS Beneficiary for services furnished to that ACCESS Beneficiary for the same Clinical Track to which the Participant is currently aligning the ACCESS Beneficiary; and

b. At baseline, at least one required OAP Measure is at least a Minimum Improvement increment worse than Control, as defined in Appendices C through F for each Clinical Track; provided that OAP Measures for which no Minimum Improvement is specified may not be used to satisfy this requirement;

ii. Notwithstanding Section 6.02(A)(1)(i)(b), an ACCESS Beneficiary in the eCKM Track or CKM Track may qualify for the Initial Period OAP Allowed Amount if the conditions specified in Section E.1.ii of Appendix D or Section E.1.ii of Appendix E, respectively, are satisfied.

2. Follow-On Period.

i. The Participant is eligible to receive Monthly OAPs for the Care Period calculated based on the Follow-On Period OAP Amount, specified in Appendices C through F for each Clinical Track, for each ACCESS Beneficiary when:

- a. The Participant has previously submitted ACCESS-specific G-code claims for services furnished to the ACCESS Beneficiary for the same Clinical Track during the two-year period preceding the alignment date; or
- b. At baseline, no required OAP Measure meets the criteria in Section 6.02(A)(1)(i)(b).

ii. At the start of each Follow-On Period, the Participant must:

- a. Validate and document that the ongoing intervention, including any medications if applicable, remains Medically Necessary and appropriate; and
- b. Submit a new OAP Measure baseline if the previous OAP Measure was collected outside the defined Clinical Validity Window, as defined in Section E of Appendices C through F.

3. For purposes of Section 6.02(A)(i)(a), the eCKM Track and the CKM Track shall be treated as the same Clinical Track.

B. Updated OAP Allowed Amounts.

- 1. CMS reserves the right to update OAP Allowed Amounts without the consent of the Participant at any time.
- 2. If CMS updates the OAP Allowed Amounts, then CMS shall notify the Participant no later than 90 Days prior to the effective date of any such change in a form and manner specified by CMS.

Section 6.03 Billing Requirements for Compliant Claims

A. Billing Requirements.

- 1. The Participant shall bill for a given ACCESS Beneficiary only for calendar months in which it furnishes Active Care Delivery to that Beneficiary, which may begin no earlier than the date of alignment, and provided that the Participant remains in compliance with the applicable Data Reporting Requirements set forth in Appendices C through F for each Clinical Track. CMS shall limit payment of Monthly OAPs to calendar months for which Compliant Claims with the appropriate ACCESS-specific G-codes are submitted.

i. If the Participant submits Early Success Reporting then the Participant may continue submitting monthly claims with the appropriate ACCESS-specific G-codes for the ACCESS Beneficiary for the remainder of the Care Period, provided that the Participant continues Active Care Delivery and submits OAP Measure data at the reporting frequency identified in Appendices C through F.

2. In order to receive payment, the Participant shall:

i. Use its single TIN for billing all services furnished under the Model and submit claims to their designated MAC for the appropriate G-code(s) for the applicable Clinical Track.

ii. Include on each claim, at the highest level of specificity and in a form and manner specified by CMS, all applicable Qualifying Condition(s) for the Clinical Track to which the Participant aligns the ACCESS Beneficiary.

iii. Submit, and the MAC must have received, each claim within 90 Days of the date of service.

a. The Participant shall identify the date of service for the claim as the first Day that the ACCESS Beneficiary receives services from the Participant, which then covers the delivery of services from the date of service through the last Day of the same calendar month. The Participant shall not be eligible to submit another claim with a new date of service until the next calendar month.

b. If the Participant fails to submit the claim within 90 Days of the date of service, then CMS shall deny the claim and no payment shall be rendered.

Section 6.04 Monthly OAPs

A. For each aligned ACCESS Beneficiary, CMS shall disburse a Monthly OAP for each Compliant Claim until the cumulative amount paid for that Beneficiary reaches 50% of the Medicare portion of the applicable OAP Allowed Amount.

B. For any additional Compliant Claims submitted after that cumulative payment level has been reached, CMS shall withhold the corresponding Monthly OAP for Reconciliation under Section 6.05.

C. CMS shall determine disbursement or withholding solely by reference to the cumulative amount disbursed for claims submitted by the Participant for the ACCESS Beneficiary during the Care Period.

Section 6.05 Reconciliation

A. Reconciliation.

1. For each Clinical Track, CMS shall conduct Reconciliation every six months for all ACCESS Beneficiaries in the Reconciliation Cohort in accordance with the schedule for Reconciliation Rounds set forth in Appendix I.
2. Reconciliation shall include:
 - i. Determining the applicable Adjustment Percentage for the Reconciliation Cohort;
 - ii. Determining how much the Participant earned by taking the lesser of:
 - a. The amount the Participant billed for all included Care Periods; and
 - b. The amount the Participant could have earned for furnishing a full 12-month Care Period reduced by the Adjustment Percentage; and
 - iii. Determining the amount, if any, owed to or by the Participant by comparing how much the Participant earned to how much the Participant was already paid.

B. Clinical Outcome Adjustment.

1. CMS shall calculate the Participant's Outcome Attainment Rate (“**OAR**”) as:
$$\text{OAR} = [\text{Number of Beneficiaries in the Assessment Cohort who achieved OAP Measure Success for all OAP Measures}] \div [\text{Number of Beneficiaries in the Assessment Cohort}]$$
2. CMS shall compare the OAR to the applicable Outcome Attainment Threshold (“**OAT**”) to determine the Clinical Outcome Adjustment (“**COA**”):
 - i. If OAR is greater than or equal to OAT, then the COA is zero.
 - ii. If OAR is less than OAT, the COA is $1 - (\text{OAR} \div \text{OAT})$.
3. The COA shall not exceed 0.50, or 50% when expressed as a percentage.
4. The OAT for all Clinical Tracks is 0.50, or 50% when expressed as a percentage.
 - i. CMS may modify the OAT for all Clinical Tracks or specific Clinical Tracks without the consent of the Participant at any time.

- ii. CMS shall notify the Participant of any such changes via written notice at least 90 days prior to the date such changes take effect.

C. Substitute Spend Adjustment.

- 1. CMS shall calculate the Participant's Substitute Spend Rate (“SSR”) as:

$$\text{SSR} = [\text{Number of Beneficiaries in the Assessment Cohort who did not receive Substitute Spend Services during the Care Period}] \div [\text{Number of Beneficiaries in the Assessment Cohort}]$$

- 2. CMS shall compare the SSR to the applicable Substitute Spend Threshold (“SST”):

- i. If SSR is greater than or equal to SST, then the Substitute Spend Adjustment (“SSA”) is zero.

- ii. If SSR is less than SST, then the SSA is $1 - (\text{SSR} \div \text{SST})$.

- 3. The Substitute Spend Adjustment shall not exceed 0.25, or 25% when expressed as a percentage.

- 4. The SST for all Clinical Tracks is 0.90, or 90% when expressed as a percentage.

- i. CMS may modify the SST for all Clinical Tracks or specific Clinical Tracks without the consent of the Participant at any time.

- ii. CMS shall notify the Participant of any changes to the SST via written notice at least 90 days prior to the date the changes take effect.

D. Determination of Final Payment.

- 1. CMS shall calculate the Adjustment Percentage, which is the larger of the COA or the SSA.

- 2. CMS shall calculate the Participant's Total Potential Earnings as:

$$\text{Total Potential Earnings} = (\text{Number of ACCESS Beneficiaries in the Reconciliation Cohort}) \times (\text{Medicare portion of the OAP Allowed Amount}) \times (1 - \text{Adjustment Percentage})$$

- 3. Subject to application of budget sequestration, CMS shall determine the Participant's Total Earned Amount, defined as the lesser of either:

- i. The Total Potential Earnings; and

- ii. The sum of all Monthly OAPs corresponding to Compliant Claims submitted for ACCESS Beneficiaries in the Reconciliation Cohort.

E. Reconciliation Payment.

- 1. CMS shall calculate the Reconciliation Payment as:

$\text{Reconciliation Payment} = \text{Total Earned Amount} - \text{Total Paid Amount} - \text{Excess Monthly OAPs.}$

- 2. If the Reconciliation Payment is positive, CMS shall release Withheld OAPs to the Participant in an amount equal to the Reconciliation Payment.

- 3. If the Reconciliation Payment is negative, CMS shall retain all Withheld OAPs and may:

- i. Offset any remaining balance owed against future ACCESS payments;
 - ii. Initiate recoupment in accordance with applicable Medicare procedures, consistent with Section 6.06.

- 4. If the Reconciliation Payment is zero, no amount is owed to or by the Participant.

F. Other Reconciliation Details.

- 1. CMS shall issue a Reconciliation Report to the Participant following each semi-annual Reconciliation.

- 2. CMS shall not include in the Reconciliation process claims or data received after Reconciliation is performed. CMS will not make any adjustments for claims or data received after Reconciliation is performed.

- 3. Beneficiary cost-sharing is not subject to Reconciliation.

- 4. For the purposes of Reconciliation, if an ACCESS Beneficiary's OAP Measure values worsen after Early Success Reporting is submitted, CMS shall not negate the Participant's Early Success Reporting, and the Participant shall retain full credit for that outcome attainment (i.e., a value of "1" in the Outcome Attainment Rate numerator) for the applicable Care Period regardless of any subsequent decline in OAP Measure values.

- 5. Illustrative examples of the Reconciliation calculations described in this Section 6.05 are set forth in Appendix H and are provided for explanatory purposes only.

G. Timely Error Notice.

1. The Participant may contest the contents of a Reconciliation Report in accordance with this Section 6.05(G).
2. The Participant shall have 30 Days from the date the Reconciliation Report is issued to provide written notice to CMS, in a form and manner specified by CMS, of an alleged error in the calculation of the payment specified in that Reconciliation Report. The Timely Error Notice must contain a detailed, written explanation of the basis for the calculation error, including any supporting documentation.
3. If CMS receives a Timely Error Notice, CMS shall issue a written determination within 30 Days of receipt to either confirm or revise the calculation of the payment specified in that Reconciliation Report. CMS may extend the deadline for its determination upon written notice to the Participant.
 - i. If CMS determines that there is an error in the amount calculated, CMS shall issue a revised Reconciliation Report, which is final on the date of issuance. The Participant may dispute the revised Reconciliation Report in accordance with Section 18.02.
 - ii. If CMS determines that the amount is correct, the Reconciliation Report is final on the date the determination is issued.
 - iii. The Participant may dispute the determination issued by CMS in accordance with Section 18.02.
4. If the Participant does not submit a Timely Error Notice to CMS in accordance with this Section 6.05(G), the Participant is precluded from later contesting the payment amounts specified in that Reconciliation Report.
5. If, as a result of any later inspection, evaluation, investigation, or audit, CMS determines that any OAPs have been calculated in error, CMS may adjust such amounts, issue a revised Reconciliation Report, and make or demand payment of any additional amounts owed in accordance with Section 6.06(A).

Section 6.06 Recoupment and Delinquent Debt

A. Recoupment. To the extent any negative Reconciliation Payments are not fully recovered through the Reconciliation process described in Section 6.05(E)(3), or if CMS during its monitoring and compliance activities (as specified at Section 9.03) identifies any payment discrepancies or overpayments, then CMS will issue the Participant a demand letter for such monies owed to CMS. The Participant shall pay CMS any monies owed within 30 Days of the date of the demand letter. If CMS does not receive timely payment in full, the remaining monies owed shall be considered a delinquent debt in accordance with Section 6.06(B).

B. Delinquent Debt.

1. If the Participant 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-Day periods and shall be assessed for each 30-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.
2. If CMS does not receive payment in full by the date the payment is due, CMS may invoke all legal means to collect the debt and will use any applicable debt collection tools, including potential referral of the debt to the United States Department of Treasury, pursuant to 31 U.S.C. § 3711.

Section 6.07 Prohibitions

A. Billing Prohibitions.

1. If CMS determines that grounds for applying Section 16.02(E) exist, then the Participant must immediately and indefinitely stop billing ACCESS-specific G-codes for all ACCESS Beneficiaries.
2. If the Participant elects to forgo the collection of ACCESS Beneficiary cost-sharing per Section 7.06(C), then the Participant must not bill the ACCESS Beneficiary for the cost-sharing amount. The Participant's decision to forgo collection of Beneficiary cost-sharing does not allow the Participant to collect the Beneficiary cost-sharing from other parties.
3. The Participant shall not, and shall ensure its Financial Affiliates do not, submit Medicare FFS Claims (except for claim lines billed with ACCESS OAP G-codes), directly or indirectly through another organization for which the Participant or Financial Affiliate(s) provides contracted services, for an ACCESS Beneficiary.
4. For purposes of Section 6.07(A)(3):
 - i. An indirect billing arrangement exists where the Participant or its Financial Affiliate is paid for furnishing any portion of a service to a Beneficiary for which another entity submits a Medicare FFS Claim.
 - ii. These provisions apply at the ACCESS Beneficiary level for the Participant and its Financial Affiliates and do not restrict the Participant or its Financial Affiliates from billing Medicare FFS for services furnished to other Beneficiaries who are not aligned in the Model to the Participant.

iii. If the Participant or its Financial Affiliate submits, directly or indirectly non-ACCESS Medicare FFS Claim(s) for ACCESS Beneficiaries during a Care Period, then the claim line(s) on the Medicare FFS Claim line(s) shall be denied, and the Participant is prohibited from billing the ACCESS Beneficiary for the balance of the denied claim, and the Participant may be subject to remedial actions pursuant to Section 16.01.

Article 7. ACCESS Beneficiary Eligibility, Voluntary Alignment, Protections, and Incentives

Section 7.01 Beneficiary Eligibility

To be considered eligible for voluntary alignment for a given Clinical Track with the Participant, a Beneficiary shall—

- A. Be enrolled in Original Medicare Parts A and B, with Medicare as the primary payer;
- B. Not receive hospice services and not be enrolled in the Program of All-Inclusive Care for the Elderly (PACE);
- C. Be residing in the Eligible Service Area provided to CMS by the Participant in its application or as communicated to CMS in a form and manner specified by CMS;
- D. Satisfy the Qualifying Condition and Clinical Exclusion criteria at Section 7.02(C); and
- E. Not have initiated alignment to any other entity participating in the Model for the same Clinical Track within the past 90 Days, unless the Beneficiary is switching between the eCKM Track and CKM Track, as described in Section 7.02(I), and excepting Beneficiaries who have since been unaligned for reasons of ineligibility, as described in Sections 7.02(H)(1), or for Participant-initiated unalignment, as described in Section 7.02(H)(2).

Section 7.02 Alignment to the Participant

To align a Beneficiary to the Participant, the Participant shall take the following steps:

A. Prior to querying the CMS ACCESS Eligibility API, the Participant shall disclose to the Beneficiary that the services it offers are part of a new CMS payment model test and that, as part of the Model’s evaluation—

- 1. The Participant may share the Beneficiary’s data with CMS, and CMS may access or request the Beneficiary’s health information, including through HIEs or other data sources, subject to federal privacy and security protections;
- 2. The Beneficiary may be randomly assigned to a Control Group and ineligible to align to a Participant and be aligned to a Clinical Track; and
- 3. Assignment to the Control Group will not affect the Beneficiary’s Medicare benefits, rights, or coverage.

B. The Participant may then submit an eligibility confirmation request to query the CMS ACCESS Eligibility API, which will designate whether the Beneficiary is ineligible for alignment, eligible for alignment (“**Eligible ACCESS Beneficiary**”), or otherwise eligible for

alignment but assigned to the Control Group (“**Control Group Assigned Beneficiary**”). In order to check the eligibility for any given Beneficiary, the Participant shall submit the Beneficiary’s identifying information, requested Clinical Track(s), and any other information specified by CMS.

1. If a Beneficiary is designated as a Control Group Assigned Beneficiary, the Participant shall notify the Control Group Assigned Beneficiary that the Beneficiary is assigned to the Control Group. The Participant shall use any standardized language provided by CMS in such notification.

C. If the CMS ACCESS Eligibility API designates a Beneficiary as an Eligible ACCESS Beneficiary, the Participant confirms that the Eligible ACCESS Beneficiary:

1. Has a diagnosis of one or more of the Qualifying Conditions required under any respective Participant-selected Clinical Track, described in Section 4.06 and Appendices C through F of the Agreement. The Participant shall validate the Eligible ACCESS Beneficiary’s Qualifying Condition by either:
 - i. Clinical assessment by the Participant;
 - ii. Referral from another licensed practitioner for the specific condition;
 - iii. Evidence of the Qualifying Condition(s) as diagnosed and documented in the ACCESS Beneficiary’s clinical record or claims history within a clinically relevant timeframe; or
 - iv. Other methods as appropriate for the Qualifying Condition(s); and
2. Does not have a diagnosis of any Clinical Exclusions of the respective Participant-selected Clinical Track, as described in Appendices C through F of the Agreement or any Participant-specified exclusions approved by CMS.

D. The Participant shall obtain and document the Eligible ACCESS Beneficiary’s consent to align to the Participant for each Care Period (no earlier than 60 days prior to the start of each Care Period). Specifically, the Participant:

1. May obtain the consent verbally or in writing, which may include the Beneficiary's acceptance of the Participant's terms and conditions upon alignment; and
2. Shall document in the Eligible ACCESS Beneficiary’s record that:
 - i. The Eligible ACCESS Beneficiary agreed to participate in the Model;

- ii. The Participant informed the Eligible ACCESS Beneficiary that alignment to the Participant and participation in the Model are voluntary;
- iii. The Participant notified the Eligible ACCESS Beneficiary that only one participant in the Model may concurrently provide services to the Eligible ACCESS Beneficiary for a given Clinical Track;
- iv. The Participant informed the Eligible ACCESS Beneficiary that the Eligible ACCESS Beneficiary may end his or her alignment to the Participant (and, if desired, align with another entity participating in the Model) any time 90 Days after aligning to the Participant;
- v. If applicable, the Participant advised the Eligible ACCESS Beneficiary of the expected ACCESS Beneficiary payment amount associated with cost-sharing; and,
- vi. If applicable based on the Participant's DRA selections regarding access to Beneficiary-identifiable claims data, the Participant notified the Eligible ACCESS Beneficiary that the Beneficiary's claims data may be shared with the Participant for purposes of health care operations, subject to applicable privacy and security protections, including but not limited to HIPAA.

E. After receiving and documenting the Eligible ACCESS Beneficiary's consent, as described in Section 7.02(D)—

- 1. The Participant shall submit an alignment request for the Eligible ACCESS Beneficiary to the CMS ACCESS Alignment API. Such alignment request will include the Clinical Track to which the Participant intends to attribute the Eligible ACCESS Beneficiary and any other information specified by CMS.
- 2. The CMS ACCESS Alignment API shall return the Eligible ACCESS Beneficiary's eligibility, as described in Section 7.02(B), confirm that the Eligible ACCESS Beneficiary's diagnosis is one of the Qualifying Conditions of the Clinical Track the Participant included in the alignment request, as described in Section 7.02(E)(1), and designate the Eligible ACCESS Beneficiary as an ACCESS Beneficiary if—
 - i. The Eligible ACCESS Beneficiary is not currently aligned to another participant in the Model for the same Clinical Track, or the Eligible ACCESS Beneficiary is aligned to a different participant in the Model for the same applicable Clinical Track and has requested to switch alignment to the Participant for the applicable Clinical Track in accordance with Section 7.02(F) or Section 7.02(I); and

- ii. The Eligible ACCESS Beneficiary is not a Control Group Assigned Beneficiary at the time the Participant submits an eligibility confirmation request to the CMS ACCESS Eligibility API, as described in Section 7.02(B), or at the time the Participant submits an alignment request to the CMS ACCESS Alignment API, as described in Section 7.02(E)(1).

F. Switching Alignment.

1. If the Participant wishes to align a Beneficiary who is currently aligned to another entity participating in the Model and has been aligned to that different entity participating in the Model for a minimum of 90 Days, then the Participant must document in writing the following elements:

- i. The Beneficiary's intent to switch alignment to the Participant for any given Clinical Track(s), and, if applicable, their intent to switch from the eCKM Track to the CKM Track (or vice versa); and
- ii. The effective date of the Beneficiary's alignment to the Participant.

G. Once an Eligible ACCESS Beneficiary is aligned to the Participant, the Participant shall report baseline OAP Measures, as applicable, through the CMS ACCESS Data Reporting API pursuant to Section 5.01(B).

H. CMS shall consider the ACCESS Beneficiary aligned to the Participant, unless the ACCESS Beneficiary—

1. Becomes ineligible for the Model at any point following the date of alignment during the Care Period;
2. Is unaligned from the Participant for one or more of the approved reasons for Participant-initiated unalignment, in accordance with Section 7.03(B)(1) at any point following the date of alignment during the Care Period;
3. Is unaligned from the Participant for one or more of the approved reasons for Beneficiary-initiated unalignment, in accordance with Section 7.03(A), 90 days following the date of alignment during the Care Period; or
4. Completes the Care Period.

I. Alignment in the eCKM Track or the CKM Track. This subsection 7.02(I) is applicable only if the Participant selects the eCKM Track or CKM Track.

1. If an ACCESS Beneficiary is eligible for both the eCKM Track and CKM Track, CMS shall only align an ACCESS Beneficiary to one of either the eCKM Track or CKM Track, but not both.

2. The Participant may initiate unalignment for an ACCESS Beneficiary who is already aligned to the eCKM Track in order to align the ACCESS Beneficiary to the CKM Track at any point during the Care Period.

i. For this change, the time limitations specified at Section 7.01(E) and 7.03(A) do not apply.

ii. If the ACCESS Beneficiary requests that the Participant change the ACCESS Beneficiary's attribution from the eCKM Track to the CKM Track and—

a. The ACCESS Beneficiary wishes to remain aligned with the Participant, then the Participant must submit updated baseline metrics; or

b. The ACCESS Beneficiary wishes to unalign with the Participant's eCKM Track and instead align with another entity participating in the Model's CKM Track, then the Participant is not required to submit updated baseline metrics.

J. The Participant shall only initiate alignment during the Agreement Performance Period and may not initiate alignment in an Initial Period or Follow-on Period with a Beneficiary between July 1, 2035 and June 30, 2036.

Section 7.03 Removing an ACCESS Beneficiary from Alignment

A. ACCESS Beneficiary-Initiated Unalignment from the Participant or Clinical Track. If an ACCESS Beneficiary requests to unalign from the Participant any time after 90 Days from the date of alignment with the Participant, then the Participant must—

1. Document the ACCESS Beneficiary's voluntary unalignment request, including the date of the request and the date that the ACCESS Beneficiary's unalignment takes effect; and

2. Deliver a written confirmation notice of unalignment, as described at Section 7.03(C) to the ACCESS Beneficiary no later than 15 Days after the date of the ACCESS Beneficiary's request to unalign, unless a different date is specified by CMS.

B. Participant-Initiated Unalignment of ACCESS Beneficiary.

1. The Participant may not initiate unalignment of an ACCESS Beneficiary via the CMS ACCESS Unalignment API unless:

- i. The ACCESS Beneficiary relocates outside of the Participant's Eligible Service Area;
 - ii. The Participant loses contact with the ACCESS Beneficiary despite efforts to conduct outreach; or
 - iii. The ACCESS Beneficiary is no longer clinically eligible for the Clinical Track to which the Participant attributes the ACCESS Beneficiary.
2. The Participant must notify the ACCESS Beneficiary in the manner specified at Section 7.03(C), that the ACCESS Beneficiary is unaligned from the Participant no later than 15 Days after the date that the Participant submits the unalignment request, unless a different date is specified by CMS should further review be required as part of Section 7.03(B)(3).
3. To unalign an ACCESS Beneficiary, the Participant must submit an unalignment request for such ACCESS Beneficiary using the CMS ACCESS Unalignment API. CMS reserves the right to review and reject unalignment requests for the reason of loss of clinical eligibility.

C. Notice of Unalignment. The Participant must include the following in the written notice of unalignment to a Formerly-Aligned Beneficiary:

1. The name of the Formerly-Aligned Beneficiary who has been unaligned from the Participant;
2. The reason that the Formerly-Aligned Beneficiary has been unaligned from the Participant;
3. The effective date of the Formerly-Aligned Beneficiary's unalignment from the Participant;
4. An explanation that the Formerly-Aligned Beneficiary's Medicare coverage and benefits are not affected by the unalignment;
5. Information about how the Formerly-Aligned Beneficiary can continue to receive care for his or her Qualifying Condition(s), including:
 - i. Information about accessing the public ACCESS Participant Directory;
 - ii. Contact information for Medicare Beneficiary assistance resources, including 1-800-MEDICARE;

iii. Information about the former ACCESS Beneficiary's right to access their medical records; and

6. Any additional content specified by CMS.

D. Requirement to Provide Unalignment Pathway.

1. The Participant shall establish a process for an ACCESS Beneficiary to unalign from the Participant, which does not impose obligations, conditions, or procedural requirements on the ACCESS Beneficiary that are more onerous than the alignment process.

2. Failure to comply with the requirements of this Section 7.03(D) may result in retroactive reversal of the relevant ACCESS Beneficiary's alignment and subject the Participant to remedial actions or termination, as pursuant to Article 16 and Article 17, respectively.

Section 7.04 Availability of Services

The Participant and its Clinicians shall not refuse to align a Beneficiary who wishes to align with the Participant, and meets Beneficiary eligibility criteria set forth at Section 7.01 and Section 7.02(C), solely based on an assessment that the Beneficiary may be less likely to achieve OAP Measure Targets. The Participant shall maintain documentation of any Beneficiary who is refused alignment after being determined to meet the eligibility criteria set forth at Section 7.01 and Section 7.02(C), including the Beneficiary identifier, date of refusal, and the basis for such refusal.

Section 7.05 Beneficiary Choice

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

B. Notwithstanding the foregoing, the Participant may communicate to Eligible ACCESS Beneficiaries the benefits of receiving care with the Participant. All such communications shall be deemed promotional and public-facing Descriptive Model Materials and thus subject to Section 14.02.

Section 7.06 Beneficiary Incentives

A. Prohibition. Except as set forth in Section 7.06(C) and Section 7.06(D) or as otherwise permitted by law, neither the Participant nor any of its Clinicians, nor other individuals or entities performing functions or services related to the Participant's Model Activities, may provide gifts or other remuneration to beneficiaries to induce them to receive items or services—or to continue receiving items or services—from the Participant or any of its Clinicians.

B. Availability of Safe Harbor Protection for Beneficiary Incentives. 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, any Clinician on the Participant's ACCESS Clinician Roster, and other individuals or entities performing functions or services related to the Participant's Model Activities, to an ACCESS Beneficiary that meets all safe harbor requirements set forth in 42 C.F.R. § 1001.952(ii)(2) and the requirements of Section 7.06(C) and Section 7.06(D) of this Agreement.

C. Beneficiary Cost-Sharing Support. Consistent with the prohibition set forth in Section 7.06(A), and subject to compliance with all other applicable laws and regulations, the Participant may elect to offer, and may permit any of its Clinicians to offer Beneficiary Cost-Sharing Support to an ACCESS Beneficiary.

1. If the Participant elects to offer Beneficiary Cost Sharing Support by foregoing collection of cost-sharing for OAP claims, then the Participant and its Clinicians must apply the incentive uniformly to all aligned ACCESS Beneficiaries, regardless of Clinical Track or Care Period. The Participant may revise its decision to forego collection of cost-sharing for OAPs after the start of this Agreement with CMS approval, provided the updated policy is applied uniformly across Clinical Tracks and Care Period on a go-forward basis for new and renewing Beneficiary alignments.

2. If the Participant elects not to offer Beneficiary Cost Sharing Support or permit any of its Clinicians to offer Beneficiary Cost Sharing Support, then the Participant must clearly disclose the expected cost-sharing amount to the aligned ACCESS Beneficiary before delivering services. The Participant may collect cost-sharing at the beginning of the applicable month of service; provided, however, the Participant must refund any cost-sharing amount collected for a month in which Active Care Delivery is not furnished in accordance with this Agreement

3. The Participant must notify CMS in a form and manner specified by CMS whether the Participant or its Clinicians intends to offer Beneficiary Cost-Sharing Support by foregoing collection of OAP cost-sharing from aligned ACCESS Beneficiaries.

D. In-Kind Items or Services Beneficiary Incentive.

1. Consistent with the prohibition set forth in Section 7.06(A), and subject to compliance with all other applicable laws and regulations, the Participant and its Clinicians may choose to offer the In-Kind Items and Services Beneficiary Incentive, which includes but is not limited to items or services to ACCESS Beneficiaries during the Agreement Performance Period, subject to the following conditions—

- i. The in-kind items or services must be provided directly by the Participant, or by its Clinicians or an agent of the Participant under the Participant's direction and control, to the ACCESS Beneficiary during a Care Period.
- ii. The in-kind item or service provided must be reasonably connected to Active Care Delivery provided to an ACCESS Beneficiary during a Care Period.
- iii. The in-kind item or service must be a preventive care item or service or an item or service that advances a clinical goal for an ACCESS Beneficiary receiving Active Care Delivery, such as by engaging the ACCESS Beneficiary in better managing his or her own health.
- iv. The in-kind item or service must not be tied to the receipt of items or services outside of Active Care Delivery.
- v. The in-kind item or service must not be tied to the receipt of items or services from a particular provider or supplier.
- vi. The in-kind item or service must not be furnished in whole or in part to reward the ACCESS Beneficiary for aligning, or agreeing to align, with the Participant.
- vii. The cost of the in-kind items or services must not exceed the annual OAP Allowed Amount for the Clinical Track and Care Period for which the Beneficiary is initially aligned and for which an in-kind item or service is intended for use. If a Beneficiary is aligned to more than one Clinical Track with the same Participant, the total cost must not exceed the combined annual OAP Allowed Amounts for all such Clinical Tracks and Care Periods for which the Beneficiary is initially aligned and for which the item or service is intended.
- viii. The cost of the in-kind items or services must not be shifted to any federal health care program, as defined at section 1128B(f) of the Act.
- ix. The in-kind item may be furnished on either a loan or ownership basis, at the Participant's discretion. If furnished on a loan basis, the Participant may recover the item at the conclusion of the Care Period or upon Beneficiary unalignment. The Participant may not require any form of payment, deposit, or financial

security from the ACCESS Beneficiary in connection with furnishing or recovering the item.

2. The Participant shall, and shall ensure its Clinicians will, make available to the Office of Inspector General (OIG), upon request, all materials and records sufficient to establish whether the items and services were distributed in a manner that meets the conditions of this Article 7. The Participant shall provide CMS copies of such records, upon request.

3. CMS reserves the right to require that the Participant immediately discontinue furnishing, deploying, or using any items or services furnished pursuant to this Section 7.06(D) within the Model if CMS makes a determination that the device presents, based on a review of clinical data, an undue risk of harm that outweighs the potential clinical benefits for individuals entitled to benefits under Medicare Part A or enrolled under Part B.

E. Access to Items and Services

1. The Participant shall accept the OAP Allowed Amount, including any applicable beneficiary cost-sharing, as payment in full for Model Activities. Accordingly, the Participant shall not require an ACCESS Beneficiary to purchase, rent, or otherwise obtain any item at the Beneficiary's own expense as a condition of alignment with the Participant or receipt of Model Activities.

2. The Participant may integrate items already in the ACCESS Beneficiary's possession on a voluntary basis. However, the Participant must ensure that Model Activities do not depend on the ACCESS Beneficiary owning or purchasing any item that is not otherwise furnished by the Participant.

3. Nothing in this Section shall be construed to prohibit the Participant from requiring general, non-clinical prerequisites that are reasonably necessary to access technology-enabled services and are in widespread use, specifically access to a mobile phone, tablet, or computer; internet access; a valid email address or phone number; or installation and use of the Participant's software application or web portal. The Participant may support ACCESS Beneficiaries in identifying financially unaffiliated programs or resources that assist with obtaining such prerequisites.

Article 8. Data Sharing by CMS

Section 8.01 General

A. Subject to the limitations discussed in this Agreement, and in accordance with applicable law, including HIPAA and the Confidentiality of Substance Use Disorder (SUD) patient records regulations at 42 C.F.R. Part 2, during the Agreement Performance Period, and any other time deemed necessary by CMS, CMS will offer the Participant (acting on its own behalf as a HIPAA Covered Entity) an opportunity to request certain CMS data. When requests are for data and/or reports that contain Beneficiary-identifiable data, such request must be made in writing by completing the Data Disclosure Request and Attestation (DRA) form at Appendix A, for purposes including those described in the first and second paragraphs of the definition of “health care operations” under the HIPAA Privacy Rule at 45 C.F.R. § 164.501. CMS will provide and maintain the DRA throughout the Agreement Performance Period. CMS will not offer the Participant an opportunity to request any Beneficiary-identifiable data before the Effective Date of this Agreement and execution of the DRA.

B. CMS describes the Beneficiary-identifiable data available to the Participant in Section 8.02(C) and in the DRA.

C. The Participant shall update its DRA if the assertions therein become inaccurate over the course of the Agreement Term through changes to the Participant’s contact information, data needs, or otherwise. Additionally, CMS shall require the Participant to periodically review the assertions in the Participant’s current DRA, at least annually. After review, the Participant shall either attest to the continued accuracy of the DRA, or submit a new or updated DRA, as applicable, as a condition of the Participant’s continued receipt of the data specified in the DRA.

D. If CMS elects to offer SUD data sharing for ACCESS Beneficiaries, CMS shall offer the Participant an opportunity to request Beneficiary-identifiable SUD data. If the Participant requests the offered SUD data, then the Participant shall receive claims data regarding SUD treatment only if the ACCESS Beneficiary—

1. Has not elected to decline data sharing or otherwise been opted out of data sharing; and
2. Has consented to SUD data sharing opt-in in a form and manner to be determined by CMS.

E. CMS may share certain Clinician-level and Participant-level data that identifies the Participant’s performance with other entities participating in the Model for the purpose of improving Model outcomes. This may include information gathered through Participant data reporting, quality scores, utilization scores, or other relevant data. Such data must not include individually identifiable health information, in accordance with the Model’s policies and de-identification requirements of the HIPAA Privacy Rule at 45 C.F.R. § 164.514.

Section 8.02 Provision of Certain Beneficiary-Identifiable Data.

A. CMS asserts sole discretion to grant or deny Participant requests for specific Beneficiary-identifiable data (including PHI), based on CMS' available resources, the limitations in this Agreement, and applicable law(s).

B. In providing the Participant with the opportunity to request Beneficiary-identifiable data, CMS does not represent that the Participant or any of its Clinicians has met all applicable HIPAA requirements for requesting data under 45 C.F.R. § 164.506(c)(4). The Participant should consult with its own legal counsel to make those determinations, prior to requesting any data from CMS.

C. The Beneficiary-identifiable data available for request by completing the DRA includes the following data and reports:

1. Beneficiary Alignment Files. At least monthly, CMS shall provide to the Participant a list of its ACCESS Beneficiaries, including relevant information such as each ACCESS Beneficiary's Clinical Track, Medicare Beneficiary Identifier (MBI), period (Initial Period or Follow-On Period), and alignment date (Beneficiary Alignment File). This file shall also include relevant information on previously aligned ACCESS Beneficiaries who have subsequently become unaligned – specifically, information used for alignment (including MBI, first name, last name, date of birth, gender, diagnosis (or diagnoses), Clinical Track, period (Initial Period or Follow-On Period), and alignment date), and information used for unalignment (including unalignment date and reason(s) for unalignment).

2. Payment Files. On a monthly basis, CMS shall provide to the Participant a monthly payment file providing data on ACCESS Payment amounts for each of its ACCESS Beneficiaries, and aggregated across the Data Requestor's total Beneficiary population. Such files will detail: the Beneficiary's MBI, first name, last name, date of birth, claim control number, service dates, performing NPI, TIN, claim line number, payment amount, and the reason(s) for any recoupment. CMS shall begin sharing payment files with the Participant at such time, form, and manner determined by CMS.

3. Line-Level Beneficiary-Identifiable Claims Data. On demand, claims data for ACCESS Beneficiaries is available for the Participant to query via the Beneficiary Claims Data API. This data will include:

i. Three years of historical Parts A, B, and D fully adjudicated claims data, specifically from the 36 months immediately preceding the ACCESS Beneficiary's Alignment date for ACCESS Beneficiaries that are aligned to the Data Requestor; and,

ii. Current Parts A, B, and D partially adjudicated claims data, corresponding to each ACCESS Beneficiary's Care Period for ACCESS Beneficiaries that are aligned to the Data Requestor.

D. The parties mutually agree that CMS retains all ownership rights to the data sources made available to the Participant, and the Participant does not obtain any right, title, or interest in any of the data furnished by CMS.

E. The Participant represents, and in furnishing the data requested via the DRA, CMS relies upon such representation, that such data shall be used solely for care management, care coordination, quality improvement activities, and population-based activities relating to improving health or reducing health care costs for ACCESS Beneficiaries, Eligible ACCESS Beneficiaries, and Formerly-Aligned ACCESS Beneficiaries, and such other purposes described in this Agreement. The Participant agrees not to disclose, use, or reuse the data except as specified in this Agreement or except as CMS shall authorize in writing or as otherwise required by law. The Participant further agrees not to sell, rent, lease, loan, or otherwise grant access to the data covered by this Agreement.

F. Information derived from the CMS data requested via the DRA may be shared and used within the legal confines of the Participant and its Clinicians in a manner consistent with Section 8.02(G) to enable the Participant to improve care integration and be a Beneficiary-centered organization.

G. The Participant may reuse original or derivative data without prior written authorization from CMS for clinical treatment, care management and coordination, quality improvement activities, population-based activities relating to improving health or reducing health care costs, and healthcare provider incentive design and implementation, but shall not disseminate (unless required by law) any individually identifiable original or derived information from the data requested via the DRA to anyone who is not a HIPAA Covered Entity, a HIPAA business associate, the Participant or its Clinicians in a treatment relationship with the ACCESS Beneficiary, or the Participant's or Clinicians' business associates. When using or disclosing PHI or PII, requested via the DRA, the Participant must make "reasonable efforts to limit" the information to the "minimum necessary" to accomplish the intended purpose of the use, disclosure or request. The Participant shall further limit its disclosure of such information to the types of disclosures that CMS itself would be permitted to make under the "routine uses" in the applicable systems of records listed in the DRA.

H. Subject to the limits specified above and elsewhere in this Agreement and applicable law, the Participant may link individually identifiable data made available via the DRA (including directly or indirectly identifiable data) or derivative data to other sources of individually-identifiable health information, such as other medical records available to the Participant and its Clinicians. The Participant may disseminate such data that has been linked to other sources of

individually identifiable health information provided such data has been de-identified in accordance with HIPAA requirements in 45 C.F.R. § 164.514(b).

I. The Participant shall establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it. The safeguards shall provide a level and scope of security that is not less than the level and scope of security requirements established for federal agencies by the Office of Management and Budget (“OMB”) in *OMB Circular No. A-130, Appendix I—Responsibilities for Protecting and Managing Federal Information Resources*¹ as well as Federal Information Processing Standard 200 entitled *Minimum Security Requirements for Federal Information and Information Systems*²; and, *NIST Special Publication 800-53 Recommended Security Controls for Federal Information Systems*.³ The Participant acknowledges that the use of unsecured telecommunications, including the Internet, to transmit directly or indirectly identifiable information from the files made available via the DRA or any such derivative data files is strictly prohibited. Further, the Participant agrees that the data made available via the DRA must not be physically moved, transmitted or disclosed in any way from or by the site of the custodian or, if applicable, alternate data custodian indicated in the DRA, other than as provided in this Agreement without written approval from CMS, unless such movement, transmission or disclosure is required by law.

J. The Participant shall grant access to the data and/or the facility(ies) in which the data is maintained to the authorized representatives of CMS or Office of Inspector General of the Department of Health and Human Services (OIG), including at the site of the custodian indicated in the DRA, for the purpose of inspecting to confirm compliance with the terms of this Agreement.

K. The Participant agrees that any use of CMS data in the creation of any document concerning the purpose specified in this section and the DRA form must adhere to CMS’ current Cell Size Suppression Policy. The policy stipulates that no cell (e.g., admittances, discharges, patients, services) representing 10 or fewer beneficiaries may be displayed. Also, no percentages or other mathematical formulas may be used if they result in the display of a cell representing 10 or fewer beneficiaries. A cell that represents or uses percentages or other mathematical formulas to represent zero beneficiaries may be displayed.

L. The Participant shall report within one hour following discovery of any actual or suspected breach of PHI or Personally Identifiable Information (“PII”) from—or derived from—CMS data, loss of these data, or improper use or disclosure of such data to the CMS Action Desk by telephone at (410) 786-2580 or by email notification at cms_it_service_desk@cms.hhs.gov.

¹ <https://obamawhitehouse.archives.gov/sites/default/files/omb/assets/OMB/circulars/a130/a130revised.pdf>

² <http://csrc.nist.gov/publications/fips/fips200/FIPS-200-final-march.pdf>

³ <http://nvlpubs.nist.gov/nistpubs/SpecialPublications/NIST.SP.800-53r4.pdf>

Furthermore, the Participant shall cooperate fully in any federal incident security process that results from such improper use or disclosure.

M. The parties mutually agree that the individual named in the DRA as the Participant's data custodian ("Data Custodian") is designated as custodian of CMS data on behalf of the Participant and shall be responsible for the observance of all conditions of use and disclosure of such data and any derivative data, and for the establishment and maintenance of security arrangements as specified in this Agreement to prevent unauthorized use or disclosure. Furthermore, such Data Custodian is responsible for contractually binding any downstream recipients of such data to the terms and conditions in this Agreement as a condition of receiving such data. In the event the Data Custodian named in the DRA is unable to perform these functions for any reason, and the Participant has named an alternate Data Custodian in the DRA, the parties mutually agree that the individual named in the DRA as the alternate Data Custodian is designated as custodian of the CMS data on behalf of the Participant and shall be responsible for performing these functions. The Participant shall ensure that any individual named in the DRA as Data Custodian or alternate Data Custodian is either an employee of the Participant or an employee of a business associate of the Participant that requires access to the requested data for the purposes for which the data is requested. The Participant shall notify CMS within 15 days of any change of Data Custodian or alternate Data Custodian, and the Participant is responsible for terminating the former custodians' access to the requested data. The parties mutually agree that CMS may disapprove the appointment of a Data Custodian or may require the appointment of a new Data Custodian at any time.

In making this request, the Data Requestor names the individual(s) identified in Table 2 of Appendix A as the designated custodian of the CMS data files on behalf of the Data Requestor ("Data Custodian"), who 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 the Agreement to prevent unauthorized use or disclosure. Furthermore, the Data Custodian is responsible for contractually binding any downstream recipients of such data to the terms and conditions in the Agreement as a condition of the receiving such data. In providing this information, the Data Requestor attests that the Data Custodian is either an employee of the Data Requestor or an employee of a Business Associate of the Data Requestor that requires access to the requested data for the purpose indicated in Section A.4 of Appendix A.

If at any time a change of custodianship is required, CMS must be notified within 15 days of the change, and the Data Requestor is responsible for terminating the former custodians' access to the data requested herein. The authorized signatory of this DRA may also act as a Data Custodian.

N. Data disclosed to the Participant pursuant to the DRA may be retained by the Participant until 30 days after the completion of the final settlement for the Agreement Performance Period, except as CMS shall authorize in writing or as otherwise required by law. The Participant is permitted to retain any individually identifiable health information from such data sources or derivative data after the expiration or termination of the Agreement if the Participant is a HIPAA Covered Entity, 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 Covered Entity to whom the Participant provides such data in the course of carrying out the Model may also retain such data if the recipient entity is a HIPAA Covered Entity or business associate and the data is incorporated into the subject Beneficiaries' medical records that are part of a designated record set under HIPAA. The Participant shall destroy all other data and send written certification of the destruction of the data sources and/or any derivative data to CMS within 30 days of completion of the final settlement for the Agreement Performance Period, except as CMS shall authorize in writing or as otherwise required by law. If the Participant or CMS terminates the Agreement Performance Period as specified by Article 17, the Participant shall destroy all other data and send written certification of the destruction of the data sources and/or any derivative data to CMS within 30 Days of completion of Reconciliation following the effective date of termination. If the Participant or CMS terminates the Agreement Performance Period as specified by Article 17 with an effective date that is prior to the Agreement Performance Period, the Participant shall destroy all data disclosed to the Participant pursuant to the DRA, including any data that has been incorporated into the subject Beneficiaries' medical records that are part of a designated record set under HIPAA, and send written certification of the destruction of the data sources and/or any derivative data to CMS within 30 Days of the effective date of termination. CMS may require the Participant to destroy all data and send written certification of the destruction of data files and/or any derivative data files to CMS at any time if CMS determines it necessary due to a program integrity concern. Except for disclosures for treatment purposes, the Participant shall bind any downstream recipients to these terms and conditions as a condition of disclosing such data to downstream entities and permitting them to retain such records under this provision. These retention provisions survive the expiration or termination of the Agreement.

O. Upon review, acceptance, and execution of the DRA, the Participant shall be approved to access the CMS ACCESS Eligibility API, CMS ACCESS Alignment API, CMS ACCESS Unalignment API, and the CMS ACCESS Data Reporting API. Access to all four CMS ACCESS APIs shall be granted prior to the start of the Agreement Performance Period or as otherwise specified by CMS.

Section 8.03 Beneficiary Rights to Opt-Out of Data Sharing

A. The Participant shall provide ACCESS Beneficiaries who inquire about or wish to modify their preferences regarding claims data sharing for care coordination and quality improvement purposes with information about how to modify their data sharing preferences. The Participant

shall direct ACCESS Beneficiaries to call 1-800-MEDICARE in order to modify their preferences regarding claims data sharing at any time.

B. The Participant shall inform the ACCESS Beneficiary that, even if an ACCESS Beneficiary has elected to decline claims data sharing, CMS may still engage in certain limited data sharing for care coordination and quality improvement activities for ACCESS Beneficiaries, and population-based activities relating to improving health or reducing health care costs.

C. CMS shall maintain the claims data sharing preferences of ACCESS Beneficiaries who elect to decline claims data sharing in the Model.

Article 9. Compliance and Oversight

Section 9.01 Compliance with Laws

A. Agreement to Comply.

1. The Participant shall comply with, and shall require all of its Clinicians to comply with the applicable terms of the Agreement and all applicable statutes, regulations, and guidance, including without limitation:

- i. Federal criminal laws;
- ii. The Social Security Act (Public Law 74-271);
- iii. Title XVIII of the Act;
- iv. The False Claims Act (31 U.S.C. § 3729 et seq.);
- v. The antikickback statute (42 U.S.C. § 1320a-7b(b));
- vi. The civil monetary penalties law (42 U.S.C. § 1320a-7a);
- vii. The physician self-referral law (42 U.S.C. § 1395nn);
- viii. Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.);
- ix. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794);
- x. Section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. § 18116);
- xi. The Age Discrimination Act of 1975 (42 U.S.C. § 6101 et seq.);
- xii. The Federal health care conscience protection statutes (see list at 45 C.F.R. 88.1);
- xiii. The Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq. (1990);
- xiv. The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191 and implementing regulations at 45 C.F.R parts 160 and 164);
- xv. Other non-discrimination authorities; and
- xvi. State laws, as applicable.

2. This Agreement does not waive any obligation of the Participant to comply with the terms of any other CMS contract, agreement, model, or demonstration.

B. Reservation of Rights.

1. Nothing contained in this Agreement or in the application process for the Model constitutes 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.

2. 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 and its Clinicians and other individuals and entities performing functions and services related to Model Activities.

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 and its Clinicians and other individuals and entities performing functions and services related to Model Activities.

Section 9.02 Compliance Plan

A. The Participant shall have a compliance plan that includes at least the following elements:

1. A designated compliance official;
2. Mechanisms for identifying and addressing compliance problems related to the Participant's operations and performance;
3. A method for employees or contractors of the Participant performing functions or services related to this Model to anonymously report suspected problems related to the Participant's compliance official;
4. Compliance training for the Participant and its Clinicians; and

5. A requirement for the Participant to report probable violations of law to an appropriate law enforcement agency.

B. The Participant shall ensure that its compliance plan is in compliance with all applicable laws and regulations. The Participant shall periodically update its compliance plan to reflect changes in those laws and regulations.

C. The Participant shall ensure that the name and contact information of the designated compliance official is communicated to CMS in a form and manner specified by CMS.

Section 9.03 CMS Monitoring and Oversight Activities.

A. Compliance with Agreement. CMS shall conduct monitoring activities to evaluate compliance by the Participant and its Clinicians with the terms of this agreement. 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. Such monitoring activities may include the following:

1. 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 ACCESS Beneficiary populations or OAP Measures), efforts to manipulate alignment of ACCESS Beneficiaries, overutilization, and cost-shifting to other payers or populations.

2. Review of the Care Update template(s), OAP Measures reporting, and any data submitted to CMS by the Participant via the ACCESS participant portal and applicable APIs.

3. Review of utilization and quality data collected by CMS or reported to CMS by the Participant in accordance with Articles 4 through 7.

4. Review of documents from the Participant, its Clinicians, and other individuals and entities performing functions and services related to Model Activities, including but not limited to documentation related to the Participant's eligibility, surveys and questionnaires.

5. Interviews of the staff and leadership of the Participant.

6. Interviews of ACCESS Beneficiaries and their representatives.

7. Audits of any of the Participant's records and documentation, as needed to demonstrate compliance with the requirements of the Agreement, including but not limited to—

- i. Medical records;

ii. Any required written documentation set forth in this Agreement, including but not limited to requirements at Section 4.05(B), Section 7.02(D), Section 7.03, and Section 17.03; and

iii. User logs pertaining to the submission of Care Updates, as described at Section 4.05.

8. Demonstration of services provided to ACCESS Beneficiaries consistent with the Participant's Care Delivery Plan, and the methods of ensuring safety and compliance.

9. Documentation requests sent to the Participant and its Clinicians, including surveys and questionnaires.

10. Model-specific reports, studies, and audits regarding particular Model elements, to be determined by CMS.

B. Program Integrity and Patient Safety. CMS shall monitor the Participant and its Clinicians on a regular ongoing basis to ensure program integrity and support patient safety.

1. CMS monitoring activities of the Participant's performance may include:

i. Data the Participant submits to CMS;

ii. Performance on utilization and quality measures;

iii. Referrals and billing patterns; or

iv. Other practice information.

2. CMS shall monitor suspicious patterns and may require documentation and device logs. The Participant may be subject to audit, corrective action, or payment recoupment if reported values cannot be substantiated. If, in the course of performing monitoring and compliance activities, CMS identifies unusual billing patterns and/or potential program integrity concerns, then CMS may take the following actions:

i. Engage in annual financial audits of the Participant's billing practices related to the Model;

ii. Commence Reconciliation and recoupment activities, as described at Section 6.06, outside of a Reconciliation Round, if applicable; and

iii. Take any other actions as may be necessary to ensure appropriate use of Medicare funds and compliance with Model requirements.

C. Nothing in this Agreement limits or otherwise prevents CMS from monitoring the Participant for compliance as permitted by applicable laws and regulations.

D. CMS may conduct monitoring activities pursuant to this Article 9 for up to two calendar years after the effective date of termination or expiration of this Agreement.

Section 9.04 Compliance with Monitoring and Oversight Activities.

A. The Participant shall cooperate with, and shall require its Clinicians and other individuals and entities performing functions and services related to the Participant's Model Activities to cooperate with, all CMS compliance monitoring requests and activities.

B. The Participant shall ensure it has sufficient access to all records, data, and information necessary to comply with the monitoring activities described in this Agreement. As necessary, the Participant shall request this information from any of its Clinicians, or individuals and entities performing functions or providing services related to the Model.

Article 10. Participation in Shared Learning Activities

Section 10.01 CMS Shared Learning Activities.

CMS shall conduct shared learning activities designed to improve Model results and share information that emerges from participation in the Model. Shared learning activities may include periodic conference calls, virtual or in-person site visits (as outlined in Article 12), virtual or in-person meetings, or other activities. As part of the shared learning activities, CMS may request the Participant and its Clinicians share non-proprietary resources used to implement the Model.

Section 10.02 Participation in Shared Learning Activities.

The Participant shall participate in CMS-sponsored shared learning activities, and shall require its Clinicians and other individuals and entities performing functions and services related to Model Activities to participate in shared learning activities, as applicable.

Article 11. Participation in Evaluation

Section 11.01 General

A. The Participant shall participate in and cooperate with any independent 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 and reducing expenditures for ACCESS Beneficiaries.

B. The Participant shall ensure that its Clinicians and other individuals and entities performing functions and services related to Model Activities, participate and cooperate in any such independent evaluation activities conducted by or on behalf of CMS. Termination or expiration of the Agreement shall not affect the right of CMS to evaluate the Model.

C. CMS shall randomly assign Beneficiaries deemed eligible to participate in the Model to the Control Group for each Clinical Track to enable evaluation of the Model. CMS does not permit Control Group Assigned Beneficiaries to be aligned to the Participant or another entity participating in the Model for a defined period following assignment to the control group.

1. CMS shall set the randomization ratio at 90:10, where 90% of Eligible ACCESS Beneficiaries are randomized to be eligible to participate in the Clinical Track and 10% of eligible beneficiaries are randomized to the control group.

2. CMS may adjust this ratio as CMS deems necessary at any time during the course of the Model to ensure valid evaluation results.

Section 11.02 Evaluation Data Sources

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

1. Site visits with the Participant, its Clinicians, and other individuals and entities performing functions and services related to Model Activities;
2. Surveys or interviews with the Participant, its Clinicians, and other individuals and entities performing functions and services related to Model Activities;
3. Surveys or interviews with ACCESS Beneficiaries and their caregivers or Control Group Assigned Beneficiaries and their caregivers;
4. Focus groups of the Participant, its Clinicians, other individuals and entities performing functions and services related to Model Activities;
5. Focus groups of ACCESS Beneficiaries and their caregivers or Control Group Assigned Beneficiaries and their caregivers;

6. Interviews with the Participant, its Clinicians, and other individuals and entities performing functions and services related to Model Activities, and their staff;
7. Focus groups with the Participant, its Clinicians, other individuals and entities performing functions and services related to Model Activities, and their staff; and
8. Direct observation of interactions between the Participant, its Clinicians, and other individuals and entities performing functions and services related to Model Activities, including staff, and other activities related to the Participant's participation in the Model.

B. Secondary Data. In its evaluation activities, CMS may use data or information submitted by the Participant as well as Active Care Delivery claims submitted to CMS for ACCESS Beneficiaries or claims submitted to CMS for Control Group Assigned Beneficiaries. These data may include, but are not limited to:

1. Claims data;
2. Survey data from patient experience surveys;
3. Medical records;
4. Clinical data;
5. Monitoring data (e.g., audit results, etc.); and
6. Quality and clinical data submitted to CMS.

Article 12. Site Visits

Section 12.01 General

A. The Participant shall cooperate and require its Clinicians and staff to cooperate in any virtual or in-person site visits conducted by or on behalf of CMS.

B. The Participant shall provide access to systems, records, and personnel during site visits. The Participant shall ensure that personnel with the appropriate responsibilities and knowledge associated with the purpose of the site visit are available during the site visit.

C. CMS or its designee(s) may perform unannounced site visits at any of the Participant's office locations at any reasonable time to investigate urgent concerns or other program integrity issues.

D. Any deficiencies identified through a site visit shall be remediated in accordance with the processes specified in Article 16.

Section 12.02 Advance Notice of Site Visit

Except as provided in this Agreement, CMS or its designee shall provide the Participant with no less than 15 days advance notice of a site visit to be conducted as part of standard compliance monitoring activities, shared learning activities, or a Model Evaluation. To the extent practicable, CMS will attempt to accommodate the Participant's request for particular dates in scheduling site visits, but the Participant shall not request a date that is more than 60 days after the date of the initial site visit notice from CMS.

Section 12.03 Authority to Conduct Site Visit

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

Article 13. CMS Rights in Data and Intellectual Property

Section 13.01 General

A. Consistent with applicable federal privacy and security laws, CMS or its designee may use or disclose any data obtained pursuant to this Agreement to:

1. Evaluate and monitor the Model;
2. Support research as permitted under 45 CFR §164.512(i) of the HIPAA Privacy Rule; and
3. Disseminate quantitative results that are de-identified in accordance with HIPAA requirements in 45 CFR § 164.514(b) and meet the CMS Cell Size Suppression Policy and successful care management techniques to other providers and suppliers and to the public.

B. Data to be used and disclosed may include, but is not limited to—

1. Results of surveys received from the Participant, its Clinicians, and other individuals and entities performing functions and services related to Model Activities;
2. Results of patient experience of care and quality of life surveys; and
3. Measures based upon claims, medical records, and other data sources.

C. CMS shall permit the Participant to comment on evaluation reports when the Participant has been specifically cited to ensure factual accuracy, but the Participant may not edit conclusions or control the dissemination of reports.

D. CMS may use the Participant's name, logo, trademarks, and service marks in connection with the administration, evaluation, promotion, public communication, or public reporting for the Model.

Section 13.02 Proprietary Trade Secret Information

A. Notwithstanding any other provision in the Agreement, the parties agree that any intellectual property or information technology developed as a result of the collaborative activity under the terms of this Agreement and the requirements associated with this Model will be dealt with by appropriate written agreements.

B. Notwithstanding any other provision in the Agreement, all proprietary trade secret information and technology of the Participant that existed prior to the Effective Date of this Agreement is and shall remain the sole property of the Participant, 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's proprietary information or technology.

C. If the Participant maintains any information that should not be publicly disclosed because the Participant considers such information to be proprietary and confidential, the Participant may submit to CMS notice in a form and manner specified by CMS, which identifies specific examples of information the Participant considers to be proprietary and confidential.

1. The Participant shall notify CMS, in a form and manner to be specified by CMS, of any updates to the information contained within this notice.

2. If the Participant does not submit a notice pursuant to the requirements at this Section 13.02(C) and in the form and manner specified by CMS, the Participant shall be deemed to have confirmed that it has no information it considers proprietary and confidential.

D. Notwithstanding any other provision of this Agreement, for all data that CMS confirms to be proprietary trade secret information and technology of the Participant, its Clinicians, and other individuals and entities performing functions and services related to Model Activities, CMS shall not release this data without the express written consent of the owner of the proprietary trade secret information and technology, unless such release is required by law.

Article 14. Participant Public Release of Information

Section 14.01 General

During the Agreement Term and for six calendar months thereafter, the Participant shall obtain, and shall require its Clinicians to obtain, prior approval from CMS for the publication or release of any statistical or analytical material that materially and substantially references the Participant's or its Clinicians' participation in the Model. Such statistical or analytical material includes but is not limited to, reports, papers, articles, professional publications, press releases, speeches, and testimony that present, analyze, or draw conclusions from data generated through the Participant's or Clinicians' participation in the Model. All external reports and statistical or analytical material that are subject to this Section 14.01 must include the following statement:

“The statements contained herein 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 herein.”

The requirement to obtain prior approval shall not apply to the use or citation of information publicly reported by CMS pursuant to Section 5.03 and Section 13.02.

Section 14.02 Descriptive Model Materials and Activities

A. General.

1. The Participant is not permitted to use the logo, seal, identifying mark or symbol of HHS or CMS, unless otherwise permitted by CMS, and shall ensure that those identifiers are not included in any Descriptive Model Materials and Activities.
2. CMS may develop and provide to the Participant template language for certain Descriptive Model Materials and Activities. The Participant shall use, and shall require its Clinicians and other individuals and entities performing functions and services related to Model Activities to use, any template language for Descriptive Model Materials and Activities required by CMS.
3. The Participant, its Clinicians, and other individuals and entities performing functions and services related to Model Activities, as applicable, shall provide any Descriptive Model Materials and Activities to CMS upon request.
4. CMS may review Descriptive Model Materials and Activities and issue written notice of approval or disapproval of Descriptive Model Materials and Activities at any time and in a form and manner specified by CMS.
5. The Participant shall immediately discontinue, and shall require its Clinicians and other individuals and entities performing functions and services related to Model

Activities to immediately discontinue, use of any Descriptive Model Materials and Activities disapproved by CMS.

6. If CMS reviews and approves the Participant's Descriptive Model Materials and Activities in accordance with Section 14.02(D), any material change to such CMS-approved Descriptive Model Materials and Activities must be submitted to CMS and approved in a form and manner and by one or more dates specified by CMS before use of the revised version of the CMS-approved Descriptive Model Materials and Activities.

7. The Participant shall not include language in any Descriptive Model Materials and Activities that directly provide for or imply CMS endorsement of the Participant or its services beyond participation in the Model.

B. The Participant shall not, and shall ensure that its Clinicians and other individuals and entities performing functions and services related to Model Activities shall not, distribute Descriptive Model Materials and Activities that are materially inaccurate or misleading.

C. The Participant shall, and shall ensure its Clinicians and other individuals and entities performing functions and services related to Model Activities, retain copies of all written and electronic Descriptive Model Materials and Activities and appropriate records for all other Descriptive Model Materials and Activities in a manner consistent with Section 15.02.

D. CMS reserves the right to review, or have a designee review, Descriptive Model Materials and Activities to determine whether or not the content is materially inaccurate or misleading. CMS shall perform this review at a time and in a manner specified by CMS once the Descriptive Model Materials and Activities are in use by the Participant.

E. If CMS determines that any promotional or public-facing materials are materially inaccurate or misleading, CMS may:

1. Require the Participant to cease distribution of such materials immediately;
2. Require the Participant to issue corrections or clarifications to any audiences that received the materials;
3. Require the Participant to submit all future promotional materials for prior review and approval for a specified period; or
4. Take remedial action as described in Article 16.

Article 15. Audits and Record Retention

Section 15.01 Right to Audit and Inspect

The Participant agrees that the government (including CMS, HHS, and the Comptroller General or their designees) has the right to audit, inspect, investigate, and evaluate any books, contracts, records, documents and other evidence of the Participant that pertain to the following:

- A. The Participant's compliance with the terms of this Agreement, including provisions that require the Participant to impose duties or requirements on its Clinicians and other individuals and entities performing functions and services related to Model Activities;
- B. Whether any Clinician or other individual and entity performing functions and services related to Model Activities complied with the duties and requirements imposed on them by the Participant pursuant to the terms of this Agreement;
- C. The quality of services performed under this Agreement, including but not limited to OAP Measures performance;
- D. Any activity by the Participant or its Clinicians or other individual or entity performing functions and services related to Model Activities that may pose a potential risk of harm to ACCESS Beneficiaries or a vulnerability to the integrity of the Model test;
- E. The accuracy of payments made to the Participant under this Model, and if applicable, the accuracy of payments owed from the Participant to CMS under this Model;
- F. The ability of the Participant to repay amounts owed to CMS under this Agreement;
- G. The Participant's financial arrangements, including any Financial Affiliation(s); and
- H. Other program integrity issues.

Section 15.02 Maintenance of Records

The Participant shall maintain and shall give the 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 requirements at Section 9.03 and Section 9.04. The Participant shall maintain such books, contracts, records, documents, and other evidence for a period of six years from the expiration or termination of this Agreement or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later, unless:

A. CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the Participant at least 30 Days before expiration of the six-year period described above; or

B. There has been a termination, dispute, or allegation of fraud or similar fault against the Participant 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.

Section 15.03 Reporting Obligations

With respect to data and information that are submitted by the Participant or its Clinicians, or other individuals or entities performing functions or services related to Participant's Model Activities, the Participant 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 the data and information to the best of his or her knowledge, information, and belief.

Article 16. Remedial Action

Section 16.01 Grounds for Remedial Action

CMS may take any one or more of the following remedial actions if CMS determines that the Participant or its Clinicians, or other individuals and entities performing functions and services related to Model Activities—

- A. Has failed to comply with any provision of this Agreement or any Medicare program requirement, rule, or regulation;
- B. Has taken any action that threatens the health or safety of an ACCESS Beneficiary, Eligible ACCESS Beneficiary, or other patient;
- C. Has demonstrated a pattern of failing to achieve OAP Measure Success for ACCESS Beneficiaries;
- D. Has failed to comply with the requirements at Section 3.02 governing the Participant's engagement with CMS, including but not limited to, truthfully and accurately responding to inquiries from CMS in a form and manner specified by CMS;
- E. Has failed to comply with the Participant's CAP, as specified at Section 16.03, or any monitoring or auditing plan developed by CMS for the Participant within the applicable specified time frame for compliance;
- F. Has failed to rectify deficiencies or demonstrate improved performance following any remedial action within the specified time frame permitted for remediation;
- G. Has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the Model or any requirement of the Medicare program;
- H. Has undergone a Change in Control that renders it ineligible for participation in the Model or presents a program integrity risk;
- I. Has demonstrated a pattern of noncompliant conduct whereby the Participant or its Financial Affiliates have submitted Medicare FFS claims for the Participant's ACCESS Beneficiaries, notwithstanding the explicit prohibition at Section 6.07(A)(3) against such billing practices;
- J. Has been in violation of Section 4.01(E);
- K. Has failed to make recoupment payments to CMS, if applicable;
- L. Poses significant program integrity risks, including but not limited to—

1. Being 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;
2. Being subject to investigation or action by HHS (including HHS-OIG 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.

M. Has demonstrated a pattern of aligning Beneficiaries with clinical exclusions for the applicable Clinical Track.

Section 16.02 Types of Remedial Action

If CMS determines that grounds for remedial action exist, CMS may take one or more of the following actions:

- A. Notify the Participant and, if CMS deems appropriate, its Clinicians and other individuals and entities performing functions and services related to Model Activities, of the violation;
- B. Require the Participant to provide additional information to CMS or its designees;
- C. Conduct site visits, interview aligned ACCESS Beneficiaries, or take other actions to gather information;
- D. Subject the Participant to additional monitoring, auditing, or both;
- E. If applicable, prohibit a Clinician from billing ACCESS-specific G-codes;
- F. If applicable, require the Participant to remove a Clinician from the ACCESS Clinician Roster;
- G. Require the Participant to terminate its relationship with any other individual or entity with respect to the individual's or entity's performance of functions or services related to Model Activities;
- H. Deny, suspend, or recoup Monthly OAPs made by CMS to the Participant or its Clinicians;
- I. Suspend or terminate the Participant's ability to bill ACCESS-specific G-codes and ability to align new Eligible ACCESS Beneficiaries;
- J. Retrospectively reverse the alignment of ACCESS Beneficiaries currently aligned to the Participant;
- K. Require the Participant to submit to and complete a CAP, pursuant to Section 16.03;

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

M. Prohibit the Participant from furnishing or implementing a Cost-Sharing Supports Beneficiary Incentive or the In-Kind Items or Services Beneficiary Incentive;

N. Discontinue the provision of data sharing and reports to the Participant under Article 8; or

O. Any other remedial actions CMS deems appropriate to ensure the integrity of the Model. Including, but not limited to, terminating the Agreement pursuant to Article 17 if CMS determines the Participant's efforts to address noncompliance, or other grounds for remedial action, were insufficient.

Section 16.03 Corrective Action Plans (CAP)

A. If CMS requires the Participant to comply with remedial actions set forth in a CAP, then the Participant must comply with the provisions of the CAP set forth by CMS, in a form and manner, and by the deadline determined by CMS.

B. If the Participant (and, if applicable, any of its Clinicians) fails to fully implement and comply with a CAP or fails to demonstrate improved performance after completion of a CAP within the time frame specified in the approved CAP, CMS may require the Participant to—

1. Submit a revised CAP for CMS review, in a form and manner determined by CMS;
2. Impose other remedial action; or
3. Terminate this Agreement.

C. Nothing in this section shall be construed to negate, diminish, or otherwise alter the applicability of provisions set forth in Sections 16.01 and 16.02.

Article 17. Termination

Section 17.01 Termination by CMS

CMS may immediately or with advance notice terminate this Agreement if—

- A. CMS determines that it no longer has the funds to support the Model;
- B. CMS modifies or terminates the Model pursuant to section 1115A(b)(3)(B) of the Act;
- C. CMS offers a revised version of this Agreement to take effect at the start of a subsequent calendar year or such other time specified by CMS, and the Participant does not sign such revised version of this Agreement by the date specified by CMS;
- D. CMS determines that the Participant's efforts to address noncompliance, or other grounds for remedial action, were insufficient;
- E. CMS determines that the Participant has failed to submit to, implement, or fully comply with the terms of a CAP;
- F. CMS determines that the Participant has failed to demonstrate improved performance following any remedial action imposed by CMS;
- G. The Participant 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;
- H. The Participant has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the Model;
- I. The Participant has undergone a Change in Control that presents a program integrity risk;
- J. The Participant has demonstrated a pattern of noncompliant conduct whereby the Participant or its Financial Affiliates have submitted Medicare FFS claims for the Participant's ACCESS Beneficiaries, notwithstanding the explicit prohibition at Section 6.07(A)(3) against such billing practices;
- K. The Participant has been in violation of Section 4.01(E);
- L. The Participant 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
- M. The Participant is subject to investigation or action by HHS (including HHS-OIG 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.

Section 17.02 Termination of the Agreement Performance Period by the Participant

A. The Participant may terminate this Agreement Performance Period at any time for any reason upon 180 Days advance written notice to CMS, in a form and manner to be determined by CMS.

B. Within ten Days of receipt of the Participant's advance termination notice, CMS will confirm receipt in a form and manner to be determined by CMS.

C. Until the effective date of termination, the Participant shall continue to provide Active Care Delivery under the Model, as described at Section 4.03, to ACCESS Beneficiaries and may not align Eligible ACCESS Beneficiaries for a new Initial Period or Follow-On Period.

Section 17.03 Notice to ACCESS Beneficiaries of Termination

A. If the Agreement is terminated under Section 17.01 or Section 17.02, the Participant shall provide written notice of the termination to all affected ACCESS Beneficiaries either via postal or electronic means.

B. The Participant shall deliver such written notice no later than 30 Days before the effective date of termination unless a different date is specified by CMS.

C. The Participant shall include in such written notice to affected ACCESS Beneficiaries:

1. The effective date of the Participant's termination from the Model;
2. An explanation that the ACCESS Beneficiary's Medicare coverage and benefits are not affected by the termination;
3. Information about how the Formerly-Aligned Beneficiary can continue to receive care for their qualifying chronic condition(s), including:
 - i. Information about accessing the public ACCESS Participant Directory;
 - ii. Contact information for Medicare Beneficiary assistance resources, specifically 1-800-MEDICARE;
 - iii. Information about the Formerly-Aligned Beneficiary's right to access their medical records;
 - iv. Any care transition recommendations or follow-up care instructions relevant to the Formerly-Aligned Beneficiary's qualifying chronic condition(s), if the

termination occurs prior to completion of the Formerly-Aligned Beneficiary's Care Period; and

v. Any additional content specified by CMS.

D. The Participant shall provide CMS with a copy of the notification template at least 30 Days before distribution for CMS review and approval. The request must be delivered via email to CMS at ACCESSModelTeam@cms.hhs.gov or at such other address specified by CMS. CMS shall respond with approval or revisions within 30 Days of receipt.

E. Within ten Days after the notification deadline, the Participant shall provide CMS with documentation demonstrating that all required notifications were sent to affected ACCESS Beneficiaries.

Section 17.04 Reconciliation of Completed Payments for Terminated Participants

If CMS or the Participant terminates the Agreement pursuant to Section 17.01 or Section 17.02, respectively, then CMS shall conduct Reconciliation(s) using the Participant's OAP Measures performance data and SSR up to the date of termination for the entire Agreement Performance Period in which the Agreement is terminated, in accordance with Article 6 of this Agreement.

Article 18. Limitations on Review and Dispute Resolution

Section 18.01 Limitations on Review

There is no administrative or judicial review under Sections 1869 or 1878 of the Act or otherwise for the following:

- A. The selection of models for testing or expansion under section 1115A of the Act;
- B. The selection of organizations, sites, or participants to test the selected models, including the decision by CMS to terminate this Agreement or to require the termination of any individual's or entity's status as a Participant;
- C. The elements, parameters, scope, and duration of such models for testing or dissemination, including without limitation to the following:
 - 1. The selection of quality performance standards for the Model by CMS;
 - 2. The methodology used by CMS to assess the quality of care furnished by the Participant; and
 - 3. The methodology used by CMS to align ACCESS Beneficiaries to the Participant.
- D. Determinations regarding budget neutrality under subsection 1115A(b)(3);
- E. The termination or modification of the design and implementation of a model under subsection 1115A(b)(3)(B); and
- F. Determinations about expansion of the duration and scope of a model under subsection 1115A(c), including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection.

Section 18.02 Dispute Resolution

A. Right to Reconsideration. The Participant 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.

- 1. Such a request for reconsideration by the Participant must satisfy the following criteria:
 - i. The request must be submitted to a designee of CMS ("Reconsideration Official") who:
 - a. Is authorized to receive such requests;

b. Did not participate in the determination that is the subject of the reconsideration request.

ii. 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;

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

2. Requests that do not meet the requirements of Section 18.02(A)(1) shall be denied.

3. Within 10 business days of receiving a request for reconsideration, the parties will be sent a written acknowledgement of receipt of the reconsideration request. Such an acknowledgement will set forth:

i. The review procedures; and

ii. A briefing 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.

1. The parties shall proceed diligently with the performance of this Agreement during the course of any dispute arising under the Agreement.

2. The reconsideration shall consist of a review of documentation that is submitted timely and in accordance with the standards specified by the Reconsideration Official.

3. The burden of proof is on the Participant to demonstrate to the Reconsideration Official with clear and convincing evidence that the determination is inconsistent with the terms of the Agreement.

C. Reconsideration Determination.

1. The reconsideration determination shall be based only upon:

i. Position papers and supporting documentation that are timely submitted to the Reconsideration Official and meet the standards for submission under Section 18.02(B)(2); and

ii. 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.

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

3. The Reconsideration Determination is final and binding 30 Days after its issuance, unless the Participant or CMS timely requests review of the Reconsideration Determination in accordance with Sections 18.02(D)(1) and (2).

D. CMS Administrator Review. The Participant or CMS may request CMS Administrator review of the Reconsideration Determination.

1. The request must be made via email to InnovationModelsReconsiderations@cms.hhs.gov or such other address as specified by CMS within 30 Days after the date of the Reconsideration Determination.

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

3. Within 30 business days after receiving a request for review, the CMS Administrator (or a delegate acting on behalf of the CMS Administrator) will send the parties a written acknowledgement of receipt of the request for review. Such an acknowledgement will set forth:

i. Whether the request for review is granted or denied; and

ii. 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.

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

5. If the request for review is granted:

i. The record for review shall consist of timely submitted briefs and the evidence contained in the record of the proceedings before the Reconsideration Official.

The CMS Administrator shall not consider documentation submitted for review other than documents and data described in Sections 18.02(B)(2);

ii. The CMS Administrator shall review the record and issue to CMS and to the Participant a written determination; and

iii. 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.

Article 19. Miscellaneous

Section 19.01 Notices and Communications

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

DESIGNATED OFFICIAL FOR THE PARTICIPANT:			FOR CMS:		
NAME:			NAME:		
TITLE:			TITLE:		
STREET ADDRESS:			STREET ADDRESS: 7500 Security Boulevard		
CITY:	STATE:	ZIP:	CITY: Baltimore	STATE: MD	ZIP: 21244
PHONE:			PHONE:		
EMAIL:			EMAIL: ACCESSModelTeam@cms.hhs.gov		

Section 19.02 Notice of Bankruptcy

A. If the Participant has filed a bankruptcy petition, whether voluntary or involuntary, then the Participant 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 under the terms of each model tested under section 1115A of the Act in which the Participant is participating or has participated and all administrative or judicial review proceedings related to any payments under such models have been fully and finally resolved.

B. The notice of bankruptcy must be sent by certified mail no later than five Days after the petition has been filed and 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 is participating or has participated. This list need not identify a model tested under

section 1115A of the Act in which the Participant 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 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 19.03 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 this Agreement to be unreasonable.

Section 19.04 Entire Agreement; Amendment; Documents Incorporated by Reference

This Agreement, including all appendices, constitutes the entire agreement between the parties. The parties may amend this Agreement or any appendix hereto at any time by mutual written consent; provided, however, that CMS may amend this Agreement or any appendix hereto in writing without the consent of the Participant as specified in this Agreement or any appendix hereto, or for good cause or as necessary to comply with applicable federal or state law, regulatory requirements, accreditation standards, licensing or rules. To the extent practicable, CMS shall provide the Participant with 30 Days' advance written notice of any such unilateral amendment, which notice shall specify the amendment's effective date.

Section 19.05 Survival of Agreement Terms

Expiration or termination of this Agreement 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 survive the expiration or termination of this Agreement and apply thereafter:

Section 3.03(A)(3) Change in Control

Article 5. Model Participation, Performance Measure(s) and Target(s), and Participant Reporting

Article 6. Payment

Article 8. Data Sharing by CMS

Article 9. Compliance and Oversight

Article 11. Participation in Evaluation

Article 13. CMS Rights in Data and Intellectual Property

Article 15. Audits and Record Retention

Article 17. Termination

Article 18. Limitations on Review and Dispute Resolution;

Section 19.01 Notice and Communications

Section 19.02 Notice of Bankruptcy

Section 19.03 Severability

Section 19.05 Survival of Agreement Terms

Appendix C. Behavioral Health Clinical Track

Appendix D. Early Cardio-Kidney-Metabolic Clinical Track

Appendix E. Cardio-Kidney-Metabolic Clinical Track

Appendix F. Musculoskeletal Pain Clinical Track

Appendix G.A.3. Merit-Based Incentive Program (MIPS) Waiver

Section 19.06 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 19.07 Prohibition on Assignment; Change in Control.

A. Except with the prior written consent of CMS, the Participant shall not transfer, including by merger (whether the Participant is the surviving or absorbed entity), consolidation, dissolution, or otherwise, any of the following:

1. Any discretion granted 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.

B. The Participant shall provide CMS with 90 Days advance written notice of any such requested transfer. This obligation remains in effect until the termination of this Agreement and final payment under this Agreement has been made and all administrative and judicial review proceedings relating to any payments under this Agreement have been fully and finally resolved. CMS may condition its consent to such transfer on the Participant's immediate payment of all amounts owed to CMS under this Agreement. Any purported transfer in violation of this section is void.

Section 19.08 Certification

The Participant executive signing this Agreement certifies to the best of his or her knowledge, information, and belief that the Participant satisfies the requirements of Section 3.01 and Section 4.02, and that he or she is authorized by the Participant to execute this Agreement and to legally bind the Participant to its terms and conditions.

Section 19.09 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. In the event that any signature is delivered by facsimile transmission or by e-mail delivery of a ".pdf" format data file, such signature shall create a valid and binding obligation of the party executing (or on whose behalf such signature is executed) with the same force and effect as if such facsimile or ".pdf" signature page were an original thereof. 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.

[SIGNATURE PAGE FOLLOWS]

Signature Page

Each party is signing this Agreement on the date stated above that party's signature. If a party signs but fails to date a signature, the date that the other party receives the signing party's signature will be deemed to be the date that the signing party signed this Agreement.

FOR THE PARTICIPANT:

Date: _____
Signature: _____
Name of Signatory: _____
Title: _____

FOR CMS:

Date: _____
Signature: _____
Name of Signatory: _____
Title: _____

Appendices

Appendix A – Data Disclosure Request and Attestation (DRA)

Appendix B – Data Collection Requirements

Appendix C – Addendum for BH Clinical Track

Appendix D – Addendum for eCKM Clinical Track

Appendix E – Addendum for CKM Clinical Track

Appendix F – Addendum for MSK Clinical Track

Appendix G – Medicare Waivers and Safe Harbors

Appendix H – OAP Sample Calculations

Appendix I – Reconciliation Rounds

Appendix J – Medical Director Acknowledgment and Attestation

FOR REFERENCE AND INFORMATIONAL PURPOSES ONLY: THE PARTICIPANT MUST EXECUTE THE DATA DISCLOSURE REQUEST AND ATTESTATION (DRA) FOR THE ADVANCING CHRONIC CARE WITH EFFECTIVE, SCALABLE SOLUTIONS (ACCESS) MODEL SEPARATELY, IN A FORM AND MANNER SPECIFIED BY CMS.

Appendix A –Data Disclosure Request and Attestation (DRA) for the Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model

A. HIPAA Covered Data Disclosure Request for Performance Year 2026

The Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model Participant (“**Data Requestor**”) requests the following types of data and the materials referenced therein, for the Agreement Performance Period; after the Agreement Performance Period due to expiration or termination of the Agreement Performance Period pursuant to the ACCESS Model’s Participation Agreement (“**Agreement**”); and as otherwise allowed by the Centers for Medicare & Medicaid Services (CMS) under applicable law.

The Data Requestor makes the following assertions regarding its ability to meet the HIPAA requirements for receiving such data:

All fields are required unless otherwise noted.

1. The Data Requestor is: *(Select one.)*

- ☐ A HIPAA Covered Entity as defined in 45 C.F.R. § 160.103.
- ☐ The Business Associate of a HIPAA Covered Entity as defined in 45 C.F.R. § 160.103.
- ☐ Neither a HIPAA Covered Entity nor a Business Associate of a HIPAA Covered Entity.

2. The Data Requestor is seeking protected health information (“**PHI**”), as defined in 45 C.F.R. § 160.103: *(Select one.)*

- ☐ For its own use as a Covered Entity.
- ☐ On behalf of a Covered Entity for which the Participant is a Business Associate.
- ☐ As a Covered Entity for its own use and for use by its Business Associates as permitted by the Agreement.
- ☐ *Other*: Please provide a detailed description of the Participant’s intended purpose or function.

3. The Data Requestor may elect to request access to the following (Table 1):

TABLE 1. DATA FILE NAMES AND DESCRIPTIONS.

Selections	Data File Name	Data Description
☐	i. Beneficiary Alignment Files	Beneficiary Alignment Files list the Participant's ACCESS Beneficiaries, including relevant information such as each ACCESS Beneficiary's Clinical Track, Medicare Beneficiary Identifier (MBI), period (Initial Period or Follow-On Period), and alignment date (Beneficiary Alignment File). This file shall also include relevant information on previously aligned ACCESS Beneficiaries who have subsequently become unaligned – specifically, information used for alignment (including MBI, first name, last name, date of birth, gender, diagnosis (or diagnoses), Clinical Track, Care Period (Initial or Follow-On), and alignment date), and information used for unalignment (including unalignment date and reason(s) for unalignment).
☐	ii. Payment Files	Payment files provide data on ACCESS Payment amounts for each of its ACCESS Beneficiaries, and aggregated across the Data Requestor's total Beneficiary population. Such files will detail: the Beneficiary's MBI, first name, last name, date of birth, claim control number, service dates, performing NPI, TIN, claim line number, payment amount, and the reason(s) for any recoupment.
☐	iii. Agreement Performance Period Line-Level Beneficiary-Identifiable Claims Data	These data include current Parts A, B, and D partially adjudicated claims data, corresponding to each ACCESS Beneficiary's Care Period for ACCESS Beneficiaries that are aligned to the Data Requestor.
☐	iv. Historical Period Line-Level Beneficiary-Identifiable Claims Data	These data include three years of historical Parts A, B, and D fully adjudicated claims data, specifically from the 36 months immediately preceding an ACCESS Beneficiary's Alignment date, for ACCESS Beneficiaries that are aligned to the Data Requestor.

4. The Data Requestor intends to use the requested data for the following purpose: *(Select one.)*

☐ To carry out health care operations that fall within the first and second paragraphs of the definition of that term under the HIPAA Privacy Rule (45 C.F.R. § 164.501).

☐ *Other:* Please provide a detailed explanation of the intended use.

5. The data requested is: *(Select one.)*

☐ The "minimum necessary", as specified in 45 C.F.R. § 164.502(b), to carry out the purpose described in Section A.4 above.

☐ *Other:* Please provide a detailed description of how the data requested exceeds what is needed to carry out the purpose described in Section A.4, above.

This DRA, when signed and submitted, will supersede all previous data disclosure requests and attestations made by the Data Requestor during its participation in the Model.

As required by Article 8 of the Agreement, in making this request, the Data Requestor names the following individual as the designated custodian of the CMS data files on behalf of the Data Requestor ("Data Custodian"), who 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 the Agreement to prevent unauthorized use or disclosure. Furthermore, the Data Custodian is responsible for contractually binding any downstream recipients of such data to the terms and conditions in the Agreement as a condition of the receiving such data. In providing this information, the Data Requestor attests that the Data Custodian is either an employee of the Data Requestor or an employee of a Business Associate of the Data Requestor that requires access to the requested data for the purpose indicated in Section A.4 above.

[SECTION LEFT BLANK INTENTIONALLY.]

TABLE 2. DATA REQUESTOR’S CONTACT INFORMATION

Data Requestor’s Legal Business Name:	
Data Custodian #1 (<i>REQUIRED</i>)	
Full Name:	
Phone Number / Extension:	
Email Address:	
Mailing Address: (Optional)	
Data Custodian #2 (<i>OPTIONAL</i>)	
Full Name:	
Phone Number / Extension:	
Email Address:	
Mailing Address: (Optional)	

B. Attestation

The Data Requestor attests that the individuals identified above are designated as custodians of the data and are authorized to act as points of contact on behalf of the Data Requestor for the purposes of data disclosures under the Model. If at any time a change of custodianship is required, CMS must be notified within 15 days of the change, and the Data Requestor is responsible for terminating the former custodians’ access to the data requested herein. The authorized signatory of this DRA may also act as a Data Custodian.

In submitting this request, the Data Requestor attests that it will protect the requested data as required by applicable law and the Agreement.

The individual signing this DRA certifies to the best of the individual’s knowledge, information, and belief that the information submitted to CMS and contained in this DRA, is accurate, complete, and truthful, and that the individual is authorized by the Data Requestor to execute this DRA.

[SIGNATURE PAGE FOLLOWS]

FOR THE PARTICIPANT:

Date: _____
Signature: _____
Name of Signatory: _____
Title: _____
Email: _____
Phone Number / Extension: _____

C. Certification

To ensure periodic confirmation of continued accuracy, CMS requires the Data Requestor to review and certify the accuracy of the assertions in the Data Requestor's current DRA on an annual basis. If there are no changes to the DRA for a given year, please check the box below to certify that this form is true, accurate, and complete.

☐ I, authorized signatory, certify that the above HIPAA Covered Data Disclosure Request and Attestation is true, accurate, and complete.

D. Data Descriptions and Applicable Privacy Act System(s) of Records Notice(s)

The table below provides certain details regarding the types of data the Participant may request from CMS under the Model. These details include the categories of data, the Privacy Act system(s) of records notice(s) applicable to each category of data included, and date range covered.

Data Element Source	System(s) of Records Notice(s)	Date Range
Medicare Part A claims	FISS (09-70-0503)	Historical Period: 3 years prior to Effective Date
		Portion of Agreement Performance Period: Effective Date - 2036
Medicare Part B claims	MCS (09-70-0501)	Historical Period: 3 years prior to Effective Date
		Portion of Agreement Performance Period: Effective Date - 2036
Medicare Part D claims	DDPS (09-70-0553)	Historical Period: 3 years prior to Effective Date
		Portion of Agreement Performance Period: Effective Date - 2036
Beneficiary identifiers and characteristics	EDB (09-70-0502)	Historical Period: 3 years prior to Effective Date
		Portion of Agreement Performance Period: Effective Date - 2036
Payment and expenditure data	DERS (09-70-0591)	Historical Period: 3 years prior to Effective Date
		Portion of Agreement Performance Period: Effective Date - 2036
Beneficiary data sharing preferences	DERS (09-70-0591)	Historical Period: 3 years prior to Effective Date
		Portion of Agreement Performance Period: Effective Date - 2036

Data Element Source	System(s) of Records Notice(s)	Date Range
Provider/supplier identifiers	NPPES (09-70-0555)	Historical Period: 3 years prior to Effective Date
		Portion of Agreement Performance Period: Effective Date - 2036
Claim and Claim Line Feed (CCLF) files	DERS (09-70-0591)	Historical Period: 3 years prior to Effective Date
		Portion of Agreement Performance Period: Effective Date - 2036
National claims history	NCH (09-70-0558)	Historical Period: 3 years prior to Effective Date
		Portion of Agreement Performance Period: Effective Date - 2036
Quality performance data	DERS (09-70-0591)	Historical Period: 3 years prior to Effective Date
		Portion of Agreement Performance Period: Effective Date - 2036

Appendix B – Data Collection Requirements

Acceptable data collection, according to the required measures for each track, shall follow the requirements outlined below.

In addition to the measure-specific requirements, all laboratory-based measures, specifically lipids, hemoglobin A1c (HbA1c), estimated glomerular filtration rate (eGFR), and urine albumin-to-creatinine ratio (uACR), must meet the following requirements (the “ACCESS Laboratory Standards”):

- Testing must be performed by a Clinical Laboratory Improvement Amendments (CLIA)-compliant laboratory or laboratory network using an FDA-authorized assay, or by an FDA-authorized Point-of-Care (POC) device operated in a CLIA-compliant setting.
- At-home collection kits are acceptable provided the sample is analyzed by a CLIA-compliant laboratory using an FDA-authorized assay.
- HIEs and laboratory networks are acceptable data sources provided the underlying data meets the Data Collection Requirements.

CMS may modify the Data Collection Requirements at any time and will provide reasonable advance written notice of any such modification.

A. Blood Pressure: Blood pressure must be collected using a medical device as defined under Section 201(h) of the Federal Food, Drug, and Cosmetic Act⁴ that has been cleared or authorized by the FDA for the non-invasive quantitative measurement of blood pressure and supports timestamped, source-verifiable data transmission. Manual entry of values is not permitted. Qualifying devices include upper arm blood pressure cuffs that meet these requirements.

Data collection should follow the 2025 AHA/ACC Hypertension Guidelines⁵ for office blood pressure (OBP), ambulatory blood pressure monitoring (ABPM), or home blood pressure monitoring (HBPM), including appropriate cuff size, seated rest period, and multiple readings per occasion. Each submission to CMS must reflect an average of at least three blood pressure readings via the CMS ACCESS Data Reporting API for any Beneficiaries aligned to the eCKM Track and CKM Track.

⁴ FDA. (2017) Classification of Products as Drugs and Devices and Additional Product Classification Issues. Available at: <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/classification-products-drugs-and-devices-and-additional-product-classification-issues#device>

⁵ Jones, D.W., Ferdinand, K.C., Taler, S.J., et al. (2025) AHA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Available at: <https://www.sciencedirect.com/science/article/pii/S0735109725064800?via%3Dihub>

B. Lipids: CMS will accept lipid panels meeting the ACCESS Laboratory Standards. Use assays and laboratories that participate in CDC standardization programs, such as the Lipids Standardization Program (LSP) and the Cholesterol Reference Method Laboratory Network (CRMLN), for accuracy. Nonfasting or fasting allowable.

C. HbA1c: CMS will accept HbA1c results meeting the ACCESS Laboratory Standards. If used for baseline eligibility (for Qualifying Condition of pre-diabetes or diabetes), a laboratory-validated HbA1c is required. Specifically, for diagnosis of diabetes, use National Glycohemoglobin Standardization Program (NGSP)-certified HbA1c assays. A POC A1c can be used for initial diagnosis of diabetes only if FDA-cleared for the diagnosis of diabetes and performed in CLIA-certified moderate- or high-complexity laboratory setting. For ongoing monitoring of glycemic control for quality reporting, POC HbA1c devices that are FDA-authorized and CLIA-waived are acceptable.

D. Weight: Weight may be reported by the ACCESS Beneficiary using a home scale. Body mass index (BMI) is calculated as weight (kilograms) divided by height (meters²). The Participant must retain documentation of the date and method of reporting (clinic versus self-report).

E. eGFR: eGFR should be calculated using clinically validated methods appropriate to the patient population and clinical context. The underlying assays must meet the ACCESS Laboratory Standards. For adults, accepted methods include serum creatinine-based eGFR equations (e.g., 2021 Chronic Kidney Disease Epidemiology Collaboration [CKD-EPI 2021]), cystatin C based eGFR when creatinine is unreliable and testing is unavailable, combined creatinine–cystatin C eGFR when greater precision is clinically indicated, or 24 hour urine eGFR (utilizing a creatinine clearance calculation) (e.g., 24-hour urine collection) when estimation equations are unreliable or impractical.

F. uACR: CMS will accept uACR results meeting the ACCESS Laboratory Standards. Point-of-care semi-quantitative dipstick tests, urine protein-to-creatinine ratio (uPCR), and total urine protein (UP) tests do not meet the measure requirements. A positive result from any of these screening tests should prompt further evaluation with a confirmatory quantitative test which result can be used for reporting. For the purpose of the measure, the recorded result must come from either a direct quantitative uACR, or a quantitative urine albumin test and a quantitative urine creatinine test from the same specimen. A first-morning urine sample is preferred clinically, but for the measure, any valid quantitative uACR performed during the measurement period is acceptable.

G. PROMs: The Participant must administer applicable PROMs to ACCESS Beneficiaries using web portals, or web-first mixed-mode approaches using web followed by phone (voice-only), and/or paper/mail. The Participant shall not make changes to the wording, response options, order, or layout conventions of any PROMs required in the model. The Participant must collect PROMs in a format that preserves scoring fidelity and allows CMS audit. The Participant must

provide screenshots, or equivalent copies, of the ACCESS Beneficiary-facing version in use upon CMS' request. For electronic administration of PROMs, the Participant must comply with the following best practices:

1. Test across browsers and devices to ensure readability and assistive-tech compatibility;
2. Provide on-device instructions and training on system use;
3. Refrain from presenting a default response selection;
4. Capture a data point for all items, while preventing out-of-range or illogical responses;
5. Provide the ability to go back to the previous screen and do not auto-advance to the next screen;
6. Provide respondents with an indication of progress; and
7. Include a final save and submit screen.

For all OAP Measures, the Participant shall retain documentation of the data source, date, and method of collection. The Participant shall submit these data via the CMS ACCESS Data Reporting API.

Appendix C – Behavioral Health Clinical Track

A. Confirmation of Clinical Track

Consistent with the Participant’s selection(s), for the applicable Qualifying Conditions of ACCESS Beneficiaries attributed to the Behavioral Health Clinical Track (“**BH Track**”), the Participant shall provide care for all Qualifying Conditions within the Behavioral Health Clinical Track.

B. Qualifying Conditions

The Participant shall be responsible for managing the following Qualifying Condition(s), as applicable, for an ACCESS Beneficiary attributed to the BH Track: anxiety and depression.

C. OAP Measure Targets

TABLE 1. OAP MEASURE TARGETS FOR BH TRACK.

Measure Name	Type	Metric	OAP Measure Target		Notes
			Control	Minimum Improvement	
Depression Reduction or Control	PROM	Patient Health Questionnaire-9 (PHQ-9)	If Baseline PHQ-9 < 10: Final PHQ-9 < 10	If Baseline PHQ-9 ≥ 10: 5 point reduction	ACCESS Beneficiary must have a minimum baseline score of 10 on the PHQ-9 to be included in the Initial Period on the basis of depression only. ⁶
Anxiety Reduction or Control	PROM	General Anxiety Disorder (GAD)-7	If Baseline GAD-7 < 10: Final GAD-7 < 10	If Baseline GAD-7 ≥ 10: 4 point reduction	ACCESS Beneficiary must have a minimum baseline score of 10 on the GAD-7 to be included in the Initial Period on the basis of anxiety only.
Patient Global Impression of Change (PGIC)	PROM	PGIC	Not Applicable	Not Applicable	Success is defined as submission of the end-of-period measure.

⁶ ACCESS Beneficiaries who score 0 – 9 in the PHQ-9 and GAD-7 at baseline are not eligible for the Initial Period; the Participant may align these ACCESS Beneficiaries directly in the Follow-on Period, if the ACCESS Beneficiary was referred by a provider and has a documented history of depression in the past 18 months (either with prior clinical documentation, or an International Classification of Diseases (ICD)-10 code indicating a qualifying diagnosis).

Measure Name	Type	Metric	OAP Measure Target		Notes
			Control	Minimum Improvement	
Overall Function	PROM	Optional: World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) 12-item	Not Applicable	Not Applicable	<i>Optional</i>

D. Required Clinical Exclusions

1. The Participant shall not align a Beneficiary who has any of the following clinical conditions:

i. Psychiatric/Psychological, which means:

- a. Patients with severe cognitive impairment or moderate to severe dementia limiting ability to engage in care.
- b. Patients with acute or unstable psychiatric conditions (e.g., active suicidal or homicidal ideation, acute psychosis) that may impede safe participation or require inpatient care.

ii. Pregnancy or up to 6 months postpartum

2. The Participant shall not align a Beneficiary who is enrolled in a Certified Community Behavioral Health Clinic (CCBHC) program.

3. If a Participant determines, after alignment, that an ACCESS Beneficiary has developed one or more of the clinical conditions identified at Section D.1 of this Appendix, then upon discovery of the excluded condition, the Participant shall:

i. Provide required Care Updates with Identified Care Team as described in Section 4.05.

ii. Execute established protocols for identifying, reporting, and addressing patient safety concerns, including care escalation pathways and management of adverse events as described in Section 4.04.

iii. Remove ACCESS Beneficiary from alignment as described in Section 7.03 for the duration of the Care Period, unless clinically appropriate to continue treatment or temporarily pause Active Care Delivery, provided that the Participant

documents the clinical rationale and does not submit claims for any period in which Active Care Delivery is not furnished.

E. Payment.

1. For the Initial Period of 12 months, CMS sets the OAP Allowed Amount at \$180.
2. For the Follow-On Period of 12 months, CMS sets the OAP Allowed Amount at \$90.

F. Participant Data Reporting Requirements

1. The Participant must submit the OAP Measure data outlined in Table 1 of this Appendix C at baseline, quarterly, and/or at the end-of-period for each ACCESS Beneficiary in the Clinical Track, as defined in Table 2 of this section of the Agreement.

i. Clinical Validity Window. The Participant must administer OAP Measures within the applicable Clinical Validity Windows described in Table 2 of this section of the Agreement via the CMS ACCESS Data Reporting API for each applicable submission.

ii. Data Submission Window. OAP Measure data are to be submitted via the CMS ACCESS Data Reporting API. The Participant must submit OAP Measure data within—

- a. 60 Days of alignment to qualify as baseline;
- b. 70 to 110 Days after the prior OAP Measure submission to qualify as quarterly, and
- c. As early as 180 Days prior to Day 365 (“**Early Success Reporting**”) or within 60 Days following Day 365 to qualify as end-of-period for the BH Track.

Table 2. OAP Measure Reporting Frequency for BH Track

OAP Measure Name	Measure Type	Metric	Reporting Frequency	Clinical Validity Window (From Date of Submission)
Depression Reduction or Remission	PROM	PHQ-9	Baseline, Quarterly, End-of-period	Up to 15 Days
Anxiety Reduction or Remission	PROM	GAD-7	Baseline, Quarterly, End-of-period	Up to 15 Days
Patient Global Impression of Change	PROM	PGIC	End-of-period only	Up to 15 Days

OAP Measure Name	Measure Type	Metric	Reporting Frequency	Clinical Validity Window (From Date of Submission)
Overall Function: Improvement or Maintenance	PROM	WHODAS 2.0 12-item	Baseline, End-of-period	Up to 15 Days

G. Substitute Spend Services

Table 3 of Appendix C identifies the Substitute Spend Services that are substitutes for the purposes of Article 6 if provided by another Medicare-enrolled provider or supplier during the Beneficiary's Care Period, and the principal diagnosis code on the claim matches any Qualifying Condition in the applicable Clinical Track.

TABLE 3. SUBSTITUTE SPEND SERVICES FOR BH TRACK.

Service Type	HCPCS / CPT® Codes
DHMT: Supply of digital device and monthly treatment	G0552-G0553
Psychiatric Diagnostic Evaluation	90791, 90792
Remote Therapeutic Monitoring (RTM): Patient education and device set-up	98975
Initial Psychiatric Collaborative Care Management	99492

Appendix D – Early Cardio-Kidney-Metabolic Clinical Track

A. Confirmation of Clinical Track

Consistent with the Participant’s selection(s), for the applicable Qualifying Conditions of ACCESS Beneficiaries attributed to the Early Cardio-Kidney-Metabolic Clinical Track (“**eCKM Track**”), the Participant shall provide care for all Qualifying Conditions within the eCKM Track.

B. Qualifying Conditions

1. The Participant shall be responsible for managing the following Qualifying Condition(s), as applicable, for any ACCESS Beneficiary attributed to the eCKM Track: hypertension (HTN), or two or more of the following conditions: dyslipidemia, obesity or overweight with marker of central obesity, and prediabetes.

2. ACCESS Beneficiaries Qualifying on Hypertension Diagnosis. For an Eligible ACCESS Beneficiary who qualifies for the eCKM Track only on the basis of a reported hypertension diagnosis, the Participant may align and begin services based on patient-attested information of a hypertension diagnosis.

i. The Participant must unalign the ACCESS Beneficiary from the eCKM Track if follow-up ambulatory or home blood pressure readings confirm that the ACCESS Beneficiary—

a. Does not have hypertension;

b. Is not on antihypertensive medication; and

c. Does not otherwise meet the Clinical Track’s Qualifying Conditions.

ii. If the Participant submits non-qualifying readings (i.e., systolic blood pressure readings that are at Control for the “Blood Pressure Reduction or Control” OAP Measure) to CMS, then the Participant may retain payments for up to two calendar months of services furnished.

iii. If the Participant does not submit the non-qualifying readings to CMS, then CMS will recoup all payments for that ACCESS Beneficiary.

iv. CMS may subject the Participant to audit and remedial action in accordance with the provisions of Article 16 if a high rate of such non-qualifying alignments (as described in Appendix D, Section B.(2)(ii)) is identified.

C. OAP Measure Targets

TABLE 1. OAP MEASURE TARGETS FOR eCKM TRACK.

Measure Name	Type	Metric	OAP Measure Target		Notes
			Control	Minimum Improvement	
Blood Pressure (BP) Reduction or Control	Clinical Measure	BP (Systolic and Diastolic)	Final systolic BP < 130 mm Hg	15 mm Hg reduction in systolic BP	Both systolic and diastolic BP must be reported. OAP Measure Target is based on systolic BP only.
Weight Reduction or Control	Clinical Measure	Weight and Body Mass Index (BMI) Optional: waist circumference	Final BMI < 30 kg/m ² AND no more than 5% weight gain from baseline	5% weight reduction	
Hemoglobin A1c (HbA1c) Reduction or Control	Clinical Measure	HbA1c	Prediabetes only: Final HbA1c < 6.5% All other beneficiaries: Not Applicable	Not Applicable	Baseline HbA1c is required for all ACCESS Beneficiaries at the start of each Care Period. For ACCESS Beneficiaries without prediabetes, success is defined as submission of the baseline measure.
Low-Density Lipoprotein Cholesterol (LDL-C) Reduction or Control	Clinical Measure	LDL-C Optional: triglycerides, total cholesterol, High-Density Lipoprotein (HDL)	Dyslipidemia only: Final LDL-C <100 mg/dL All other beneficiaries: Not Applicable	Dyslipidemia only: 30 mg/dL reduction All other beneficiaries: Not Applicable	Baseline LDL-C is required for all ACCESS Beneficiaries at the start of each Care Period. For ACCESS Beneficiaries without dyslipidemia, success is defined as submission of the baseline measure.

D. Required Clinical Exclusions

1. The Participant shall not align a Beneficiary who has any of the following clinical conditions:

- i. Severe cardio-kidney-metabolic conditions with severe, unstable, or advanced cardiovascular or renal disease, where participation may pose safety risks or provide limited meaningful benefit, including, but not limited to, advanced heart failure, unstable ischemic heart disease, complex secondary hypertension, advanced CKD (Stage 4+ , ESRD), severe valvular disease, hypertensive emergency, or hyperglycemic crises.

ii. Patients with clinical conditions such that cardiometabolic quality measures are not appropriate, for example, severe malnutrition or cachexia; chronic catabolic or inflammatory states (including advanced malignancy under active treatment); or conditions where achievement of cardiometabolic targets may pose safety risks (e.g., active eating disorders, recurrent hypoglycemia, syncope or orthostatic hypotension).

iii. Pregnancy or 6 months postpartum

iv. Psychiatric/Psychological, which means:

a. Patients with severe cognitive impairment or moderate to severe dementia limiting ability to engage in care.

b. Patients with acute or unstable psychiatric conditions (e.g., active suicidal or homicidal ideation, acute psychosis) that may impede safe participation or require inpatient care.

v. Frailty and advanced illness which means:

a. Patients with documented evidence of moderate-to-severe frailty, such as standardized indicators of limited physiologic reserve or functional dependence.

b. Patients with advanced or progressive illness associated with high risk of harm from disease-focused interventions or limited likelihood of meaningful clinical benefit.

c. Patients who have an order for or are receiving hospice or palliative care.

d. Patients who are in a nursing home for 101 Days or longer during the Care Period and meet criteria for moderate-to-severe frailty or functional dependence, as evidenced by standardized functional assessments or documented limitations in activities of daily living (ADLs).

e. Age alone shall not constitute an exclusion; age may be considered only in combination with the above criteria.

2. If the Participant determines, after alignment, that an ACCESS Beneficiary has developed one or more of the clinical conditions identified at Section D.1 of this Appendix, then upon discovery of the excluded condition, the Participant shall:

- i. Provide required Care Updates with Identified Care Team as described in Section 4.05.
- ii. Execute established protocols for identifying, reporting, and addressing patient safety concerns, including care escalation pathways and management of adverse events as described in Section 4.04.
- iii. Remove the ACCESS Beneficiary from alignment as described in Section 7.03 for the duration of the Care Period, unless clinically appropriate to continue treatment or temporarily pause Active Care Delivery, provided that the Participant documents the clinical rationale and does not submit claims for any period in which Active Care Delivery is not furnished.

E. Payment

- 1. For the Initial Period of 12 months, CMS sets the OAP Allowed Amount at \$360.
 - i. During the Initial Period, CMS pays an additional fixed one-time payment of \$15 for each ACCESS Beneficiary residing in a rural area, as defined by Health Resources and Services Administration's Federal Office of Rural Health Policy.
 - ii. If an ACCESS Beneficiary is referred by a clinician who is not on the Participant's ACCESS Clinician Roster for the Qualifying Condition, then the Participant may receive the Initial Period OAP Allowed Amount, even if the requirement in Section 6.02(A)(1)(i)(b) is not met. For these referred ACCESS Beneficiaries, the Participant must include the referring clinician's NPI on the claim when billing.
- 2. For the Follow-On Period of 12 months, CMS sets the OAP Allowed Amount at \$180.

F. Participant Data Reporting Requirements

- 1. The Participant shall submit the OAP Measure data in the following table at baseline, quarterly, and/or at the end-of-period for each ACCESS Beneficiary in the Clinical Track.
 - i. Clinical Validity Window. The Participant shall administer OAP Measures within the applicable Clinical Validity Windows described in Table 2 of this section of the Agreement via the CMS ACCESS Data Reporting API for each applicable submission.
 - ii. Data Submission Window. The Participant shall submit OAP Measure data within—

- a. 60 Days of alignment to qualify as baseline;
- b. 70 to 110 Days after the prior OAP Measure submission to qualify as quarterly, and
- c. As early as 90 Days prior to Day 365 (“**Early Success Reporting**”) or within 60 Days following Day 365 to qualify as end-of-period for the eCKM Track. OAP Measure data are to be submitted via the CMS ACCESS Data Reporting API.

TABLE 2. OAP MEASURE REPORTING FREQUENCY FOR eCKM TRACK.

OAP Measure Name	Measure Type	Data for Reporting	Reporting Frequency	Clinical Validity Window (From Date of Submission)
Blood Pressure Reduction or Control	Clinical	Blood pressure (systolic and diastolic)	Baseline, Quarterly, End-of-period	Up to 15 Days
Low-Density Lipoprotein Cholesterol (LDL-C) Reduction or Control	Clinical	LDL-C <i>Optional:</i> triglycerides, total cholesterol, HDL	Baseline, End-of-Period	Up to two years, <i>except</i> up to one year for ACCESS Beneficiaries with dyslipidemia
Weight Reduction or Control	Clinical	Weight, BMI <i>Optional:</i> waist circumference	Baseline, Quarterly, End-of-period	Up to 15 Days
Hemoglobin A1c (HbA1c) Reduction or Control	Clinical	HbA1c	Baseline, End-of-Period	Up to two years, <i>except</i> up to one year for ACCESS Beneficiaries with diabetes or prediabetes

G. Substitute Spend Services

Table 3 of Appendix D identifies the Substitute Spend Services that are substitutes for the purposes of Article 6 if provided by another provider or supplier during the Beneficiary’s Care Period, and the principal diagnosis code on the claim matches any Qualifying Condition in the applicable track.

TABLE 3. SUBSTITUTE SPEND SERVICES FOR eCKM TRACK.

Service Type	HCP/CS / CPT® Codes
Ambulatory Blood Pressure Monitoring	93784, 93786, 93788, 93790
Ambulatory Continuous Glucose Monitoring	95249-95251
Remote Physiologic Monitoring (RPM) (includes Self-Measured Blood Pressure Monitoring (SMBP)): Device set-up	99453, 99473

Service Type	HCPSC / CPT® Codes
Diabetes Self-Management Training (DSMT)	G0108
Intensive Behavioral Therapy (IBT) for Cardiovascular Disease	G0446
Intensive Behavioral Therapy (IBT) for Obesity	G0447
Medical Nutrition Therapy (MNT): Individual initial visit	97802
Remote Therapeutic Monitoring (RTM): Patient education and device set-up	98975
Medicare Diabetes Prevention Program (MDPP)	G9880, G9881, G9886, G9887

Appendix E – Cardio-Kidney-Metabolic Clinical Track

A. Confirmation of Clinical Track

Consistent with the Participant’s selection(s), for the applicable Qualifying Conditions of ACCESS Beneficiaries attributed to the Cardio-Kidney-Metabolic Clinical Track (“**CKM Track**”), the Participant shall provide care for all Qualifying Conditions within the CKM Track.

B. Qualifying Conditions

The Participant shall be responsible for managing the following Qualifying Condition(s), as applicable, for any ACCESS Beneficiary attributed to the CKM Track: Type 2 diabetes mellitus, chronic kidney disease (CKD), and atherosclerotic cardiovascular disease (ASCVD).

C. OAP Measure Targets

TABLE 1. OAP MEASURE TARGETS FOR CKM TRACK.

Measure Name	Type	Metric	OAP Measure Target		Notes
			Control	Minimum Improvement	
Blood Pressure (BP) Reduction or Control	Clinical Measure	BP (Systolic and Diastolic)	Final systolic BP < 130 mm Hg	15 mm Hg reduction in systolic BP	Both systolic and diastolic BP must be reported. OAP Measure Target is based on systolic BP only.
Weight Reduction or Control	Clinical Measure	Weight and BMI Optional: waist circumference	Final BMI < 30 kg/m ² AND no more than 5% weight gain from baseline	5% weight reduction	
Hemoglobin A1c (HbA1c) Reduction or Control	Clinical Measure	HbA1c	Diabetes only: Final HbA1c < 7.5% All other beneficiaries: Not Applicable	Diabetes only: 1% point reduction All other beneficiaries: Not Applicable	Baseline HbA1c is required for all ACCESS Beneficiaries. For ACCESS Beneficiaries without diabetes, success is defined as submission of the baseline measure.

Measure Name	Type	Metric	OAP Measure Target		Notes
			Control	Minimum Improvement	
Low-Density Lipoprotein Cholesterol (LDL-C) Reduction or Control	Clinical Measure	LDL-C Optional: triglycerides, total cholesterol, HDL	Dyslipidemia only: Final LCL-C < 100 mg/dL; or, for those with Atherosclerotic Cardiovascular Disease (ASCVD), Final LDL-C < 70 mg/dL All other beneficiaries: Not Applicable	Dyslipidemia or ASCVD only: 30 mg/dL reduction in LDL-C All other beneficiaries: Not Applicable	Baseline LDL-C is required for all ACCESS Beneficiaries at the start of each Care Period. For ACCESS Beneficiaries without dyslipidemia or ASCVD, success is defined as submission of the baseline measure.
Kidney Health Monitoring: eGFR	Clinical Measure	eGFR	Not Applicable	Not Applicable	Baseline eGFR and uACR are only required for ACCESS Beneficiaries with a diagnosis of diabetes, CKD at the start of each Care Period. Success is defined as submission of each baseline measure.
Kidney Health Monitoring: uACR	Clinical Measure	uACR			

D. Required Clinical Exclusions

1. The Participant shall not align a Beneficiary who has any of the following clinical conditions:

- i. Severe cardio-kidney-metabolic conditions with severe, unstable, or advanced cardiovascular or renal disease, where participation may pose safety risks or provide limited meaningful benefit, including, but not limited to, advanced heart failure, unstable ischemic heart disease, complex secondary hypertension, advanced CKD (Stage 4+ , ESRD), severe valvular disease, hypertensive emergency, or hyperglycemic crises.
- ii. Patients with clinical conditions such that cardiometabolic quality measures are not appropriate, for example, severe malnutrition or cachexia; chronic catabolic or inflammatory states (including advanced malignancy under active treatment); or conditions where achievement of cardiometabolic targets may pose safety risks (e.g., active eating disorders, recurrent hypoglycemia, syncope or orthostatic hypotension).

iii. Pregnancy or up to 6 months postpartum

iv. Psychiatric/Psychological, which means:

- a. Patients with severe cognitive impairment or moderate to severe dementia limiting ability to engage in care
- b. Patients with acute or unstable psychiatric conditions (e.g., active suicidal or homicidal ideation, acute psychosis) that may impede safe participation or require inpatient care.

v. Frailty and advanced illness, which means:

- a. Patients with documented evidence of moderate-to-severe frailty, such as standardized indicators of limited physiologic reserve or functional dependence.
- b. Patients with advanced or progressive illness associated with high risk of harm from disease-focused interventions or limited likelihood of meaningful clinical benefit
- c. Patients who are in a nursing home for 101 Days or longer during the Care Period and meet criteria for moderate-to-severe frailty or functional dependence, as evidenced by standardized functional assessments or documented limitations in activities of daily living (ADLs).
- d. Patients who enter into long term nursing home care during the Care Period
- e. Age alone shall not constitute an exclusion; age may be considered only in combination with the above criteria

2. If the Participant determines, after alignment, that an ACCESS Beneficiary has developed one or more of the clinical conditions identified at Section D.1 of this Appendix, then upon discovery of the excluded condition, the Participant shall:

- i. Provide required Care Updates with Identified Care Team as described in Section 4.05.
- ii. Execute established protocols for identifying, reporting, and addressing patient safety concerns, including care escalation pathways and management of adverse events as described in Section 4.04.

iii. Remove the ACCESS Beneficiary from alignment as described in Section 7.03 for the duration of the Care Period, unless clinically appropriate to continue treatment or temporarily pause Active Care Delivery, provided that the Participant documents the clinical rationale and does not submit claims for any period in which Active Care Delivery is not furnished.

E. Payment

1. For the Initial Period of 12 months, CMS sets the OAP Allowed Amount at \$420.

i. During the Initial Period, CMS will provide an additional one-time fixed payment of \$15 for each ACCESS Beneficiary residing in a rural area, as defined by Health Resources and Services Administration's Federal Office of Rural Health Policy.

ii. If an ACCESS Beneficiary is referred by a clinician who is not on the Participant's ACCESS Clinician Roster for the Qualifying Condition, then the Participant may receive the Initial Period OAP Allowed Amount, even if the requirement in Section 6.02(A)(1)(i)(b) is not met. For these referred ACCESS Beneficiaries, the Participant must include the referring clinician's NPI on the claim when billing.

2. For the Follow-On Period of 12 months, CMS sets the OAP Allowed Amount at \$210.

F. Participant Data Reporting Requirements

1. The Participant shall submit the OAP Measure data in the following table at baseline, quarterly, and/or at the end-of-period for each ACCESS Beneficiary in the Clinical Track.

i. Clinical Validity Window. The Participant must administer OAP Measures within the applicable Clinical Validity Windows described in Table 2 of this section of the Agreement via the CMS ACCESS Data Reporting API for each applicable submission.

ii. Data Submission Window. The Participant must submit OAP Measure data within—

a. 60 Days of alignment to qualify as baseline;

b. 70 to 110 Days after the prior OAP Measure submission to qualify as quarterly, and

c. As early as 90 Days prior to Day 365 (“**Early Success Reporting**”) or within 60 Days following Day 365 to qualify as end-of-period for the CKM Track. OAP Measure data are to be submitted via the CMS ACCESS Data Reporting API.

TABLE 2. OAP MEASURE REPORTING FREQUENCY FOR CKM TRACK.

OAP Measure Name	Measure Type	Data for Reporting	Reporting Frequency	Clinical Validity Window (From Date of Submission)
Blood Pressure Reduction or Control	Clinical	Blood pressure (systolic and diastolic)	Baseline, Quarterly, End-of-period	Up to 15 Days
Low-Density Lipoprotein Cholesterol (LDL-C) Reduction or Control	Clinical	LDL-C <i>Optional:</i> triglycerides, total cholesterol, HDL	Baseline, End-of-Period	Up to two years, <i>except</i> up to one year for ACCESS Beneficiaries with dyslipidemia
Weight Reduction or Control	Clinical	Weight, BMI <i>Optional:</i> waist circumference	Baseline, Quarterly, End-of-period	Up to 15 Days
Hemoglobin A1c (HbA1c) Reduction or Control	Clinical	HbA1c	Baseline, End-of-Period	Up to two years, <i>except</i> up to one year for ACCESS Beneficiaries with diabetes or prediabetes
Kidney Health Monitoring	Clinical	eGFR, uACR	Baseline (type 2 diabetes mellitus and types 3a/3b chronic kidney disease (CKD) only)	Up to one year

G. Substitute Spend Services

Table 3 of Appendix E identifies the Substitute Spend Services that are substitutes for the purposes of Article 6 if provided by another provider or supplier during the Beneficiary’s Care Period, and the principal diagnosis code on the claim matches any Qualifying Condition in the applicable track.

TABLE 3. SUBSTITUTE SPEND SERVICES FOR CKM TRACK.

Service Type	HCP/CS / CPT® Codes
Ambulatory Blood Pressure Monitoring	93784, 93786, 93788, 93790
Ambulatory Continuous Glucose Monitoring	95249-95251

Service Type	HCPCS / CPT® Codes
Remote Physiologic Monitoring (RPM) (includes Self-Measured Blood Pressure Monitoring (SMBP)): Device set-up	99453, 99473
Diabetes Self-Management Training (DSMT)	G0108
Intensive Behavioral Therapy (IBT) for Cardiovascular Disease	G0446
Intensive Behavioral Therapy (IBT) for Obesity	G0447
Medical Nutrition Therapy (MNT): Individual initial visit	97802
Remote Therapeutic Monitoring (RTM): Patient education and device set-up	98975
Medicare Diabetes Prevention Program (MDPP)	G9880, G9881, G9886, G9887

Appendix F – Musculoskeletal Pain Clinical Track

A. Confirmation of Clinical Track

Consistent with the Participant’s selection(s), for the applicable Qualifying Conditions of ACCESS Beneficiaries attributed to the Musculoskeletal Pain Clinical Track (“**MSK Track**”), the Participant shall provide care for all Qualifying Conditions within the MSK Track.

B. Qualifying Conditions

The Participant shall be responsible for managing the following Qualifying Condition for any ACCESS Beneficiary attributed to the MSK Track: chronic musculoskeletal pain.

C. OAP Measure Targets

TABLE 1. OAP MEASURE TARGETS FOR MSK TRACK.

Measure Name	Type	Metric	OAP Measure Target		Notes
			Control	Minimum Improvement	
Musculoskeletal Pain: Improvement in Physical Function and Pain Interference	PROM	Any site or multiple sites of pain: PROMIS Physical Function (PF) short form (6b) or Version 2.0 Computer Adaptive Test (CAT) <u>AND</u> PROMIS Pain Interference (PI) short form (6a) or Version 1.1 CAT	Not Applicable	2 point reduction in PROMIS PI; AND 2 point increase in PROMIS PF (using T-score not raw)	The minimum improvement Target is the same whether the designated short form or CAT is used.
<i>The Participant must report <u>one</u> PROM from the listed options in this OAP Measure, according to the ACCESS Beneficiary’s anatomical site of pain⁷</i>		Lower back: Oswestry Disability Index (ODI)	Not Applicable	8 point reduction (using score scale of 100 points)	
		Neck: Neck Disability Index (NDI)	Not Applicable	8 point reduction (using score scale of 50 points)	
		Shoulder, arm, hand: Quick Disabilities of Arm, Shoulder & Hand (QuickDASH)	Not Applicable	10 point reduction (using score scale of 100 points)	
		Knee: Knee Injury and Osteoarthritis	Not Applicable	10 point increase	

⁷ Participants must use the same PROM for each ACCESS Beneficiary throughout the period. The PROMIS instruments may be used for all sites of pain.

Measure Name	Type	Metric	OAP Measure Target		Notes
			Control	Minimum Improvement	
		Outcome Score for Joint Replacement (KOOS JR)		(using score scale of 100 points)	
		Hip: Hip Dysfunction and Osteoarthritis Outcome Score for Joint Replacement (HOOS JR)	Not Applicable	10 point increase (using score scale of 100 points)	
Pain Intensity	PROM	Numeric Rating Scale (NRS) or PROMIS NRS v1.0 - Pain Intensity 1a	Not Applicable	No more than 2 point increase	Required for all ACCESS Beneficiaries in the MSK track, regardless of Qualifying Condition.
Patient Global Impression of Change (PGIC)	PROM	PGIC	Not Applicable	Not Applicable	Required for all ACCESS Beneficiaries in the MSK track, regardless of Qualifying Condition. Success is defined as submission of the end-of-period measure.

D. Required Clinical Exclusions

1. The Participant shall not align a Beneficiary who has any of the following clinical conditions:

i. Patients with musculoskeletal conditions or injuries for which participation may be unsafe or clinically inappropriate, for example, recent or unstable fractures; inability to bear weight on the affected limb; significant surgery or trauma to the affected area within the prior three calendar months; peri- or post-surgical recovery (e.g., joint replacement); severe arthritis with marked mobility limitation, severe osteoporosis with high fracture risk, or conditions associated with high fall risk.

ii. Patients whose pain is primarily attributable to non-musculoskeletal causes, such as active cancer undergoing treatment, systemic autoimmune or inflammatory disease, or infection, where MSK-focused interventions would not be clinically appropriate.

iii. Patients with progressive neurological disorders that have symptom severity that would make participating in the service unsafe (e.g., Parkinson's, Multiple Sclerosis).

iv. Pregnancy or up to 6 months postpartum.

v. Psychiatric/Psychological, which means:

- a. Patients with severe cognitive impairment or moderate to severe dementia limiting ability to engage in care.
- b. Patients with acute or unstable psychiatric conditions (e.g., active suicidal or homicidal ideation, acute psychosis) that may impede safe participation or require inpatient care.

vi. Frailty and advanced illness, which means:

- a. Patients with documented evidence of moderate-to-severe frailty, such as standardized indicators of limited physiologic reserve or functional dependence.
- b. Patients with advanced or progressive illness associated with high risk of harm from disease-focused interventions or limited likelihood of meaningful clinical benefit; for example, patients with advanced disease and substantial functional impairment, recurrent or prolonged acute care use, or a clinical focus on comfort or supportive care rather than disease modification.
- c. Patients who have an order for or are receiving hospice or palliative care.
- d. Patients who are in a nursing home for 101 Days or longer during the Care Period and meet criteria for moderate-to-severe frailty or functional dependence, as evidenced by standardized functional assessments or documented limitations in activities of daily living (ADLs).
- e. Age alone shall not constitute an exclusion; age may be considered only in combination with the above criteria.

vii. Patients meeting Medicare requirements for maintenance therapy, such as the maintenance of functional status or prevention of a slow deterioration in function, as defined by the Medicare Benefit Policy Manual, Chapter 15.⁸

2. If the Participant determines, after alignment, that an ACCESS Beneficiary has developed one or more of the clinical conditions identified at Section D.1 of this Appendix, then upon discovery of the excluded condition, the Participant shall:

⁸ Centers for Medicare and Medicaid. (2025) Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services. Available at: <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf>

- i. Provide required Care Updates with Identified Care Team as described in Section 4.05.
- ii. Execute established protocols for identifying, reporting, and addressing patient safety concerns, including care escalation pathways and management of adverse events as described in Section 4.04.
- iii. Remove ACCESS Beneficiary from alignment as described in Section 7.03 for the duration of the Care Period, unless clinically appropriate to continue treatment or temporarily pause Active Care Delivery, provided that the Participant documents the clinical rationale and does not submit claims for any period in which Active Care Delivery is not furnished.

E. Payment

- 1. For the Initial Period of 12 months, CMS sets the OAP Allowed Amount at \$180.
- 2. CMS does not offer an OAP Allowed Amount for a Follow-On Period for the MSK Track.

F. Participant Data Reporting Requirements

- 1. The Participant shall submit the OAP Measure data in the following table at baseline, quarterly, and/or at the end-of-period for each ACCESS Beneficiary in the Clinical Track.

- i. Clinical Validity Window. The Participant must administer OAP Measures within the applicable Clinical Validity Windows described in Table 2 of this section of the Agreement via the CMS ACCESS Data Reporting API for each applicable submission.
- ii. Data Submission Window. The Participant must submit OAP Measure data within—
 - a. 60 Days of alignment to qualify as baseline;
 - b. 70 to 110 Days after the prior OAP Measure submission to qualify as quarterly, and
 - c. As early as 180 Days prior to Day 365 (“**Early Success Reporting**”) or within 60 days following Day 365 to qualify as end-of-period for the MSK Track. OAP Measure data are to be submitted via the CMS ACCESS Data Reporting API.

TABLE 2. OAP MEASURE REPORTING FREQUENCY FOR MSK TRACK.

OAP Measure Name	Measure Type	Data for Reporting	Reporting Frequency	Clinical Validity Window (From Date of Submission)
Musculoskeletal Pain: Improvement in Pain and Function	PROM	One PROM selected according to site of pain: <ul style="list-style-type: none"> ▪ PROMIS PF short-form 6b or Version 2.0 CAT AND PROMIS PI short-form 6a or Version 1.1 CAT (any site or multiple sites of pain) ▪ QuickDASH (shoulder, arm, hand) ▪ KOOS JR (knee) ▪ HOOS JR (hip) ▪ ODI (low back) ▪ NDI (neck) 	Baseline, Quarterly, End-of-period	Up to 15 Days
Pain Intensity	PROM	NRS or PROMIS NRS v1.0 – Pain Intensity 1a	Baseline, Quarterly, and End-of-period	Up to 15 Days
Patient Global Impression of Change (PGIC)	PROM	PGIC	End-of-period	Up to 15 Days

G. Substitute Spend Services

Table 3 of Appendix F identifies the Substitute Spend Services that are substitutes for the purposes of Article 6 if provided by another provider or supplier during the Beneficiary's Care Period, and the principal diagnosis code on the claim matches any Qualifying Condition in the applicable Clinical Track.

TABLE 3. SUBSTITUTE SPEND SERVICES FOR MSK TRACK.

Service Type	HCPCS / CPT® Codes
Physical Therapy (PT) Evaluation	97161-97163
Occupational Therapy (OT) Evaluation	97165-97167
Remote Therapeutic Monitoring (RTM): Patient education and device set-up	98975

Appendix G – Medicare Waivers and Safe Harbors

A. Innovation Center Waivers Under Section 1115A(d)(1)

Under section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and certain provisions of section 1934 of the Act as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b). For this Model and consistent with the authority under section 1115A(d)(1), the Secretary may consider issuing waivers of certain payment provisions in sections 1833, 1835, and 1842 of the Act.

1. Timely Filing Requirements.

- i. Sections 1814(a)(1), 1835(a)(1) and 1842(b)(3)(B) requires providers and suppliers of Medicare Part A and Part B services to file all claims no later than the close of the period ending one calendar year after the date of service.
- ii. In accordance with section 1115A(d)(1) of the Act, CMS finds it is necessary for purposes of testing the Model to waive the requirements at section 1835(a) and 1842(b)(3)(B) such that the Participant must file all OAP claim requests within 90 Days of the date of service.

2. Telehealth.

- i. CMS waives the following requirements with respect to otherwise covered telehealth services furnished by an Eligible Telehealth Provider (as that term is defined in Paragraph 2.iii.a) to an ACCESS Beneficiary in accordance with the terms and conditions set forth in this Appendix:
 - a. 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) - (4) with respect to telehealth services furnished in accordance with this Appendix.
 - b. 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.
 - c. 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 an ACCESS Beneficiary at his or her home when furnished in accordance with this Appendix.

ii. The waivers described in this Section A.3 of this Appendix are collectively referred to as the “Telehealth Waiver.”

iii. Eligible Telehealth Providers.

a. For purposes of this Telehealth Waiver, an “Eligible Telehealth Provider” is an individual who is:

(A). A Clinician listed at 42 CFR § 410.78(b)(2) who has reassigned Medicare billing rights to the Participant; and

(B). Authorized under relevant Medicare rules and applicable state law to bill for telehealth services and included on the ACCESS Clinician Roster, if applicable.

b. CMS reserves the right to review the Participant and the Clinician(s) included on the ACCESS Clinician Roster to determine suitability to provide services in accordance with the Telehealth Waiver under this Appendix, including consideration of the program integrity history of the Participant and Clinician(s) and any other factors that CMS determines may affect the qualifications of the Participant and Clinician(s) to provide telehealth services under the terms of the Telehealth Waiver.

iv. ACCESS Beneficiary Eligibility Requirements.

a. The Eligible Telehealth Provider must furnish telehealth services offered under the Telehealth Waiver to an ACCESS Beneficiary that is located at an originating site that is either:

(A). One of the sites listed in section 1834(m)(4)(C)(ii) of the Act; or

(B). The ACCESS Beneficiary’s home or place of residence.

b. All telehealth services must be furnished in accordance with all other applicable state and Federal laws and 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. An Eligible Telehealth Provider shall not furnish telehealth services in lieu of in person services or encourage, coerce, or otherwise influence an ACCESS Beneficiary to seek or receive telehealth services in lieu of in person services when the Eligible Telehealth Provider knows or should know in-person services are Medically Necessary.

v. Compliance and Enforcement.

- a. CMS may reject the Participant's designation of Clinician(s) as an Eligible Telehealth Provider at any time if the Clinician's participation in this Telehealth Waiver might compromise the integrity of the Model.
- b. The Participant shall have appropriate procedures in place to ensure that Clinician(s) have access to the most up-to-date information regarding ACCESS Beneficiary alignment to the Participant.
- c. In accordance with Article 17 and Article 16 of this Agreement, respectively, CMS may terminate or suspend one or more of the waivers under Paragraph B of this Appendix G or take other remedial action if the Participant or any of Clinician(s) fail to comply with the terms and conditions of the Telehealth Waiver.

3. Merit Incentive-Based Payment System (MIPS).

- i. Section 1848(q) requires eligible professionals, as defined at section 1848(q)(1)(C), to be subject to the Merit Incentive-Based Payment System (MIPS) and corresponding payment adjustments for covered professional services, as defined at section 1848(k)(3)(A) of the Act.
- ii. In accordance with section 1115A(d)(1) of the Act, CMS finds it necessary for purposes of testing the Model to waive the requirements of section 1848(q) of the Act and its implementing regulations within 42 CFR Part 414 Subpart O, solely with respect to services consistent with the applicable Care Delivery Plan, furnished under the Model, and billed using ACCESS-specific G-codes under the Participant's TIN. Additionally, MIPS payment adjustments shall not apply to services furnished under the Model and billed using ACCESS-specific G-codes. In any case, this waiver does not affect MIPS requirements, including eligibility determinations and reporting obligations, nor does it affect MIPS payment adjustments, for covered professional services defined at section 1848(k)(3)(A) and billed using codes other than ACCESS-specific G-codes.

B. Withdrawal or Amendment of Waivers Granted

- 1. At any time and for any reason, CMS may withdraw or amend one or more waivers described herein.
- 2. CMS shall use its best efforts to provide the Participant with 30 Days of advance written notice of any changes to a waiver and the notice shall specify the effective date of such changes.

Appendix H – OAP Sample Calculations

A. General

The examples in this Appendix H are provided for illustrative purposes only and do not modify or supersede the terms of this Agreement. CMS applies budget sequestration to the Total Earned Amount.

B. Example 1 — No Adjustment; Total Billed Amount Below Total Potential Earnings

1. Inputs.

- a. Clinical Track: eCKM
- b. OAP Allowed Amount: \$360 per ACCESS Beneficiary
- c. Monthly OAP: \$24 per ACCESS Beneficiary, corresponding to the – Medicare portion of the OAP Allowed Amount
- d. Reconciliation Cohort: 1,000 ACCESS Beneficiaries
- e. Assessment Cohort: 1,000 ACCESS Beneficiaries
- f. OAR: 80 percent
- g. OAT: 50 percent
- h. SSR: 95 percent
- i. SST: 90 percent
- j. Total Billed Amount: \$240,000
- k. Total Paid Amount: \$144,000

2. Calculation.

- a. Clinical Outcome Adjustment = 0 percent
- b. Substitute Spend Adjustment = 0 percent
- c. Adjustment Percentage = 0 percent
- d. Total Potential Earnings =
 $(1,000 \times 80\% \times \$360 \times (1 - 0 \text{ percent})) = \$288,000$
- e. Total Earned Amount =
the lesser of \$288,000 and \$240,000, which equals \$240,000
- f. Reconciliation Payment =
 $\$240,000 - \$144,000 = \$96,000$

3. Result.

CMS shall pay the Participant a Reconciliation Payment of \$96,000.

C. Example 2 — Clinical Outcome Adjustment Applies

1. Inputs.

- a. Clinical Track: eCKM
- b. OAP Allowed Amount: \$360 per ACCESS Beneficiary
- c. Monthly OAP: \$24 per ACCESS Beneficiary, corresponding to the Medicare portion of the OAP Allowed Amount
- d. Reconciliation Cohort: 1,000 ACCESS Beneficiaries
- e. Assessment Cohort: 1,000 ACCESS Beneficiaries
- f. OAR: 40 percent
- g. OAT: 50 percent
- h. SSR: 95 percent

- i. SST: 90 percent
 - j. Total Billed Amount: \$240,000
 - k. Total Paid Amount: \$144,000
- 2. Calculation.
 - a. Clinical Outcome Adjustment =
 $1 - (40 \text{ percent} \div 50 \text{ percent}) = 20 \text{ percent}$
 - b. Substitute Spend Adjustment = 0 percent
 - c. Adjustment Percentage = 20 percent
 - d. Total Potential Earnings =
 $(1,000 \times 80\% \times \$360 \times (1 - 20 \text{ percent})) = \$230,400$
 - e. Total Earned Amount =
 the lesser of \$230,400 and \$240,000, which equals \$230,400
 - f. Reconciliation Payment =
 $\$230,400 - \$144,000 = \$86,400$
- 3. Result.
 CMS shall pay the Participant a Reconciliation Payment of \$86,400.

D. Example 3 — Substitute Spend Adjustment Applies

- 1. Inputs.
 - a. Clinical Track: eCKM
 - b. OAP Allowed Amount: \$360 per ACCESS Beneficiary
 - c. Monthly OAP: \$24 per ACCESS Beneficiary, corresponding to the Medicare portion of the OAP Allowed Amount
 - d. Reconciliation Cohort: 1,000 ACCESS Beneficiaries
 - e. Assessment Cohort: 1,000 ACCESS Beneficiaries
 - f. OAR: 40 percent
 - g. OAT: 50 percent
 - h. SSR: 70 percent
 - i. SST: 90 percent
 - j. Total Billed Amount: \$240,000
 - k. Total Paid Amount: \$144,000
- 2. Calculation.
 - a. Clinical Outcome Adjustment =
 $1 - (40 \text{ percent} \div 50 \text{ percent}) = 20 \text{ percent}$
 - b. Substitute Spend Adjustment =
 $1 - (70 \text{ percent} \div 90 \text{ percent}) = 22.2 \text{ percent}$
 - c. Adjustment Percentage = 22.2 percent
 - d. Total Potential Earnings =
 $(1,000 \times 80\% \times \$360 \times (1 - 22.2 \text{ percent})) = \$224,064$
 - e. Total Earned Amount =
 the lesser of \$224,064 and \$240,000, which equals \$224,064
 - f. Reconciliation Payment =
 $\$224,064 - \$144,000 = \$80,064$
- 3. Result.
 CMS shall pay the Participant a Reconciliation Payment of \$80,064.

E. Example 4 — Adjustment Cap Applies; No Additional Payment Is Owed

1. Inputs.

- a. Clinical Track: eCKM
- b. OAP Allowed Amount: \$360 per ACCESS Beneficiary
- c. Monthly OAP: \$24 per ACCESS Beneficiary, corresponding to the Medicare portion of the OAP Allowed Amount
- d. Reconciliation Cohort: 1,000 ACCESS Beneficiaries
- e. Assessment Cohort: 1,000 ACCESS Beneficiaries
- f. OAR: 20 percent
- g. OAT: 50 percent
- h. SSR: 95 percent
- i. SST: 90 percent
- j. Total Billed Amount: \$240,000
- k. Total Paid Amount: \$144,000

2. Calculation.

- a. Clinical Outcome Adjustment before applying cap=
 $1 - (20 \text{ percent} \div 50 \text{ percent}) = 60 \text{ percent}$
- b. Clinical Outcome Adjustment after applying cap= 50 percent
- c. Substitute Spend Adjustment = 0 percent
- d. Adjustment Percentage = 50 percent
- e. Total Potential Earnings =
 $(1,000 \times 80\% \times \$360 \times (1 - 50 \text{ percent})) = \$144,000$
- f. Total Earned Amount =
the lesser of \$144,000 and \$240,000, which equals \$144,000
- g. Reconciliation Payment =
 $\$144,000 - \$144,000 = \$0$

3. Result.

CMS shall not owe any additional Reconciliation Payment. CMS shall retain any applicable Withheld OAPs, and no further payment shall be made to the Participant for the applicable Reconciliation.

Appendix I – Reconciliation Rounds

TABLE 1. RECONCILIATION COHORTS AND CORRESPONDING RECONCILIATION ROUNDS.

Reconciliation Cohort Start Date*	Reconciliation Cohort End Date**	Reconciliation Round***
July 5, 2026	December 31, 2026	Spring 2028
January 1, 2027	June 30, 2027	Fall 2028
July 1, 2027	December 31, 2027	Spring 2029
January 1, 2028	June 30, 2028	Fall 2029
July 1, 2028	December 31, 2028	Spring 2030
January 1, 2029	June 30, 2029	Fall 2030
July 1, 2029	December 31, 2029	Spring 2031
January 1, 2030	June 30, 2030	Fall 2031
July 1, 2030	December 31, 2030	Spring 2032
January 1, 2031	June 30, 2031	Fall 2032
July 1, 2031	December 31, 2031	Spring 2033
January 1, 2032	June 30, 2032	Fall 2033
July 1, 2032	December 31, 2032	Spring 2034
January 1, 2033	June 30, 2033	Fall 2034
July 1, 2033	December 31, 2033	Spring 2035
January 1, 2034	June 30, 2034	Fall 2035
July 1, 2034	December 31, 2034	Spring 2036
January 1, 2035	June 30, 2035	Fall 2036
July 1, 2035	December 31, 2035	Spring 2037
January 1, 2036	June 30, 2036	Fall 2037

* This is the earliest date that Active Care Delivery could begin for CMS to include the ACCESS Beneficiary's claims and outcomes for the corresponding Reconciliation Round.

** This is the latest date that Active Care Delivery could begin for CMS to include the ACCESS Beneficiary's claims and outcomes for the corresponding Reconciliation Round.

*** CMS reserves the right to change the dates contained within this Appendix, with notice to be given in a form and manner specified by CMS.

Appendix J – Medical Director Acknowledgment and Attestation

This Medical Director Acknowledgment and Attestation (“**Attestation**”) is entered into by the undersigned Physician and Participant in connection with the Advancing Chronic Care with Effective, Scalable Solutions Model (“**ACCESS Model**”) Participation Agreement (“**Agreement**”) between the Participant and the Centers for Medicare & Medicaid Services (“**CMS**”) for the ACCESS Model.

The undersigned Physician hereby attests that:

1. I am a licensed Physician with active Medicare enrollment in good standing;
2. I have been designated as the Medical Director for the Participant pursuant to Section 4.04 of this Agreement;
3. I have read and understand the responsibilities associated with that role, including but not limited to those described in Section 4; and
4. I will carry out the responsibilities of the Medical Director position for the duration of my designation.

This Attestation does not make the undersigned Physician a party to the Agreement, nor does it create obligations or liabilities beyond those described in Section 4.04.

[LEFT BLANK INTENTIONALLY – SIGNATURE PAGE FOLLOWS]

MEDICAL DIRECTOR / PHYSICIAN:

Date:

Signature:

Name of Physician:

National Provider Identifier (NPI):

Email:

Phone Number / Extension: